Examiner®

Volume 37
Number 2
Summer 2012

Official Publication of the Society of Financial Examiners®

Examiner®

Volume 37 | Number 2 | Summer 2012
ISSN 0190-2733

Publisher
Society of Financial Examiners
12100 Sunset Hills Road | Suite 130
Reston, Virginia 20190
703.234.4140
800.787.SOFE (7633)
Fax 703.435.4390

Society Executive Committee
Michael Dinius, CPS, CFE | **President**
Richard. Foster, CFE | **Treasurer**
Sandra Bigglestone, CFE, CPA | **Secretary**

Vice Presidents
Eric Dercher, CFE
Ryan Havick ,CFE
Jenny Jeffers, CISA, AES
James Kattman, CFE
Annette Knief ,CFE
Wanda LaPrath, CFE
Neil Miller, CFE, CPA
Richard Nelson, CFE
Colette Hogan Sawyer, CFE, CPM
William Umbaugh, CFE ,AES

Immediate Past President
Dennis L. Kluk, CFE

Legal Counsel Pro Bono
William D. Latza, Esq.

Account Executive
L. Brackett

Editorial and Publications Committee
Jenny Jeffers, CISA, AES, Chair
Jean Adams, CPA, CFE, CISA, AES
Lewis D. Bivona, Jr., AFE, CPA
Tammy Gavin
Darlene Lenhart-Schaeffer, CFE
Jan Moenek, CFE, CRP, CIA, CBA, FLMI
Robert H. Moore, CFE
P. Sean O'Donnell, CFE, CPA
Joanne Smith

© Society of Financial Examiners

IN THIS ISSUE

7 **Get Full Value from Your Actuary: Integrating the Examining Actuary into the Risk Focused Exam**
John Humphries, ASA, MAAA, CFE, CISA, AES, MCM
Joanne Smith

11 **The State of IT in Financial Regulation**
Jerry Link, MCSE, CCA

20 **Reserving for Universal Life Policies with Secondary Guarantees and the Evolution of AG 38**
Dimitris Karapiperis, CIPR Research Analyst II

26 **Government Releases Summary of Benefits and Coverage and Uniform Glossary Final Regulations, Plus Separate Guidance Document, Templates and Instructions**
Towers Watson Digest

Articles in The Examiner reflect the views of the individual authors and do not necessarily represent the official position or views of the Society of Financial Examiners nor any state or federal agency.

CRE READING PROGRAM INSTRUCTIONS

The Society of Financial Examiners has a Reading Program for earning Continuing Regulatory Education credit by reading the articles in The *Examiner*.

You can earn 2 CRE credits for each of the 4 quarterly issues by taking a simple, online test after reading each issue for a maximum total of 8 CREs per year. There will be a total of 9–20 questions depending upon the number of articles in the issue. The passing grade is 66%.

To take the test, read all of the articles in the issue. Go to the Members section of the SOFE website to locate the online test. This is a password protected area of the website and you will need your user name and password to access it. If you experience any difficulty logging into the Members section, please contact sofe@sofe.org.

NOTE: The Reading Program Test from this issue and future issues of the Examiner will be taken online. You will no longer print out the test and send it in for scoring. Each new test will be available online as soon as possible within a week of the publication release. The Reading Program online tests are free. Scoring is immediate upon submission of the online test.

Earn Continuing Regulatory Education Credits by Reading The Examiner!

Retain a copy of your online test score in the event you are audited or if you need the documentation for any other organization's CE requirements. Each test will remain active for one year or until there is a fifth test ready to be made available. In other words, there will only be tests available for credit for four quarters at any given time.

The questions are on the following page. Good luck!

CRE READING PROGRAM QUESTIONS

All quizzes MUST be taken online

The Reading Program Test from this issue and future issues of the *Examiner* will be offered and scored online. Please see the details on the previous page.

All answers are True or False

Get Full Value from Your Actuary

True or False Questions — Submit Answers Online

1. Even though actuarial items and reserves tend to be larger or more volatile than most balance sheet accounts, the examination approach or framework is not the same as other balance sheet accounts.
2. Most overall inherent risks related to actuarial items and reserves are often "High" because of the use of estimates, complexity of calculations and professional judgment.
3. When conducting either Phase 3 internal controls testing or Phase 5 detail testing, the examiners should closely coordinate with the examining actuary in order to make sure that the data and fields tested are the data fields actually used for actuarial calculations.
4. It is not necessary for the examining actuary to actively participate during the process of considering and assessing prospective risk and other than financial reporting risk in Phases 1-4.

The State of IT in Financial Regulation

True or False Questions — Submit Answers Online

5. Cloud computing generally refers to a homogeneous user community.
6. Most Cloud computing technology is based on a wireless infrastructure
7. Most State IT support personnel are ill equipped / trained to provide proactive TeamMate support
8. State use of TeamMate & electronic work papers is a NAIC accreditation prerequisite.

continued on page 5

CRE READING PROGRAM QUESTIONS

(continued)

All quizzes MUST be taken online

Reserving for Universal Life Policies with Secondary Guarantees & the Evolution of AG 38

True or False Questions — Submit Answers Online

9. Universal Life contracts with secondary guarantees have received close scrutiny from regulators relating to their statutory accounting treatment.
10. With certain secondary guarantee products, the secondary guarantee remains in effect as long as the shadow fund is greater than or equal to zero, even if the policy account value is zero or negative.
11. Companies marketing these products are uniform in strict compliance with AG38.
12. The NAIC has taken efforts to resolve differences in interpretation by establishing a joint working group of the Life Insurance and Annuities (A) Committee and the Financial Condition (E) Committee which has issued a draft framework for evaluating policies issued before and after a certain date.

Government Releases Summary of Benefits and Coverage and Uniform Glossary

True or False Questions — Submit Answers Online

13. The applicability date for the requirements relating to the disclosures to participants and beneficiaries enrolling in a group health plan during open enrollment is April 14, 2012.
14. The SBC will be applied to account-type arrangements such as health FSAs, HRAs and health savings accounts.
15. One of the requirements to be included in the SBC is the renewability and continuation of coverage provisions.
16. Fines will not be imposed for failure to comply with the requirements of the SBC.

continued on page 6

CRE READING PROGRAM QUESTIONS

(continued)

All quizzes MUST be taken online

NAIC 2012 Spring Meeting Notes

True or False Questions — Submit Answers Online

17. At the NAIC Spring 2012 National Meeting, the Executive Committee and Plenary adopted a new model law to implement the ORSA requirement.

18. The Blanks Working Group adopted a proposal to add new instructions for risk retention groups (RRGs) that report on a GAAP basis, utilizing the NAIC "Yellow Book". The instructions clarify how certain GAAP items that are inconsistent with SAP should be reported.

19. The Financial Regulation Standards and Accreditation Committee adopted a revision to the Accreditation Guidelines requiring state insurance departments to notify the Examination Oversight Task Force if an exam report has not been issuedwithin 22 months of the examination "as-of" date.

20. The results of an NAIC survey of industry regarding risk-focused examinations disclosed no concerns or recommendations from industry regarding the risk-focused examination process.

Get Full Value from Your Actuary: Integrating the Examining Actuary into the Risk Focused Exam

By John Humphries, ASA, MAAA, CFE, CISA, AES, MCM

Joanne Smith

Get the Full Value of Your Actuary

Even though actuarial items and reserves tend to be larger or more volatile than most balance sheet accounts, the examination approach or framework is the same. The risk-focused process is intended to include actuarial risks just like all other risks. Therefore, the financial examiners should include the examining actuary as an integral team member in the risk-focused examination.

The Reserving Activity is no different than any other examination risk area. Examining actuaries should follow the same seven-phase risk-focused examination methodology when performing a review of the actuarial reserves for the statutory financial examination. This makes their assessments compatible with the work performed by the financial examiners, and it can be fully integrated into the financial examination file. The examining actuary can also prepare the reserving risk matrix in the same style as the other financial balances risk matrices. Of course, actuarial items have a unique set of risks, which must be properly identified and considered by the examining actuary. A basic understanding of these unique actuarial risks is essential for the Examiner-In-Charge, in order to more fully incorporate the examining actuary into the primary exam team.

Key financial reporting risks for actuarial items typically fall into the following four key risk areas that will be discussed in more detail below:

1. Assumptions and Methods
2. Performance of Calculations
3. Reporting of Results
4. Data Completeness and Accuracy

Don't overlook your actuaries, or keep them on the sidelines of the statutory financial examination. Make them an integral part of your team. Examining Actuaries can provide a valuable perspective to financial examiners during the risk focused examination process.

Assumptions and Methods

This risk refers to the assumptions and methods used by the Company to calculate the actuarially determined reserves. For this risk area, the overall inherent risk is often "High" because of the use of estimates and professional judgment in determining assumptions and methods. And while the Likelihood of unreasonable assumptions and methods may vary between "Low" and "Moderate-Low", the Impact will typically be "Severe" to "Threatening", because of the large reserve balances which compose a substantial percentage of surplus resulting in an Inherent Risk of at least "Moderate", if not "High". A number of controls are available to help mitigate the Assumptions and Methods risk such as the use of qualified actuaries, peer review and attestations, but these controls are generally not sufficient to be assessed as "Strong" because of the difficulty in fully controlling any areas that is heavily dependent on professional judgment.

continued on page 8

Performance of Calculations

This risk refers to the process by which the Company actually performs the actuarial calculations. For this risk area, the overall inherent risk is often "High" due to the complexity of actuarial calculations; however, there is also often more opportunity for stronger risk mitigation at the company-level. Systems which collect and record actuarial data (i.e. claims and underwriting) may have good internal controls in place, including automated controls, which can lead to strong mitigating controls. It is important for examiners to understand the difference between manual and automated controls. Manually executed controls can vary from occurrence to occurrence, so audit sampling is used to verify completeness and accuracy. Automated controls do not vary, so one or two sample items is often sufficient since the program will repeat the same control consistently. During Phase 3 testing of automated controls, examiners should consider and cover points where automated control vary from one application to another, such as for different products or line of business, and of course general controls over the entire system and any program changes.

Reporting of Results

This risk refers to the risk that the Company reports amounts that are materially different than amounts determined by the Company's appointed actuary. For this risk area, overall inherent risk can be "High" driven by the potential for "Severe" or "Threatening" impact. Fortunately, "Strong" risk mitigation is often possible for this risk through levels of management review and attestations such as the Actuarial Opinion and Memorandum that accompany financial reports.

Data Completeness and Accuracy

This risk refers to the risk that input data used in actuarial calculations is not complete and accurate. Since the actuaries place reliance on the data provided to them by the Company in order to calculate reserves, it is crucial that this information be not only accurate, but also fully complete. Discrepancies in data can lead to significant reserving issues. We have all heard the adage, "garbage in, garbage out", and reserving is no different. Strong risk mitigation of data risk is commonly possible with sophisticated transaction-oriented systems and associated controls that can be tested. When conducting either Phase 3 internal controls testing or Phase 5 detail testing, the examiners should closely coordinate with the examining actuary in order to make sure that the data and fields tested are the data fields actually used for actuarial calculations. Also be careful to not overlook key actuarial data such as account values for annuities, universal life products case basis reserves, and earned premium for casualty products

continued on page 9

Get Full Value from Your Actuary

(continued)

For all of the four actuarial risk areas described above, common risk mitigation strategies which are implemented by insurers include: the use of a qualified actuary to determine and set reserves, obtaining a signed Actuarial Opinion from an independent opining actuary on at least an annual basis, conducting an actuarial peer review of calculation processes, maintaining formally documented procedures of the reserving process, maintaining an audit trail of workpapers documenting the calculation process, and finally, producing Actuarial Reports.

All of these risk mitigation strategies are very good and considered best practices, but as Winston Churchill once said, "However beautiful the strategy, you should occasionally look at the results." The effectiveness of the Company's risk mitigation strategies must be carefully considered by both the examining actuary and the examination team. This is where close coordination and communication between the examining actuary and the financial examiners will become essential. The examining actuary can provide invaluable insights into the true strength of any actuarial risk mitigation strategy, and assist with the internal controls assessment in Phase 3.

Just as in the risk-focused examination process of any risk, the Residual Risk assessment is made during Phase 4. If Residual Risk is "Moderate" or "High", additional work will be needed. But what procedures and how much is necessary? Should reliance be placed on the work performed during the statutory audit, and did it cover all risk identified in the exam? The examining actuary should serve a lead role in the development of Phase 5 detail testing for actuarial items and reserves. This also includes any data testing to be conducted related to actuarial data to be sure that the proper data and fields within the data are tested. Additional procedures which focus on key emerging issues, adverse trends, or other concerns noted during planning and interviews may also be included in the Phase 5 testwork as coordinated with the examining actuary.

Actuarial Risk other than Financial Reporting Risks

The examining actuary should also participate actively during the process of considering and assessing prospective risk and other than financial reporting risk in Phases 1-4. The examining actuary can provide a unique perspective on a number of key risks such as pricing, underwriting, mortality, morbidity, hedging and asset liability matching.

continued on page 10

Get Full Value from Your Actuary

(continued)

Reaching the Risk-Focused Goal

Fully integrating the examining actuary into the examination team can lead to increased examination efficiency and effectiveness by allowing their expertise to specifically focus on actuarial risks throughout the entire examination process, and to call attention to key areas that might otherwise be overlooked by the financial examiners. Don't leave your actuary on the sidelines, make them an integral part of your team.

About the Authors

John Humphries, ASA, MAAA, CFE, CISA, AES, MCM is the Managing Partner of AGI Services, where he has worked exclusively with State Insurance Departments for the past twenty years as a consultant on examinations of Managed Care Organizations, Life and Accident companies, Property & Casualty companies, as well as numerous other regulatory projects covering both financial and market conduct issues. Because John's work is focused on the needs of regulators, he understands the regulatory process and works hard to identify both problems and solutions. John can be contacted at **humphries@agiservices.net** or **770-774-1102**.

Joanne Smith is an Examiner at AGI Services and serves on the SOFE Publications Committee. Joanne can be contacted at **smith@agiservices.net** or **770-774-1101** ext **219**.

Source:
Article modified from the "Actuaries and the Risk Focused Exam" presentation given at the 2011 SOFE Career Development Seminar in Jacksonville, FL.

continued on page 11

The State of IT in Financial Regulation

By Jerry Link, MCSE, CCA
Director of IT
INS Services, Inc.

I remember as if it was yesterday...

I was 12 yrs old and I had entered the city's first ever computer science competition. I worked all summer long, writing in Basic language on my Atari 800 computer with a television as the monitor and the blinking curser always eager for input. Three months later and 5,400 lines of code, I had developed my first video game. It was an action/role-play adventure called, "James Bond 007." Similar to the ever-popular Commodore 64 and Apple 2e game called Zork, for all you classic gamers, but with graphics and sound. It was ahead of its time; I was absolutely convinced of its superiority, ingenuity, and well let's be frank, it was really fun. I think my parents saw early on my gift of all things tech, and while they bought my now civil engineer brother model planes, cars, and ships every Christmas and birthday, I received either a new computer or accessory for the computer. My dad was an electrical engineer and he made sure we were always exposed to math and sciences, and in fact, encouraged us along those lines. He would include mathematics in our daily language, something like, "I think we need to dig a hole 4 feet down; do you know how many inches that is?" As I become older, I find myself doing the same with my 10 year old son.

It wasn't until I went to college that computers jumped back in my life and this time it was dominated by Windows 3.1 and Windows NT. As I entered Corporate America, Windows 95 and NT were dominating and corporations really didn't understand technology and how to use it to expand and increase efficiencies. Business led the way and IT followed, but the IT function was never fully incorporated into everyday business decisions such as operations, finance and accounting, logistics, administration, etc. We were all known as the company's "Computer Guy." Now every large organization has a CIO and realizes the potential of IT, how it can increase productivity and efficiency, and reduce overall costs. No more is this more apparent than in the insurance companies and banks we examine for financial solvency, market conduct, and IT assurance. As regulators, we must stay ahead, or at the very least parallel the technologies and policies that we enforce upon these entities.

What are the IT requirements to ensure security, efficiency, and cost effectiveness?

Do states have uniform standards that are shared and implemented amongst each other?

What technologies are available and are we as examiners using the correct tools to examine these companies properly?

— But have we?

— What are the IT requirements to ensure security, efficiency, and cost effectiveness?

continued on page 12

— Do states have uniform standards that are shared and implemented amongst each other?

— What technologies are available and are we as examiners using the correct tools to examine these companies properly?

— What is available and how can we implement them into our examination process?

— Can we make them more user-friendly and compatible to increase the efficiency of the exam?

— Is TeamMate the right product for us and are we using it to its full capacity?

— If not, why aren't we?

— What is the future of TeamMate and IT in financial regulation?

These are some of the questions we will pose, discuss, and examine in this article.

If we look at the role of IT in modern day financial regulation, and in particular, state insurance regulation, the transition to an electronic medium is relatively new. Some of you may remember performing insurance examinations with pen and paper. However, the younger generation has rarely completed an exam outside of TeamMate. There's that word. It has been part of my life, my very soul, if you will, since 2004.

I was a Systems Engineer for a state insurance department when I was first introduced to TeamMate. I was hired to design a more efficient way to utilize IT in the function to support our Insurance Regulatory Bureaus and in particular how to use and support TeamMate. When I arrived in late 2004, they were using TeamMate R7, installed both on local laptops and desktops, using a process called replication and using a Network Attached Storage device (NAS) for exam staff running examinations at the insurance companies' sites. As you all know, it is important to allow the exam staff to be able to share and access the TeamMate projects and data files, so in essence, they are collaborating and storing all the examination data on this NAS. My initial assessment was that this process was at the very least insecure, unstable, unreliable, inefficient and an administrative and support nightmare for the IT department. The success of examinations of billion dollar companies, and months, sometimes up to 18 months of work relied on the functionality of a $300 piece of hardware. Let alone the fact that it was left behind daily at the company site.

The success of examinations of billion dollar companies, and months, sometimes up to 18 months of work relied on the functionality of a $300 piece of hardware.

continued on page 13

The State of IT in Financial Regulation

(continued)

Never mind the fact every time you wanted to connect on VPN you ran the risk of disconnecting from the NAS and potentially losing all your work and corrupting the project for everyone else. Then, when the examination was completed, the NAS was brought in to the Department and so the examination data, including the TeamMate project, were moved to internal department servers for access by internal department staff and archiving for the purpose of NAIC accreditation. What is even more perplexing is that most of this process was handled by the exam staff and not IT professionals. Next, let's throw in the mix of replicas and backups and you have the combination of potential disasters. If any of you have performed an examination under these conditions, you have a nightmare story or two that you can laugh about now, but at the time lost a few hairs to the stress gods.

This type of setup and work process was similar, if not more advanced, than other states that had not implemented TeamMate and were barely using computers to run examinations at all. I had spent my entire career up until that point in the private sector and had worked the majority of that time for a Navy Defense Systems contractor and one of the largest telecommunications companies in the world. During that time, I got my feet wet on different systems; however, remote solutions was a new idea. A company called Citrix was leading the pack in providing solutions for running applications remotely, thanks to the increased broadband speeds and Microsoft Terminal Server technology. My employer at the time sent me to be trained in designing and supporting Citrix environments. Wall Street firms had started to use it and other Fortune 500 companies had implemented similar infrastructures. With my newly trained skill set in Citrix and the understanding of the business process and requirements for the design, I was designated project lead and charged with the task of designing and using Citrix to deploy customer and billing applications to our 2,000 customer care reps in four different locations around the country. Within six months, all customer care reps at our company were using Citrix to launch all applications. So, when I was employed by the state, I naturally saw the fit between TeamMate and Citrix and set out again to design an environment that allowed users of different locations access to applications via the web. Many state insurance agencies have since implemented Citrix for the purpose of deploying TeamMate but find added issues in supporting the environment. I have attended many TeamMate User Forums and the same problems we face as an industry; others are facing in other industries as well. I get asked about a plethora of complex problems and issues using TeamMate on Citrix environments every time I attend a TeamMate User Forum.

Within six months, all customer care reps at our company were using Citrix to launch all applications.

continued on page 14

The State of IT in Financial Regulation

(continued)

It is clear the majority of the problems organizations face in using the TeamMate applications deployed on Citrix can be summed up by two factors;

1) improper design *and*

2) Lack of experienced support.

Many of the organizations I have worked with allow IT professionals who do not have the expertise in Citrix and TeamMate to setup, configure, deploy, and support TeamMate environments running on Citrix. Citrix design and support is a specialized skill set that requires specialized training and experience including industry standard accreditations. We should also require our support staff to have experience in supporting the TeamMate applications and more importantly expertise in supporting TeamMate on Citrix. If Citrix environments are designed from the beginning by a Citrix expert for the purpose of deploying TeamMate and its supporting applications, then you will find this allows the support function to be more pro-active instead of re-active. Cloud technologies allow IT to design and provide pro-active solutions more easily accessible to users and quickly deploy upgrades, updates, patches, and new software to an entire user group or groups instantly.

I heard the term "Cloud Computing" for the first time at an IT conference in the late 90's where Steve Jobs was a guest speaker. During his presentation, he spoke mostly about the future of remote application deployment and the devices and software that IT professionals would have at their disposal in the very near future. Looking back it is obvious and easy to say, "Well of course," but you have to understand that he was talking about an age when devices didn't matter. Operating systems will no longer control how we use software; going back to terminal days of the late 70's and early 80's. He spoke of controlling your computer with a touch screen and said we had the broadband to thank for these new ideas, and reached up in the sky as to point to an infinite possibility and someone jokingly chirped, "Yeah right, we'll put it in the Cloud!"

Many considered Steve Jobs a genius and innovator, but I truly believe that he was a master systems integrator. What is an iPod but an MP3 and portable video player with an LCD and integrated mouse as a control mechanism? Manufacturers already had these on the shelves, but individually. Steve put them all together, and it was genius. What is the iPhone but a smart phone with iPod like function and accessibility to music, video, and Apps? This conference opened my eyes to the future of IT. Systems integrators are the new inventors of tomorrow, and I wanted to understand what makes a great systems integrator. To integrate systems that were once sepa-

continued on page 15

The State of IT in Financial Regulation

(continued)

rate or unmanageable, and to make them work more smoothly, took a very good understanding of all systems and applications. As we look at Cloud technologies, it makes sense to integrate systems so we can publish required applications to an exam staff via the World Wide Web. Now let's take it further. What if we are able to publish all applications that are needed to run an entire examination and make it accessible via a secure website which be accessed by any device anywhere in the world? Now we are talking! That is examination software in the Cloud. In order to do this well, and make it user-friendly, and most importantly make sure the applications that were designed for desktops can perform quickly or maybe even faster than they were designed to be, we must be experts in integrating systems. This was a major undertaking, but necessary to design unique environments such as this. Thanks to my years in the private sector designing Citrix systems and my work with the state agencies supporting insurance examiners, I had the perfect skill set to accomplish this goal. One thing we cannot ignore is the importance of understanding the business process, one that a Deputy Insurance Commissioner taught me when I worked for him all those years. His leadership and guidance during those years was an integral part of my concept and design behind the idea to run examinations in the Cloud. We IT professionals must understand how our users work and what is important to them so we can formulate concepts and designs, or in this case integrate for their specific purpose. All that was needed was to learn Cloud technologies.

What if we are able to publish all applications that are needed to run an entire examination and make it accessible via a secure website which be accessed by any device anywhere in the world?

Now we are talking!

That is examination software in the Cloud.

The Merriam-Webster dictionary defines Cloud Computing as, "Cloud computing refers to the delivery of computing and storage capacity as a service to a heterogeneous community of end-recipients. The name comes from the use of clouds as an abstraction for the complex infrastructure it contains in system diagrams. Cloud computing entrusts services with a user's data, software and computation over a network. It has considerable overlap with software as a service (SaaS). End users access cloud-based applications through a web browser or a lightweight desktop or mobile app, while the business software and data are stored on servers at a remote location. Proponents claim that cloud computing allows enterprises to get their applications up and running faster, with improved manageability and less maintenance, and enables IT to more rapidly adjust resources to meet fluctuating and unpredictable business demand. Cloud

continued on page 16

The State of IT in Financial Regulation

(continued)

computing relies on sharing of resources to achieve coherence and economies of scale similar to a utility (like the electricity grid) over a network (typically the Internet). At the foundation of cloud computing is the broader concept of converged infrastructure and shared services."

There are three most commonly used forms of Cloud technology, **SaaS** (software as a service), **PaaS** (platform as a service), and **IaaS** (infrastructure as a service). All three are considered Cloud computing technologies.

The most commonly used example is Gmail—a Web accessible email application that runs on a web browser; this is a perfect example of SaaS.

Another example is Rackspace—they provide hosting of your physical infrastructure only, so you do not have physical equipment in-house. Rackspace houses IT equipment, and IT staff are given access to them via the Web; this is considered IaaS. Our design at INS Services, Inc. to integrate all software required to run an insurance examination (Financial, IT, Market Conduct, and Financial Analysis) is considered Platform as a Service (PaaS), simply because we are doing more than providing applications on the Web, we are also managing backend systems, securing and managing data, managing both user and system credentials, and storing all of that in an offsite physical datacenter for physical security, backup, and redundancies. Following is an example of these three cloud technologies in visual format.

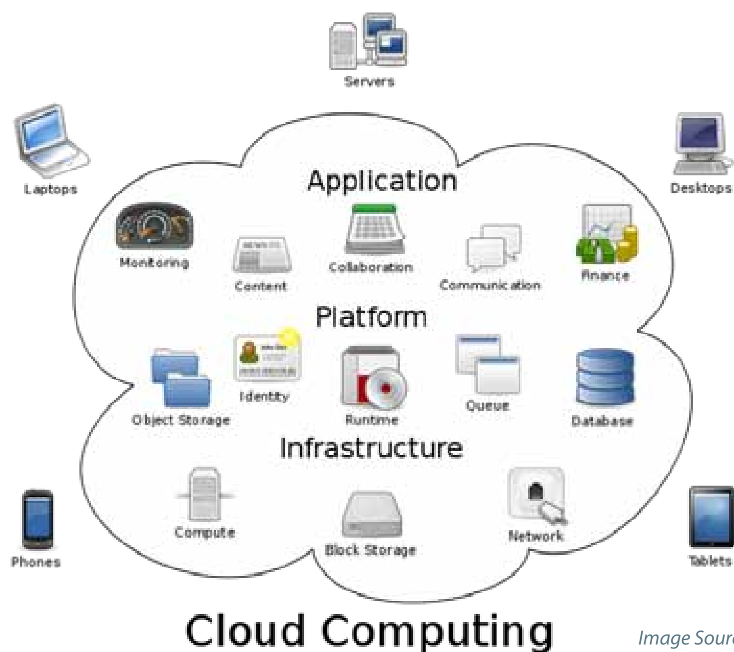

Image Source: Wikipedia

continued on page 17

The State of IT in Financial Regulation

(continued)

With the technology that is available today and the mediums to deliver technology, there should not be an organization that is not using what is right in front of them. Bill Gates said that we are in the horse and buggy age of computing, and with computing processors increasing exponentially every six months and the network bandwidths doubling every year, if you are not hosting your examinations in the cloud in the near future, then you will still be in the horse and buggy age. That will inherently create disastrous outcomes for insurance examinations. As one state advances, another will be left behind and in the insurance regulation game; we need to coordinate our data, efforts, and time, especially in multi-state exams. We all know how logistically difficult it is to coordinate a multistate examination, and in recent years we have been spoiled as far as IT is considered because a common version of TeamMate has been used. TeamMate R8 for the most part is a good desktop application. Similar to Windows XP, it has been around for years, we all learned on the job and devoted a lot of time troubleshooting and understanding how the application works and can have a conversation amongst users on how to fix the majority of the issues. TeamMate R8 was designed as a desktop application and so users were able to troubleshoot their own installs and it was easy to manage, although time-consuming and exhausting at first, a stable application. We were spoiled.

Now with the end of life support for R8 fast approaching, and the introduction of Teammate R9 and R10, we are left with a bucket full of problems. Each application has its own and unique problems. With the introduction of Teammate R9, CCH ushered in the ability to fully integrate all of the TeamMate components such as TeamCentral and TeamRisk. This required installation and management of a central database which in turn requires more support from your IT staff. All three different versions however are not compatible with each other, and if your organization has Teammate R9.1.1 you cannot open a R9.1.2 or R9.1.3 project. We IT professionals found this to be a problem on every level.

We must find a standard, not just in the application version, but in the work process: a central repository of technology specifically designed and supported for the purpose of state insurance regulation. This was, and will ever be, my charge.

What about TeamMate R10? As I mentioned before, all three applications are not compatible with each other, so as some organizations look to upgrade to R10 for its more stable design and compatibility with the newer MS Office versions. We are an industry that requires efficient, proper, and secure communication and coordination with each other; however, we are left with three applications not designed to be compatible. This more than anything else is the most important and dire challenge we must all face as TeamMate users in the Insurance Regulatory industry. We must find a standard, not just in the application version, but in the work process: a central repository of technology specifically designed and supported for the purpose of state insurance regulation. This was,

continued on page 18

The State of IT in Financial Regulation

(continued)

and will ever be, my charge. I left the state and now work for INS Services, Inc. I could not provide my designs and solutions to other states as a state employee, so now that I work in the private industry again, I can focus on this task. I believe that we at INS Services, Inc. have accomplished this goal with our new Cloud designs. These designs can and will provide a standard to all state insurance regulatory agencies. They allow an entire agency to work from anywhere, at anytime, with any device, with all applications required to run an entire insurance examination from a secure website without a VPN client. All data is therefore housed in a datacenter, and not on individual machines where they could be lost or corrupted and easily accessible. The Cloud is great for that purpose; if your computer breaks, you can login to the environment on any other device and all your work is still there waiting for you. We at INS Services are also introducing Virtual Desktops to our customers as well and feel that the future of examinations is in the Cloud.

TeamMate, ACL, MS Office, Adobe Pro are all solid applications. The problem is in how we use and support them. I honestly believe there is a major disconnect between examiners and IT professionals in state government. To properly implement and support TeamMate in a Cloud design you must first be an expert in TeamMate, both in its use and support. You must also be an expert in cloud technologies so you can properly support your people and the systems required to run your environment. You must also have a great understanding of the insurance examination process so you know how your users work, and what they need to efficiently complete an examination. Let us also understand the NAIC Accreditation process because many, if not all states, must pass the NAIC accreditation. Understanding this will help design the other pieces in your Cloud environment; and of course providing great customer service for all applications to your users. If TeamMate is not working properly, then the examiners suffer, so we must provide great customer service with speed and accuracy. In designing our cloud infrastructure at INS Services, Inc., we took all these considerations and made it available in most cases, within a week, another positive about Cloud. If we can consider how long the design, testing, implementation, and deployment takes for state IT, then we can really appreciate what the Cloud can do for all of us. We now have the option to avoid so many of the mistakes we have made in the past and demand something better. Especially when the cost can be allocated to the insurance companies you are examining. It is in the truest sense a service you are purchasing and not hardware, software, or personnel. But a service much like the kinds of other services you purchase for the purpose of

In designing our cloud infrastructure at INS Services, Inc., we took all these considerations and made it available in most cases, within a week, another positive about Cloud.

continued on page 19

The State of IT in Financial Regulation

(continued)

the examination. For most Departments, the expense is insignificant considering the cost of one examination or all your examinations in one year. The value far exceeds any other value added component in an examination and in some cases costs less than your staff's travel expenses alone. In choosing the correct vendor to provide this solution, you must take into account all the areas I spoke of earlier, expert in Citrix, TeamMate, cloud design experience, state insurance examination experience, NAIC Accreditation knowledge, and of course great customer service. I can't think of a reason why anyone would want to take on all of these responsibilities when you can contract them out to certified experts and gain years of expertise, have it available and supported for you in a week, so you and your staff can login and do what you do best, examinations.

I look forward to seeing all of you at the annual SOFE conference where I'm presenting and demonstrating TeamMate in the Cloud. By the way, to finish my story about my first computer science competition; I came in second; the 14 year old who won wrote an accounting program called Quick Bookkeeping; sound familiar?

About the Author

Jerry Link, MCSE, CCA is the Director of IT for INS Services, Inc., which provides IT hosting and consulting services. Jerry is a systems engineer, nationally recognized for his designs in virtualization and implementation of audit software including the TeamMate Suite of applications. He is a member of several national IT committees including the NAIC IT Audit Working Group where he led the group's efforts in providing guidance in standardizing the use and implementation of audit software. During his 18-year involvement with IT, Jerry has attained several industry accreditations including the Microsoft Certified Systems Engineer and Citrix Certified Administrator designations.

Reserving for Universal Life Policies with Secondary Guarantees and the Evolution of AG 38

By Dimitris Karapiperis
CIPR Research Analyst II

Introduction

Universal life policies with secondary guarantees (ULSG) have been around for more than 10 years and comprise a significant part of a growing segment of the life insurance market. A key profit driver and an important component in many life insurers' product portfolios, ULSG policies have been popular among those seeking affordable, guaranteed long-term life insurance. In a competitive market landscape and demanding economic environment ULSG policies' product design has been constantly evolving to meet insurers' core market and regulatory changes. Since the introduction of secondary guarantees, universal life contracts have attracted close scrutiny from insurance regulators in order to ensure the adequacy of statutory reserves for such products. Every step in product design complexity has been met with a corresponding regulatory measure to eliminate the possibility of any potential misalignment of guarantees and reserves.

The latest development is the currently unfolding discussion over the correct or intended regulatory interpretation of *Actuarial Guidance XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation* (AG 38) for the calculation of reserves for later designed ULSG policies. The dialog is occurring because regulators noticed insurers were using different interpretations of AG 38 to calculate reserves. Regulators are addressing the differing interpretations going forward to assure policyholders are protected, reserves are adequate and insurers are consistently interpreting regulatory guidance. The purpose of this article is to explain how ULSG policies work and to explore the public policy issues surrounding ULSG reserves.

ULSG Product Design

Universal life products offer permanent life insurance that will commonly run until the death of the insured or to maturity (usually when the insured reaches 95 years of age). A premium is paid for the insurance and a part of it is invested in a cash value element. The policy allows for premium flexibility and it will remain in force as long as premiums are paid or are funded from the cash value. Should premium payments cease and the cash value is extinguished, the policy automatically lapses.

To add to the appeal of universal life policies, insurers added secondary guarantees that would ensure the policy would not lapse even if the cash value dropped to zero or negative, if certain minimum premium payments equal to or greater than the cumulative premium requirement are made for a stipulated period. Due to the generally low premiums needed to satisfy the secondary guarantee, these policies could generate very modest cash surrender values or none at all. Generally, stipulated premium secondary guarantee policies allow limited funding flexibility although some offer a catch-up provision to make up the cumulative premium.

continued on page 21

Reserving for Universal Life Policies

(continued)

The addition of shadow fund accounts produced a more complex secondary guarantee design. In this design, there is no specific premium stated but instead the secondary guarantee remains in effect and, hence, the policy remains in force as long as the shadow fund is greater than or equal to zero, even if the policy account value is zero or negative. The shadow fund account works just like a policy cash account with interest credited and expenses and other charges debited. The shadow account though, only exists to keep the guarantee in effect as long as a positive balance is maintained. The cash in the shadow account is not available to the policyholder.

The latest step in ULSG product evolution involves a multi-fund shadow account design with multiple sets of shadow fund charges. The multiple sets of cost of insurance charges, credited interest rates and policy loads that apply to the shadow fund account are different from the cost of insurance charges, credited interest rates and policy loads that apply to the policy account value. Because the insurer can set the shadow account charges, shadow account credited interest rates and shadow account policy loads to any chosen level when the product is designed, the insurer can effectively control the desired level of the shadow account. Often, the shadow fund account has much lower levels of cost of insurance charges than the cost of insurance charges that apply to the policy account value.

The "Regulation XXX" Background and AG 38 Progress

Regulation XXX Section 7A(2) States:
"… the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in Subsections B and C below shall be recalculated from issue to reflect these changes."

When secondary guarantees for universal life products were first introduced, reserves were calculated according to the NAIC *Universal Life Insurance Model Regulation* (#585), which did not differentiate reserves for the existence of the secondary guarantees. As a result, statutory reserves for these policies did not account for the new product design.

In 2000, the NAIC *Valuation of Life Insurance Policies Model Regulation* (#830)—commonly referred to as Regulation XXX—was introduced to account for the secondary guarantees present in universal life contracts. Regulation XXX clarified how minimum gross premiums must be calculated. The regulation states that "the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads and expense charges) and the interest crediting rate, which are all guaranteed at issue."

continued on page 22

Reserving for Universal Life Policies

(continued)

While some contracts used specified-premium secondary guarantees captured by Regulation XXX, which treated them similarly to guaranteed level term contracts, others opted for the shadow fund account design in order to compensate for the increased XXX reserve requirements. As a response to these new complex product designs, AG 38 (also referred to as AXXX) was presented in 2003 to clarify reserve requirements for all universal life products that employ secondary guarantees, with or without shadow account funds. AXXX indicated that the minimum gross premiums are supposed to be the lowest schedule of premiums a policyholder could pay to satisfy the secondary guarantee.

Although AXXX was intended to track the extent to which secondary guarantees were prefunded (contracts that need less future premium to satisfy a secondary guarantee require larger reserves than those that need more future premium), the existence of certain ambiguities used by sophisticated shadow fund designs necessitated a further revision of AG 38 in 2005. Still, despite this revision, there was lack of uniformity in implementation by insurers. Regulators recognized that a number of companies, based on an alternative interpretation of AG 38, designed contracts that may have resulted in an imbalance of guarantees and reserves.

Regulation XXX Section 7A(4) also States:

"For purposes of this section, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation

The prospect of contracts with inadequate reserves for ULSG policies led some regulators to bring the issue to the NAIC's Life Actuarial (A) Task Force (LATF), which put forth a statement on AG 38 in September 2011 to caution about the possibility of some insurers holding "reserves [that] do not properly reflect the full benefits of the secondary guarantee as required by the law, regulation and guideline."

What's at the Core of the Debate?

A number of insurers created new ULSG products that appear to have been designed with an alternative interpretation of AG 38. According to this interpretation, the usage of shadow accounts, along with multiple sets of charges applied to these accounts, allows a calculation of minimum premiums that could result in comparatively lower reserves.

The reserve method for all ULSG policies begins with the calculation of the present value of future benefits less the present value of future valuation premiums. According to Regulation XXX, the minimum reserves during the

continued on page 23

Reserving for Universal Life Policies

(continued)

secondary guarantee period are the greater of the basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees and the minimum reserves required by other rules or regulations governing universal life plans.

The current debate revolves around a ULSG product design issued by several companies that employs two separate schedules of guaranteed charges that apply to the shadow fund account. The first schedule of guaranteed charges is low and applies as long as the shadow account value is greater than zero. The second set of guaranteed charges is much higher and applies when the shadow account value goes to zero or negative. The second set of guaranteed charges are the guaranteed charges that take a zero shadow account value at the beginning of the policy year to a zero shadow account value at the end of the policy year. When the company is calculating the reserves on the secondary guarantee, they are using the second (higher) set of guaranteed charges, which lowers the reserve and, in some cases, lowers the reserve significantly over what the reserve would be if the first (lower) schedule of guaranteed charges were used in the reserve calculation.

Regulators intended to account for these complexities when they developed AG 38 to clarify how reserves for ULSG policies subject to Regulation XXX are to be determined, defining the minimum gross premiums as those that will keep the secondary guarantee in effect. As noted above, the lower charges are guaranteed and they will keep the secondary guarantee in effect. If the shadow account value were going to go exactly to zero, the policyholder could deposit as little as a cent more than the low guaranteed set of charges to keep the shadow account value positive so the higher guaranteed set of charges never come into play. Therefore, the consensus position of the LATF was that this lower set of guaranteed charges should be considered the minimum gross premiums that keep the secondary guarantee in effect.

The companies' contention is centered on the fact that the purpose of AG 38, as an interpretive guidance to Regulation XXX, is to only interpret and not change.

Others contend the latest LATF statement on AG 38 attempts to define the term "minimum gross premiums" by introducing novel terms—such as the "lowest schedule of premiums"—that are not found in AG 38. Some life insurers instead, employ the definition of "minimum premiums" as the year-by-year premiums that satisfy the zero-to-zero description found in Section 7A(4) of Model Regulation XXX. The companies' contention is centered on the fact that the purpose of AG 38, as an interpretive guidance to Regulation XXX, is to only interpret and not change.

continued on page 24

Reserving for Universal Life Policies

(continued)

According to Section 7A(2) of Model Regulation XXX, if a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Hence, if the lower guaranteed set of charges produces a higher reserve than the higher guaranteed set of charges, Section 7A(2) requires the higher reserve must be held.

The phrase "more than one secondary guarantee" as found in the LATF statement, some would argue, is inconsistent with its original use in Regulation XXX, which referred to more than one secondary guarantee "period." Because Regulation XXX talks of secondary guarantee periods, and not guaranteed sets of charges and/or credits, these commenters maintain that the reference of the LATF statement to "more than one secondary guarantees" is confusing and inappropriate.

NAIC Efforts Towards Resolution

During the NAIC 2011 Fall National Meeting, the Executive (EX) Committee received the amended statement on AG 38 from the Life Insurance and Annuities (A) Committee as it was adopted by the LATF. The Executive (EX) Committee believed that, due to the interpretive differences on this issue and considering the sensitivities on all sides, it was sensible to forward the statement to the newly established Joint Working Group (of the Life Insurance and Annuities (A) Committee and Financial Condition (E) Committee) for further study instead of adopting it at that point.

The Joint Working Group is tasked with determining whether it is prudent and necessary to develop interim guidelines and/or tools to be utilized by regulators in evaluating reserves for ULSG policies. The interim nature of the guidelines and/or tools is due to the fact the future implementation of a principle-based reserving (PBR) system will render them inapplicable.

In January 2012, the Joint Working Group issued a draft framework for how to evaluate policies issued before a specified date (in-force business), as well as policies issued on and after a specified date (prospective business). As drafted, the first are to be treated as closed blocks of in-force business that would be evaluated by actuaries on a stand-alone basis to determine reserve adequacy. The second would be reserved using a formulaic approach consistent with the LATF's interpretation of AG 38 (as modified or clarified to address any questions regarding its requirements). Lastly, policies issued after the effective date of PBR would be reserved using PBR methodology.

continued on page 25

Reserving for Universal Life Policies

(continued)

The Joint Working Group noted that, before fully implementing the Framework, a number of key decisions still need to be made. These decisions will be made in an open process with input from regulators and interested parties. At the time this article was written, the Joint Working Group had released its draft framework for public comment and established a Jan. 30, 2012, deadline to receive comments. In a public news release, Texas Insurance Commissioner Eleanor Kitzman, chair of the Joint Working Group said, "This framework, in addition to the process in general, reflects the states' commitment to develop a uniform interpretation regarding existing reserving requirements for ULSG and term UL products, while also considering how reserves for these products should be set in the future."

This is a reprinted article.

Source: *This article was originally published in the January 2012 NAIC Center for Insurance Policy and Research (CIPR) newsletter. This article is reprinted with permission of the NAIC. Further distribution is prohibited.*

About the Author

Dimitris Karapiperis joined the NAIC in 2001 and he currently works as a research analyst with the Center for Insurance Policy and Research (CIPR). For nine years he worked as an analyst at the Financial & Insurance Market Research Group of the Securities Valuation Office of the NAIC covering economic and financial market trends and developments. He attended Rutgers University and New School for Social Research where he earned an M.A. in economics and pursued his Ph.D. specializing in macroeconomics and development economics.

continued on page 26

Government Releases Summary of Benefits and Coverage and Uniform Glossary Final Regulations, Plus Separate Guidance Document, Templates and Instructions

By Towers Watson Digest

Summary:

The Departments of Health and Human Services, Treasury and Labor (Departments) have issued the *"Summary of Benefits and Coverage and Uniform Glossary"* final regulations, as well as a separate corresponding document, *"Templates, Instructions, and Related Materials, and Guidance for Compliance."* The Patient Protection and Affordable Care Act (PPACA) amended the Public Health Service Act (PHSA) to require health insurers and group health plans offering health care coverage to enrollees and beneficiaries in a health plan to provide a Summary of Benefits and Coverage (SBC) and Uniform Glossary to those individuals. This information is intended to ensure that individuals enrolled in these plans receive an easy-to-understand summary of the benefits and coverage available under their plan. The final regulations address requirements on who must provide an SBC, to whom it must be provided, when it must be provided, as well as requirements for content and appearance, a Uniform Glossary, modifications of benefits and notice, preemption and penalties. This regulatory package provides templates, instructions and related materials, and compliance guidance.

Affected Entities:

The requirement to distribute the SBC and related material applies to group health plan sponsors and health insurance issuers in the group and individual markets, and applies to both non-grandfathered and grandfathered plans.

Effective Date:

These final regulations are effective **April 14, 2012**. However, the applicability date for the requirements applies for disclosures to participants and beneficiaries who enroll or reenroll in group health coverage through an open enrollment period beginning on the first day of the first open enrollment period that begins on or after **September 23, 2012**. For disclosures to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the requirements under the final regulations apply beginning on the first day of the first plan year that begins on or after **September 23, 2012** (i.e., January 1, 2013, for a calendar-year plan).

continued on page 27

Government Releases Summary of Benefits and Coverage

(continued)

Key Implications:

While the final regulations offer relief and flexibility for some of the requirements imposed by the proposed SBC regulations (August 2011), the final regulations continue to impose a significant undertaking for plan sponsors and insurers, and pose employee communication and vendor coordination challenges. Initially drafted with the assistance of the National Association of Insurance Commissioners (NAIC), the proposed regulations focused heavily on insurers and the insurance industry. The application of the proposed regulations to self-insured plans was awkward, and deadlines were tight.

The proposed regulations left open many issues, including, for example, the SBC's treatment of account-based arrangements (e.g., health reimbursement arrangements [HRAs]) integrated with major medical plans, wellness and disease management programs, and the unique operation of pharmacy benefits. Among other items detailed below, the final regulations provide that a separate SBC does not need to be furnished where a health flexible spending arrangement (health FSA) or HRA is integrated with major medical coverage. The final regulations provide flexibility for plan designs that "do not fit the mold" set out in the template instructions, such as certain tiered pharmacy benefits or a wellness or disease management program that reduces cost sharing. Allowing for flexibility in the description of such benefits, the final regulations tell plan sponsors and insurers to do the best they can to conform: "The plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still consistent with the instructions and template format as reasonably possible."

The final regulations provide flexibility for plan designs that "do not fit the mold" set out in the template instructions, such as certain tiered pharmacy benefits or a wellness or disease management program that reduces cost sharing.

The proposed regulations required plans to be ready to distribute the SBC beginning March 23, 2012. The final regulations extend that date, generally requiring compliance by the first open enrollment period beginning on or after September 23, 2012. This provision also clarifies that a mass distribution is not required until open enrollment. Plans will need to work quickly to create SBCs that meet the regulatory standards. The regulations, however, provide some flexibility in terms of form, content and distribution (i.e., SBCs may be provided electronically in some instances, and the requirement to provide premium and cost of coverage information has been removed). Additionally, the final regulations reduce the number of plan-specific information required, including the need to draft examples of how certain benefits will be calculated under the plan (i.e., the required coverage examples have been reduced from three to two).

continued on page 28

Government Releases Summary of Benefits and Coverage

(continued)

The final regulations continue to mandate compliance by all large group health plans, including self-insured plans. This means that even large employers with streamlined communications and benefit enrollment processes need to comply. Plan sponsors should consider how their enrollment materials will change to incorporate this requirement. The plan will need to consider whether to continue current practices and incorporate the addition of an SBC, or to change current practices all together. Furthermore, plan sponsors should consider how and from whom employees will receive this information. Because an SBC is required for each option offered by the insurer or plan, a plan sponsor providing a variety of insured and self-insured benefits should consider whether employees will receive SBCs directly from vendors or only from the group health plan, as well as how they will coordinate efforts with their insurers and other vendors, such as third-party administrators.

General Information and Discussion

Under the PPACA amendments to the PHSA, a four-page summary of benefits and coverage (SBC) must be provided to applicants and enrollees before enrollment or reenrollment. The SBC must "accurately describe the benefits and coverage under the applicable plan or coverage." Accordingly, the final regulations apply to both group health plans and health insurance issuers offering health insurance coverage.

The Departments issued final regulations on the SBC and Uniform Glossary. In addition, they separately issued SBC and Uniform Glossary templates, instructions and related materials, as well as guidance for compliance.

Final Regulations

Cost of the SBC—The SBC must be provided in writing and free of charge.

Applicability to ERISA Plans—Commenters asked the Departments to exempt large or self-insured group health plans from the requirement to provide the SBC because ERISA currently requires the plans to provide information, including summary plan descriptions (SPDs) and open enrollment materials that accurately describe the plan and any coverage options. Noting that the PPACA includes no exemption for those plans, the regulations maintain the application of the SBC's uniform format and appearance requirements for large or self-insured group health plans. The Departments contend that by complying with the SBC requirements, it will make it easier for individuals to compare coverage options across different types of plans and insurance products, including those offered through the public Exchanges (Exchanges) beginning in 2014.

continued on page 29

Government Releases Summary of Benefits and Coverage

(continued)

Applicability to Certain Account-Type Arrangements:

The Departments also confirmed the application of the SBC to all group health plans, including certain account-type arrangements such as health FSAs, HRAs and health savings accounts (HSAs):

Health FSA—An SBC is not required for plans, policies or benefit packages that constitute "excepted benefits" under HIPAA. So, for example, an SBC need not be provided for a stand-alone dental or vision plan or health FSA as long as the plans are excepted benefits under HIPAA. If benefits under a health FSA are not excepted benefits, the health FSA is a group health plan generally subject to the SBC requirements. If a health FSA is not an excepted benefit, but is integrated with other major medical coverage, the SBC should be prepared for the other major medical coverage. The effects of the health FSA can be shown in the appropriate spaces on the SBC for deductibles, copayments, coinsurance and benefits otherwise not covered by the major medical coverage. A stand-alone health FSA that is not an excepted benefit must satisfy the SBC requirements independently.

HRA—An HRA is a group health plan. The preamble of the final regulations provides that an HRA generally is not considered an excepted benefit, so HRAs are generally subject to the SBC requirements. A stand-alone HRA generally must satisfy the SBC requirements, even though many of the limitations that apply under traditional fee-for-service or network plans do not apply. An HRA integrated with other major medical coverage need not separately satisfy the SBC requirements; the SBC is prepared for the other major medical coverage, and the effects of employer allocations to an account under the HRA can be shown in the appropriate spaces on the SBC for deductibles, copayments, coinsurance and benefits otherwise not covered by the other major medical coverage.

HSA—HSAs generally are not group health plans, and thus not subject to the SBC requirements. Even so, an SBC prepared for a high-deductible health plan (HDHP) associated with an HSA can mention the effects of employer contributions to HSAs in the appropriate spaces on the SBC for deductibles, copayments, coinsurance and benefits not otherwise covered by the high-deductible health plan.

continued on page 30

Government Releases Summary of Benefits and Coverage

(continued)

When and to Whom an SBC Is to Be Provided:

Generally, an SBC will be provided:

1. By a group health insurance issuer to a group health plan
2. By a group health insurance issuer and a group health plan to participants and beneficiaries
3. By a health insurance issuer to individuals and dependents in the individual market

In general, the proposed regulations directed that, in each of these scenarios, the SBC be provided when an employer or individual is comparing health coverage options, including prior to purchasing or enrolling in a particular plan or policy.

The proposed regulations specified that an SBC had to be provided as soon as practicable following an application for health coverage or a request for an SBC, but in no event later than seven calendar days following the application or request. The final regulations substitute a seven-business-day period for the seven-calendar-day period.

In addition to applicants, participants and beneficiaries, under the final regulations, SBCs must be provided to special enrollees. The proposed regulations would have required that the SBC be provided within seven calendar days of a request for special enrollment, but the final regulations do not provide expedited treatment for special enrollees. The final regulations provide that special enrollees must be given the SBC no later than 90 days from enrollment (i.e., when an SPD is required to be provided under ERISA). The preamble to the regulations notes that if an individual is eligible for special enrollment and would like to receive an SBC earlier to help choose a coverage option, he or she may request an SBC for any plan, policy or benefit package, and the SBC is required to be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

SBC Provided at Renewal or Reissuance of Coverage:

The final regulations retain the proposed regulations provision that, if written application materials are required for renewal, the SBC must be provided no later than the date on which the application materials are distributed. In addition, upon an automatic renewal of coverage, the Departments have provided some flexibility with respect to when an SBC must be furnished.

continued on page 31

Government Releases Summary of Benefits and Coverage

(continued)

The final regulations generally require that, if renewal or reissuance of coverage is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year. However, for insured coverage, in situations in which the SBC cannot be provided within this time frame (i.e., because the issuer and the purchaser have not yet finalized the terms of coverage for the new policy year), the final regulations provide an exception. Here, the SBC must be provided as soon as practicable, but in no event later than seven business days after the issuance of the policy, or the receipt of written confirmation of intent to renew, whichever is earlier. The regulations provide this flexibility only when the terms of coverage are finalized in fewer than 30 days in advance of the new policy year; otherwise, the SBC must be provided upon automatic renewal no later than 30 days prior to the first day of coverage under the new plan or policy year.

Provision of the SBC by an Issuer to a Plan:

The final regulations require a health insurance issuer offering group health insurance coverage to provide an SBC to a group health plan (including, for this purpose, its sponsor) upon an application by the plan for health coverage.

Initial SBC — The SBC must be provided as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. If the information is unchanged, the SBC does not need to be provided again in connection with coverage for that plan year, except upon request.

Updated SBC — If there is any change to the information required to be in the SBC before the first day of coverage, the issuer must update and provide a current SBC to the plan no later than the first day of coverage.

Omitting premium or cost of coverage information as a required element of the SBC — The Departments believe that the number of circumstances in which issuers will have to provide a second SBC will be significantly fewer under the final regulations than they would have been under the proposed regulations.

Provision of the SBC by a Plan or Issuer to Participants and Beneficiaries:

Under the final regulations, a group health plan (including the plan administrator) and a health insurance issuer offering group health insurance coverage must provide an SBC to a participant or beneficiary for each benefit package offered by the plan or issuer for which the participant or beneficiary is

continued on page 32

Government Releases Summary of Benefits and Coverage

(continued)

eligible. The final regulations retain the requirement that the SBC be provided to participants and beneficiaries, as well as special enrollees, as discussed above. However, the final regulations include an anti-duplication rule under which a single SBC may be provided to a family unless any beneficiaries are known to reside at a different address. Accordingly, separate SBCs need to be provided to beneficiaries only in limited circumstances.

Provision of the SBC Upon Request in Group Health Coverage:

The final regulations retain the proposed regulations' provision that an issuer must provide an SBC to a group health plan (and a plan or issuer must provide the SBC to a participant or beneficiary) upon request (including prior to submitting an application for coverage) for an SBC or summary information about the health coverage as soon as practicable, but no later than seven business days following receipt of the request.

Special Rules to Prevent Unnecessary Duplication with Respect to Group Health Coverage:

The final regulations also include special rules to prevent unnecessary duplication in the provision of SBCs with respect to group health coverage. The proposed regulations provided three rules to streamline provision of the SBC and prevent unnecessary duplication. The final regulations retain these special rules, with some changes:

(1) the requirement to provide an SBC generally will be considered satisfied for all entities if it is provided by any entity, so long as all timing and content requirements are satisfied,

(2) a single SBC may be provided to a participant and any beneficiaries at the participant's last known address, and

(3) if a beneficiary's last known address is different from the participant's last known address, a separate SBC must be provided to the beneficiary at the beneficiary's last known address, and under the rule providing that SBCs are not required to be provided automatically upon renewal for benefit packages in which the participant or beneficiary is not enrolled, a plan or issuer generally has up to seven business days (rather than seven calendar days, under the proposed regulation) to answer a request to provide the SBC with respect to another benefit package for which the participant or beneficiary is eligible.

continued on page 33

Government Releases Summary of Benefits and Coverage

(continued)

SBC Required Content—The SBC must include:

- Uniform definitions of standard insurance terms and medical terms so that consumers can compare health coverage and understand the terms of (or exceptions to) their coverage
- A description of the coverage, including cost sharing, for each category of benefits identified by the Departments
- The exceptions, reductions and limitations on coverage
- The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations
- The renewability and continuation of coverage provisions
- A coverage facts label that includes examples to illustrate common benefit scenarios (including pregnancy, and serious or chronic medical conditions) and related cost sharing based on recognized clinical practice guidelines
- A statement about whether the plan provides minimum essential coverage and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements
- A statement that the SBC is only a summary and that the plan document, policy or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage
- A contact number to call with questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained

The proposed regulations added four additional content elements as recommended by the NAIC. The final regulations retain the first two proposed additions without change, modify the third and delete the fourth (regarding provision of premiums or cost of coverage), as follows:

- If a plan has one or more networks of providers, it must provide an Internet address (or similar contact information) for obtaining a list of the network providers.
- If a plan has a prescription drug formulary, it must provide an Internet address where an individual may find more information about the prescription drug coverage under the plan or coverage
- Information must be provided for obtaining copies of the Uniform Glossary, including an Internet address where an individual may review the Uniform Glossary, a contact phone number to obtain a paper copy of the Uniform Glossary and a disclosure that paper copies of the Uniform Glossary are available.

continued on page 34

Government Releases Summary of Benefits and Coverage

(continued)

The final regulations delete the requirement to provide information on premiums and cost of coverage because of the administrative and logistical complexity of providing this information to individuals (i.e., when premiums differ based on family size, and when, in the group market, employer contributions impact cost of coverage).

Minimum Essential Coverage and Minimum Value Statement:

The SBC is also required to include a statement about whether a plan or coverage provides minimum essential coverage (minimum essential coverage statement) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable minimum value requirements (minimum value statement). The final regulations provide a delayed applicability date for this requirement. The minimum essential coverage and minimum value statements must be included in SBCs with respect to coverage beginning on or after January 1, 2014, when the public Exchanges and "play-or-pay penalty" have been implemented. Future guidance will address the minimum essential coverage and minimum value statements.

Coverage Facts Label:

An SBC must contain a "coverage facts label," known in the proposed regulations as "coverage examples." The final regulations retain the general approach to the coverage examples, but phase in the implementation of the coverage examples. The Departments believe such examples will facilitate understanding of the benefits and limitations of a plan or policy and help individuals make more informed choices about their options.

Expatriate Coverage:

In lieu of summarizing coverage for items and services provided outside the U.S., the final regulations state that a plan or issuer may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the U.S. Also, to the extent the plan or policy provides coverage available in the U.S., the plan or issuer is still required to provide an SBC that accurately summarizes benefits and coverage available in the U.S.

continued on page 35

Appearance:

The SBC must be presented in a uniform format¸ using terminology understandable by the average plan enrollee that does not exceed four pages in length and does not include print smaller than a 12-point font. The final regulations retain the interpretation in the proposed regulations that the four-page limitation is four double-sided pages.

In response to requested comments, the final regulations allow SBCs furnished in connection with group health plan coverage to be provided either as a stand-alone document or in combination with other summary materials (for example, an SPD), as long as the SBC information is intact and prominently displayed at the beginning of the materials (such as immediately after the Table of Contents in an SPD) and in accordance with the timing requirements for providing an SBC.

Form:

The proposed regulations and final regulations allow the SBC to be provided in writing or electronically, as long as certain requirements are met. The final regulations generally retain the approach from the proposed regulations with respect to an SBC provided electronically by an issuer to a plan. For SBCs provided electronically by a plan or issuer to participants and beneficiaries, the final regulations make a distinction between a participant or beneficiary who is already covered under the group health plan and a participant or beneficiary who is eligible for coverage but not enrolled in a group health plan. For participants and beneficiaries who are already covered under the group health plan, the final regulations permit provision of the SBC electronically if the requirements of the Department of Labor's electronic distribution regulations are satisfied. For participants and beneficiaries who are eligible for but not enrolled in coverage, the final regulations permit the SBC to be provided electronically if the format is readily accessible and a paper copy is provided free of charge upon request. Additionally, if the electronic form is an Internet posting, the plan or issuer must, in a timely manner, advise the individual in paper form (such as a postcard) or e-mail that the documents are available on the Internet, provide the Internet address and notify the individual that the documents are available in paper form upon request. Finally, as in the proposed regulations, plans, and participants and beneficiaries (both covered, and eligible but not enrolled) have the right to receive an SBC in paper format, free of charge, upon request.

continued on page 36

Government Releases Summary of Benefits and Coverage

(continued)

Language:

The SBC must be "presented in a culturally and linguistically appropriate manner." The final regulations

retain the approach of the proposed regulations and provide that, to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules for providing notices with respect to claims and appeals in a culturally and linguistically appropriate manner under the claims and appeals language of the PHSA and its implementing regulations.

Notice of Modification:

Under the final regulations, if a material modification is made to any of the terms of the plan or coverage that would affect the content of the SBC, the plan or issuer must provide notification of the modification no later than 60 days prior to the date on which the modification will become effective. This rule applies only for modifications other than those in connection with a renewal or reissuance of coverage For ERISA-covered group health plans, this notice is required in advance of the timing requirements under the DOL's regulations for providing a summary of material modification (SMM) (generally not later than 210 days after the close of the plan year in which the modification or change was adopted or, in the case of a material reduction in covered services or benefits, not later than 60 days after the date of adoption of the modification or change). Where a complete notice is provided in a timely manner under the PHSA, an ERISA-covered plan will also satisfy the requirement to provide an SMM under ERISA.

Under ERISA, a material modification includes any change to the coverage offered under a plan or policy that, independently, or in conjunction with other contemporaneous modifications or changes, would be considered by an average plan participant to be an important change in covered benefits or other terms of coverage under the plan or policy. The final regulations provide examples of material modifications:

- — An enhancement of covered benefits or services, or other more generous plan or policy terms
- — Coverage of previously excluded benefits or reduced cost sharing
- — A material reduction in covered services or benefits
- — More stringent requirements for receipt of benefits
- — Changes reducing or eliminating benefits, increasing cost sharing or imposing a new referral requirement

continued on page 37

Government Releases Summary of Benefits and Coverage

(continued)

The Departments note, however, that changes to the information in the SBC because of changes in regulatory requirements are not changes to the plan or policy requiring a midyear notification, unless specified in such new requirements.

Uniform Glossary:

In accordance with the PHSA, the Departments developed standards for definitions of common insurance-related and medical terms, as well as other terms to help consumers understand and compare the terms of coverage and the extent of medical benefits (including any exceptions and limitations):

Insurance-Related Terms—Coinsurance, copayment, deductible, excluded services, grievance and appeals, non-preferred provider, out-of-network copayments, out-of-pocket limit, preferred provider, premium and UCR (usual, customary and reasonable) fees

Medical Terms—Durable medical equipment, emergency medical transportation, emergency room care, home health care, hospice services, hospital outpatient care, hospitalization, physician services, prescription drug coverage, rehabilitation services and skilled nursing care

Other Terms—Allowed amount, balance billing, complications of pregnancy, emergency medical condition, emergency services, habilitation services, health insurance, in-network coinsurance, in-network copayment, medically necessary, network, out-of-network coinsurance, plan, preauthorization, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, specialist and urgent care

The final regulations make only minor changes to the Uniform Glossary, including a disclaimer that the terms and definitions of terms in particular plans or policies may differ from those in the glossary and information on how to get a copy of the actual policy or plan document. Like the proposed regulations, the final regulations direct a plan or issuer to make the Uniform Glossary available upon request within seven business days. This requirement is satisfied if the SBC includes an Internet address where an individual may review and obtain the Uniform Glossary, a contact phone number to obtain a paper copy of the Uniform Glossary and a disclosure that paper copies are available upon request. The Internet address may be a place where the document can be found on the plan's or issuer's website, or the website of either the DOL or HHS. However, a plan or issuer must make a paper copy of the glossary available within seven business days upon request. Plans and issuers must provide the Uniform Glossary in the appearance specified by the Departments, so that the glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee.

continued on page 38

Government Releases Summary of Benefits and Coverage

(continued)

Preemption:

The SBC and Uniform Glossary provisions are incorporated into the PHSA, ERISA and the Internal Revenue Code, and are subject to the preemption provisions of ERISA and the PHSA. The final regulations do not prevent states from imposing separate, additional disclosure requirements on health insurance issuers. However, if a state imposes lesser requirements regarding SBCs, those requirements will be preempted. Finally, if states require health insurance issuers to provide information not contained in the SBC or Uniform Glossary, they may require issuers to provide that information only if it is provided in a document that is separate from the SBC. This separate document can, however, be provided at the same time as the SBC.

Failure to Provide:

The law provides that a group health plan (including its administrator) or issuer that willfully fails to provide the SBC will be subject to a fine of not more than $1,000 for each such failure. In addition, a separate fine may be imposed for each individual or entity for whom there is a failure to provide an SBC. Because this law is enforced by three different government departments (HHS, Treasury and DOL), the mechanisms for imposing the new penalty vary slightly and are discussed in the final regulations.

Templates, Instructions and Related Materials; and Guidance for Compliance

Templates, Instructions and Related Materials—The Departments have made available at (cciio.cms.gov and dol.gov/ebsa/healthreform) the SBD template, sample completed template, instructions, "why this matters" language and coverage examples.

Documents Authorized for the First Year of Applicability—The documents posted by the Departments (SBC template, with instructions, samples and a guide for coverage example calculations and the Uniform Glossary) may only be used with respect to coverage beginning before January 1, 2014 ("the first year of applicability"). The Departments intend to issue updated materials for later years.

Coverage Examples—The Departments have retained only two of the proposed three coverage examples (maternity and diabetes). They also modified some of the language to clarify that the coverage examples are not intended to demonstrate costs for an actual specific person (for example, "You Pay" was changed to "Patient Pays").

continued on page 39

Government Releases Summary of Benefits and Coverage

(continued)

Appearance:

This guidance reiterates that the SBC can be provided as a stand-alone document or as part of an SPD, as discussed above. In addition, the guidance allows the SBC to be provided in color or gray scale.

Special Rule:

Generally, health plans and issuers must use the full SBC template. However, the guidance provides that if a plan's terms that are required to be described in the SBC template cannot reasonably be described consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still consistent with the template and instructions format as reasonably possible. Examples of these situations include (1) a plan provides a different structure for provider network tiers or drug tiers from the SBC and instructions template, (2) the plan denotes the effects of a related health FSA or HRA, and (3) a plan provides different cost sharing based on participation in a wellness program.

Language:

As discussed above, the SBC must be issued in a culturally and linguistically appropriate manner as provided under the PHSA claims and appeals rules. Under those rules, plans and issuers must provide notices in a culturally and linguistically appropriate manner when 10% or more of the population residing in the claimant's county are literate only in the same non-English speaking language. Currently, 255 U.S. counties (including 78 in Puerto Rico) meet this threshold. To help plans and issuers meet the language requirements, HHS will provide (at cciiio.cms.gov) written translations of the SBC template and Uniform Glossary in several languages.

Uniform Glossary:

According to the guidance, the Uniform Glossary of health coverage and medical terms may not be modified by plans or issuers. The Departments have made several changes to the glossary:

- Changed "policy" and "insurer" to "coverage" and "plan," to make the terms more appropriate for self-insured plans
- Modified the description of rights to continue coverage to reference federal and state protections more generally and include contact information for questions
- Changed "policy period" to "coverage period"

Government Releases Summary of Benefits and Coverage

(continued)

— Revised the disclaimer language to clarify that the glossary is intended to be educational and that the definitions in the glossary may not be the same as the definitions used by a particular plan or insurer

— Removed the premium information from the SBC template in accordance with the final regulations' deletion of that item

— Specify that to the extent that a plan's terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still consistent with the instructions and template format as reasonably possible

Source:

This article orginally appeared in the February 2012 edition of the U.S. Health Care Reform Bulletin, published by Towers Watson Digest.

Reprinted with permission.

© 2012 Towers Watson

For more information, please visit ***www.towerswatson.com***

AUTHORS WANTED

The Publications Committee is looking for members to write articles for the quarterly Examiner magazine. Authors will receive six Continuing Regulatory Credits (CRE) for each technical article selected for publication.

Interested authors should contact the Publications Committee Chair, **Jenny Jeffers**, via **sofe@sofe.org**.

www.pwc.com/us/en/insurance

NAIC Meeting Notes

Global Insurance Industry Group, Americas

NAIC 2012 Spring National Meeting

The National Association of Insurance Commissioner held its Spring National Meeting in New Orleans March 1-6. This newsletter contains information on activities that occurred in some of the committees, task forces and working groups that met there. For questions or comments concerning any of the items reported, please feel free to contact us at the address given on the last page.

pwc

Executive Summary

- The NAIC gave final adoption to the ORSA Guidance Manual and approved the accompanying request to develop a new model law to implement the requirement by statute. (page 2)
- The Commissioners narrowly approved on November 22 a resolution to "expeditiously consider legislation amending the MLR provisions of the PPACA in order to preserve the consumer access to agents and brokers." The resolution was rejected by HHS shortly thereafter. (page 3)
- The joint working group of the Life Insurance and Annuities and Financial Condition Committees made significant progress on its project related to reserving for universal life products with secondary guarantees; separate guidance will be developed for in-force and prospective business. (page 3)
- The Statutory Accounting Principles Working Group adopted as final SSAP 92 on OPEB, SSAP 102 on pensions, SSAP 103 on transfers of financial assets and Issue Paper 129 on share-based payments. The working group exposed for comment an SSAP 101 Question and Answers Implementation Guide for income taxes, but deferred adoption of the controversial proposed guidance on accounting for the annual fee mandated by the federal government under PPACA. (page 4)
- The Capital Adequacy Task Force is close to adoption of significant revisions to the 2012 RBC factors for deferred tax assets that would be consistently applied for all three formulas. The regulators adopted the current factors for commercial mortgages through 2012 and heard a more detailed report of the long-term commercial loan proposal. The C-1 Factor Review Subgroup continues to study a recalibration of RBC C-1 risks and is considering a "plus/minus" scale to augment 2, 3 and 4 rated securities. The Life RBC Working group has a new chair and met for the first time in over a year. The Catastrophe Risk Subgroup hopes to expose for comment shortly a proposed narrative disclosure of catastrophe risk for the 2012 RBC filing while work on the catastrophe risk formula continues. (pages 7)
- The SMI Task Force voted to expose a draft white paper describing its conclusions thus far on the future of US insurance regulation. The Group Solvency Issues Working Group agreed with industry that the ORSA requirement should be adopted through a new standalone model law, expected to be developed by the end of the year. The ORSA Subgroup was formed to oversee an ORSA feedback project and work on other implementation issues. (page 10)
- The International Accounting Standards Working Group heard updates on ComFrame and the insurance contracts and financial instruments projects of the FASB and IASB. (page 13)
- The Valuation of Securities Task Force approved a new policy that will permit additional ratings organization to receive ARO status. The task force is considering reforming the Derivatives Market Study Working Group to consider certain technical issues that have arisen with the Schedule DB reporting instructions. The Invested Assets Working Group continued its consideration of Working Capital Finance Notes. (page 15)
- The Reinsurance Task Force discussed next steps in assisting states adopting the revised Credit for Reinsurance Model Law and Regulation and the concept of Certified Reinsurer. (page 16)
- The newly formed Captives and Special Purpose Vehicles Subgroup developed a survey completed by 31 states on how they regulate captives and SPVs. Results of the survey were reviewed in New Orleans. (page 17)
- The Blanks Working Group adopted three blanks proposals as final and exposed twenty-five new proposals for public comment, including a controversial proposal which would require insurers sponsoring separate accounts to file separate statements for insulated separate accounts and non-insulated separate accounts. (page 18)
- The Financial Regulation Standards and Accreditation Committee approved 2010 revisions to the Financial Condition Examiners Handbook and 2008 revisions to the *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition* as applicable for accreditation

purposes. A proposal to approve the 2010 revisions to *the Insurance Holding Company System Regulatory Act and the Model Regulation* as applicable for accreditation purposes was exposed for public comment. (page 19)

- The Life Insurance and Annuities Committee adopted the report of its Contingent Deferred Annuities Subgroup which concluded that CDAs are annuities and should be regulated as such, but also formed a working group to further study solvency and consumer protection issues identified by its subgroup. (page 20)
- The Life and Health Actuarial Task Force re-exposed a revised PBR Valuation Manual until May 1 and heard recommendations related to the PBR VM-20 Impact Study. (page 21)
- The NAIC held an Annuity Sales and Suitability Issues Symposium in New Orleans to discuss issues related to the implementation of the new suitability model. (page 24)
- The Casualty Actuarial and Statistical Task Force approved significant changes to the P/C Actuarial Opinion and Summary, which will be effective for 2012 after adoption by the Blanks Working Group. (page 25)
- The Examination Oversight Task Force reviewed comments from its industry survey of views on the implementation of the risk-focused examination process. (page 26)

Executive Committee and Plenary

Note: All documents referenced in this Newsletter can be found on the NAIC's website at naic.org.

Adoption of New or Revised Models
The Commissioners adopted the following items which were the subject of public hearings and debate as they were considered by various groups of the NAIC:

- NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual and related model law development request
- Amendments to the Standard Nonforfeiture Law for Life Insurance
- Amendments to the Health Carrier Grievance Procedure Model Act
- Amendments to the Utilization Review and Benefit Determination Model Act
- Accreditation Standards in the 2008 revisions of the Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition
- Revisions to the Capital and Surplus Part A Standard Applicable to Risk Retention Groups
- Consumer Alert: Limited Medical Benefit Insurance Plans/Mini-Med Plans

In addition, Executive Committee discussed the following matters:

- Establishment of a joint working group of the Property and Casualty Insurance Committee and the Market Regulation and Consumer Affairs Committee to review issues relating to low-income households and the auto insurance marketplace.
- Designation of the NAIC President and CEO or their designees as representatives on the US/European Union Steering Committee to speak on behalf of the U.S. national state-based system of insurance regulation.

FIO Update

The Treasury Department's Federal Insurance Office (FIO) was expected to complete and issue its report to Congress on how to modernize the insurance regulatory system in January 2012. Many observers are anxiously waiting for the FIO's report to gain insight into how the FIO sees insurance regulation evolving, but the report has not yet been issued. Until then, regulators, the insurance industry, and other interested parties are left to speculate as to when the report will be released and what the FIOs recommendations will be.

Health Care Reform

NAIC Resolution

The NAIC held an Executive/Plenary call on November 22 to vote on a resolution sponsored by 22 states to ask HHS to consider legislation amending the MLR provisions of the PPACA. The resolution was entitled *Resolution Urging the US Department of Health and Human Service to Take Action to Ensure Consumer Access to Professional Health Insurance Producers*. While most commissioners stated support for the work of agents and brokers, they had procedural concerns about the process (e.g. no opportunity for the public to comment at Plenary). One regulator stated that he believes the resolution is a symbolic gesture only and puts HHS on the spot as Congress is the body that must act on the resolution. After a very lengthy and spirited debate, the resolution was adopted in a 26-20 vote, with five states abstaining.

On December 2nd, the Centers for Medicare & Medicaid Services issued a final regulation prescribing how the Patient Protection and Affordable Care Act's medical-loss ratio should be applied, which rejected the NAIC's adopted resolution.

Health Reform Solvency Impact Subgroup

The working group met February 21 via conference call and adopted changes to the Supplemental Health Care Exhibit and instructions for 2012 reporting. The proposal was then referred to the Blanks Working Group and exposed at the Spring National Meeting (agenda item 2012-24). The most significant change adopted was to amend line 1.6, State Insurance, Premium and Other Taxes and Assessments, of Part 2 of the Exhibit to be consistent with the final guidance of PPACA as it relates to community benefit expenditures. The issue of whether for-profit health plans are allowed to utilize this category was deferred as this needs to be confirmed with HHS.

The subgroup also adopted a new charge to develop a reconciliation between the Supplemental Health Care Exhibit and the HHS MLR rebate form. The subgroup expects to use the reconciliation for the 2012 reporting year for analysis and auditing purposes and to consider whether an annual statement reconciliation form should be developed for reporting in 2013 and later.

Joint Working Group

The joint working group of the Life Insurance and Annuities Committee and the Financial Condition Committee was formed at the Fall National Meeting to address the contentious issue of reserving for universal life products with secondary guarantees (ULSGs). The charge of the joint working group is to "determine whether it is prudent and necessary to develop interim guidelines and/or tools to be utilized by regulators in evaluating reserves for these products and, if so, to promptly develop such interim guidelines and/or tools." Per the joint working group's chair (Texas) the overarching goal of the group is to have a "level playing field" for all insurers who write these products. This project is one of the NAIC's top priorities for 2012.

The working group met twice in December and quickly concluded that no new guidance will be effective for year-end 2011 as the working group carefully deliberates the complex issues. In January the working group exposed a Draft Framework document covering in-force and prospective business separately and extended the scope to include Term UL products. On February 21, the joint working group adopted the Phase I Decisions of the Draft Framework which recommends a bifurcated approach for in-force and prospective business and approves retaining independent actuarial consultants to advise the working group. The Draft Framework anticipates that the closed blocks of in-force business would be evaluated by actuaries on a standalone basis and all states would rely on the conclusions reached in the actuarial evaluations. If reserves are determined to be deficient based on the evaluations, reserves would be increased by the company.

Work will now commence on the Phase II and Phase III issues including decisions on which products and blocks of business will be subject to the actuarial evaluations, which actuaries will perform the evaluations, the methodologies and assumptions that will be used, and the cut-off date for the in-force blocks, in addition to many other issues. The Draft Framework suggests July 1, 2012 as a possible cut-off date for the closed block of in-force policies.

Statutory Accounting Principles Working Group

The working group met in via conference call December 7 and in New Orleans and discussed the following issues. (After each discussion is a reference to the NAIC's agenda item number.)

Adoption of New Standards or Revisions to SSAPs

SSAP 94- State Tax Credits
During its December 7 public hearing, the working group adopted both Issue Paper 145 and SSAP 94R on transferable and non-transferable state tax credits, effective for 2011 financial statements. The revisions allow entities that purchase or acquire tax credits that are subsequently non-transferable to reflect the credits as admitted assets if the domestic state law requires the credit to be used in that taxable year. (#2011-08)

SSAP 92, Accounting for Postretirement Benefits Other than Pensions, and SSAP 102, Accounting for Pensions - After six years of consideration, the working group unanimously adopted both these SSAPs as final, with an effective date of January 1, 2013, with early adoption permitted and the ability to elect a ten year phase-in period. Prior to adoption, the working group discussed the three final comment letters received and agreed to minor revisions to the guidance suggested by interested parties and agreed to draft additional implementation guidance for underfunded plans with a prepaid benefit cost. The working group did not adopt revisions long-suggested by the American Academy of Actuaries (and others) related to not requiring accrual for non-vested employees in an OPEB plan. (#2006-30)

SSAP 103, Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities
The working group voted to adopt this SSAP as final, which supercedes SSAP 91R effective January 1, 2013. The new standard adopts the guidance in FAS 166 and is to be applied prospectively. The SSAP also includes the guidance from *ASU 2011-03 Transfers and Servicing, Reconsideration of Effective Control for Repurchase Agreements*. (#2009-14)

SSAP 86 Revisions - The working group adopted revisions to SSAP 86 for the disclosure requirements for embedded credit derivatives within a financial instrument (including beneficial interests) that expose the holder to the possibility (however remote) to make future payments in the financial statements. They also adopted revisions to SSAP 86 to adopt guidance from ASU 2010-11 that revises the seller of credit derivatives disclosures in 815-10-50-4K (already adopted for statutory) to clarify those disclosures do not apply to embedded derivatives features related to the transfer of credit risk that is only in the form of subordination of one financial instrument to another. Thirdly, the working group voted to reject all other revisions from ASU 2010-11, as embedded derivatives are not separately recognized as derivatives under SSAP 86. (#2011-19)

SSAP 27 Revisions - The working group adopted amendments to SSAP 27 to ensure that the embedded derivatives discussed above in the SSAP 86 revisions are included in the disclosures of financial instruments with off-balance-sheet risk. (#2011-19)

Fund Demand Disclosures for Institutional Business
The working group adopted new guidance for SSAP 1 to reference the stress liquidity templates that were recently approved to be included in the Financial Condition Examiners Handbook. The disclosures are considered confidential and will not be included in the statutory financial statements. (#2004-27)

SSAP 43R Revisions - During its December 7 conference call, the working adopted changes to SSAP 43R to reflect changes in the modified filing exempt process adopted by the Valuation of Securities Task Force in late 2011. The working group also adopted the SSAP 43R Flowchart which has been posted to the SAP Working Group's webpage. (#2011-37)

National Flood Program - The working group adopted additional accounting and reporting guidance in SSAP 62R for National Flood Program expenses during its December conference call. (#2011-43)

Issue Paper 129, Share-Based Payment - At the Fall National Meeting, the working group exposed for comment a revised issue paper which significantly amends the previous issue paper originally exposed in 2006. The issue paper has been modified to adopt, with minor modifications, all the related GAAP guidance currently included in the FASB Codification. At the Spring National Meeting, the working group adopted Issue Paper 129 and voted to expose for comment the draft SSAP 13R, Stock Options, which reflects revisions from interested parties related to the intent of the guidance for

consolidated/holding company plans, and suggests a January 1, 2013 effective date. (#2006-13)

Exposure of New Guidance and Discussion of New and On-going Projects

Items exposed for comment had a comment deadline of May 18 (unless otherwise stated).

SSAP 101 Questions and Answers Implementation Guide - The working group exposed for comment this draft Q&A via an email vote February 20, which is a comprehensive update of the SSAP 10 Q&A. Per NAIC staff, the guide includes the following:

- Guidance for the requirements of the statutory valuation allowance adjustment (Question 2)
- Updated examples for calculating the amount of admitted adjusted gross DTA for RBC and non-RBC reporting entities. (Question 4a)
- Together Question 2 and Question 4a provide guidance related to admission of DTAs by offset with DTLs related to reversal patterns
- Guidance for calculating the ExDTA ACL RBC Ratio (Question 4b)
- A practical expedient to determining the current period adjusted capital and surplus as required by paragraph 11.b.ii. of SSAP 101 (Question 4c)
- Updated examples for illustrating how to apply the phrase "expected to be realized" in paragraph 11.b.i. (Question 6)
- Updated guidance related to recognition of a liability for tax loss contingencies under paragraph 3. (Question 9a and 9b)
- Updated illustrations for presentation of deferred income taxes in the statutory financial statements, exhibits and footnote disclosures,
- Guidance for the use of tax-planning strategies for determining the need for a statutory valuation allowance adjustment and admission of DTAs.

An expedited comment period ending March 23 was agreed to with interested parties so that the guide can be finalized and used for the first quarter 2012 statutory statements. (#2011-42)

SSAP 61 and SSAP 62 Amendments to Incorporate the Concept of Certified Reinsurer - The working group exposed for comment proposed revisions to the life and P/C reinsurance SSAPs to provide specific accounting guidance for reinsurance ceded to certified reinsurers, a concept that was adopted by the NAIC as part of the Reinsurance Modernization Framework. The proposed guidance defines a certified reinsurer as "an assuming insurer that does not meet the requirements to be considered authorized in the domestic state of the ceding insurer, but has been certified by such state and is required to provide collateral as security for its reinsurance obligations incurred under contracts entered into or renewed on or after the effective date of certification." The proposed effective of the guidance is December 31, 2012. (#2011-10 & 11)

Appendix A-785, Credit for Reinsurance - The working group exposed for comment proposed revisions to A-785 to reflect the recent changes to the Credit for Reinsurance Model Law. (This is the version of the model law maintained in the APP Manual.) The proposed changes are extensive and also include the concept of certified reinsurer discussed above. (#2012-12)

SSAP 100 and Review of ASU 2011-04 - The working group exposed for comment proposed revisions to SSAP 100 to adopt, with some modifications, the GAAP guidance in ASU 2011-04, *Fair Value Measurements*. The proposed revisions are extensive and may result in a new SSAP which would supercede SSAP 100. The working group wants the guidance to mirror US GAAP as much as possible, but has also proposed rejecting the guidance for fair value of liabilities, including non-performance risk. No effective date was suggested in the meeting materials.

Not included in the proposed revisions is clarification of the issue of transfers in and out of the Level 3 rollforward; the preliminary conclusion would require all transfers in and out of Level 3 in the same reporting period to be included in the reconciliation. Resolution was expected during the December 7 conference call but a final consensus was deferred then and in New Orleans due to the complexity of the issues. (#2012-14)

SSAP 35R - ASU 2011-06, Fees Paid to the Federal Government by Health Insurers - The working group had exposed for comment a proposed conclusion that the guidance in ASU 2011-06 be rejected for statutory accounting and instead proposed that SSAP 35R prescribe the accounting for the annual fee mandated by the Patient Protection and Affordable Care Act. These proposed changes would require accrual of the annual fee on health insurers in 2013, instead of 2014 as prescribed by ASU 2011-06.

The working group received four comment letters, all of which had similar arguments that the no liability arises in 2014 and requiring accrual in 2013 would create complexity and cause unintended harm to industry and consumers. As a result of the extent of comments received, the working group voted to defer action at the Spring National Meeting to allow time for additional review and discussion. The working group also re-exposed the issue for comment until March 30 and requested additional information from the health insurance industry; a conference call will be scheduled for early April. (#2011-38)

ASU 2010-20 Receivables-Disclosures About the Credit Quality of Financing Receivables and the Allowance of Credit Losses and ASU 2011-02, Receivables-A Creditors' Determination of Whether a Restructuring is a Troubles Debt Restructuring
At the Fall National Meeting the working group exposed nonsubstantive revisions to adopt guidance from ASU 2011-02 into SSAP 36 to provide additional guidance on whether a restructuring constitutes a troubled debt restructuring. The working group also recommended rejection of the troubled debt restructuring disclosures pertaining to financing receivables from ASU 2010-20 but proposed additional disclosures for creditors that pertain to all troubled debt restructuring.

At its meeting in New Orleans, the working group reviewed comments from interested parties asking that the GAAP disclosures required by ASU 2010-20 be included for statutory reporting because insurers will have to prepare them anyway in the audited financial statements due to the requirements for Other Comprehensive Basis of Accounting financial statements. Interested parties also requested that the additional disclosures developed by NAIC staff not be adopted. The working group re-exposed the document for comment which includes proposed revisions to SSAP 37 and narrows the scope of the ASU 2010-20 disclosures to mortgage loans only. (#2011-22)

SSAPs 48, 97 and 68 "Basis Differences" - Exposed for comment was a clarification to three SSAPs that the basis difference between purchase price and underlying GAAP equity of minority owned SSAP 48 entities should be amortized, similar to goodwill for SCA entities. (#2012-05)

SSAP 86 Revisions - The working group exposed for comment a proposal to move guidance currently shown as a criteria for a hedged forecasted transaction (par. 21e) to reflect it as a criteria for a fair value hedge (new par. 19f). (#2012-08)

SSAP 26 and Credit Tenant Loan Disclosures - The working group exposed for comment proposed deletion of credit tenant loan disclosures in the bond footnote of the audited financial statements because this separate category was eliminated from Schedule D beginning with 2011. Interested parties suggested that this revision seems to reach a conclusion that all credit tenant loans are not SSAP 26 bonds. The working group disagreed, stating that since such investments are no longer a separate bond category in Schedule D, the category should be eliminated in the audited financial statement disclosures, but that interested parties should comment why the disclosure should be retained. (#2012-13)

On a related matter, the chair noted that a six member SSAP 43R Definitional Subgroup has been formed (at the request of interested parties) to study whether the recently revised definition of loan-backed and structured securities in SSAP 43R should be further clarified or amended. The subgroup will be chaired by New York and plans to meet sometime this spring. Industry is hopeful that the subgroup does not reach the conclusion that all asset-backed bonds are "SSAP 43R-like" securities, because many of these securities have SSAP 26 bond-like characteristics.

SSAP 11 and EITF 06-2 - The working group voted to expose for comment proposed changes to SSAP 11 on postemployment benefits to address this EITF guidance on sabbatical leaves. (#2012-01)

Title Insurer Admitted Assets - Revisions to paragraph 19g of SSAP 57 on title insurance were proposed to make the guidance consistent with paragraph 16 of Appendix A-628. (#2012-03)

Retained Asset Disclosures - The working group concluded it will not move these disclosures from an annual statement note to Exhibit 7 as proposed last fall.

Impact of Loss Portfolio Transfer on Provision of Reinsurance - This proposal from a large P/C insurer addresses situations where collection risk for third party reinsurance has been transferred and secured by the counterparty in a LPT, but where novation has not occurred. The proposal would allow the minimum reserve to be reduced in such situations. At the Spring National Meeting, the working group deferred action and requested that the interested party provide additional information on the proposal including how to define the exception to a Schedule F penalty more narrowly. (#2011-45)

GAAP Guidance Rejected for SAP
The working group proposed rejecting the following recently issued GAAP guidance, EITF 07-1, Accounting for Collaborative Arrangements. The working group asked interested parties to comment on whether such arrangements are prevalent within the insurance industry. (#2012-02)

Emerging Accounting Issues Working Group

The working group voted to nullify twelve INTs issued in 2000 and include the guidance directly in the relevant SSAPs. The SAP Working Group also approved these changes, which will be reflected in the 2013 APP Manual.

Capital Adequacy Task Force

The working group met three times December through February and at the Spring National Meeting and discussed the following issues.

RBC Deferred Tax Proposal
During its December 8th conference call, after a lengthy discussion, the task force exposed for comment the proposed RBC treatment for deferred taxes for all three formulas:

- a 1% charge (outside covariance) on DTAs admitted per paragraph 11a of SSAP 101 (taxes paid in prior years that can be recovered through loss carrybacks) if the insurance company files its tax return with its non-insurance company parent, or
- a .5% charge on DTAs admitted under paragraph 11a if the insurer files a standalone tax return or the parent company is an insurance entity, plus
- a 1% charge on DTAs admitted under paragraph 11b of SSAP 101.

At its meeting in New Orleans, the task force discussed a comment letter from interested parties regarding the DTA RBC treatment, which supported the proposal but suggested amendments to correct referencing and for clarification. The task force elected not to adopt the proposal until the changes have been made by NAIC staff, and can be reviewed by the task force. A conference call will be scheduled to adopt the proposal, which would be effective for 2012 RBC filings.

Short-Term Commercial Loan Project
During its December 13th conference call, the task force voted to extend for 2012 reporting the current factors for commercial mortgages and the mortgage experience adjustment factor because the long term project will not be completed in time for 2012 RBC.

Long-Term Commercial Mortgage Project
At the Fall National Meeting, the task force received a written report and short presentation from the ACLI on its proposed treatment of commercial mortgages within the Life RBC formula. During its December 13th conference call, the task force had a longer discussion of the written report. A representative from the ACLI noted that the goals of the project are five-fold: 1) balance precision with a workable framework for reporting, 2) a verifiable framework for regulators, 3) confidentiality, 4) create a system that encourages sound economic decisions and 5) hold commercial mortgages to a similar standard to other assets held by life insurers.

Debt service coverage and loan-to-value will be the metrics used to categorize the loans, which the ACLI believes are key metrics tracked by most mortgage lenders and are readily available. These two metrics will be used in the modeling to produce five risk categories and grids that show the risk factors for each of the components. With respect to debt service, they are proposing a standardized 25 year amortization period, which they believe will "level the playing field" between different types of loan structures. One regulator stated the concern that the proposal may include company information that might not be available to regulators and may require new filings.

At the New Orleans meeting of the Life RBC Working Group, the regulators heard a brief update from a representative of the ACLI, who noted that they will be submitting a revised and more formal proposal in the next few weeks. The chair responded that it very critical that the working group is comfortable with the proposed modeling and would like to get the American Academy of Actuaries involved in the review of the modeling.

Life Trend Test
The task force adopted at the Spring National Meeting changes to the Life RBC formula to reflect the previously adopted changes to the RBC model to increase the trigger of the trend test from 250% to 300%. However, until all states have adopted changes to their RBC models the formula page will still have to reflect that either 250% or 300% triggered the trend test. This change will be effective

for 2012. The task force also voted to recommend to F Committee that this change to the trend test be made an accreditation standard.

ACLI Callable Assets Proposal
The task force adopted the callable assets proposal which clarifies in the Life RBC instructions that callable assets are excluded from the interest rate risk calculation. This change will be effective for 2012.

Response to PBR Working Group
During its February 15th conference call, the task force reviewed its response to the PBR Working Group on various SMI related projects. With respect to the project of "consider regulatory capital versus economic capital," the new chair of the Life RBC Working Group asked that the status be changed from "completed" to "in progress" as he would like his working group to reconsider the conclusion that RBC be maintained as a regulatory minimum capital calculation versus a target capital calculation.

C-1 Factor Review Subgroup

The newly formed C-1 Factor Review Subgroup is charged with reviewing the current C-1 factors and delivering a recommendation for the new factors to the Capital Adequacy and Valuation of Securities Task Forces. C-1 is the risk of assets' default of principal and interest or fluctuation in fair value used in the RBC calculation.

The subgroup has met frequently since the Fall National Meeting, focusing primarily on the corporate bond modeling project and discussions of granularity within the bond portfolio. With respect to the modeling project, the subgroup has enlisted the help of the AAA, which has been working to recruit additional resources for this large project. At the Spring National Meeting, the Academy representative noted they hope to deliver a report on the working construct of the model with initial assumptions and methodologies within the next two months and perhaps generated numbers within six months. Among the tentative conclusions that appear to have been reached include the use of cumulative bond default rate (as opposed to an annual rate), a time horizon of ten years of projecting out cash flows and a modeling size of 400-600 bonds.

With respect to the granularity issue, the subgroup is currently focusing on four categories of bonds: corporate, municipal, foreign government and loan-backed and structured securities. With respect to expanding the number of NAIC designations from the current 1 through 6, the chair noted that the goal of the subgroup is to use existing structure as much as possible due to the pervasive use of the these designations in NAIC materials and state law. The chair noted that rating agencies have been internally using plus and minuses for 2, 3 and 4 rating designations for some time, which could be an easy fix for expanded NAIC designations, e.g. an NAIC 2 designation could be expanded into 2+, 2 and 2-. The chair also commented that they might not need plus and minus for municipal bonds.

During its February 16 conference call the subgroup had a lengthy discussion of whether the bond factors should be pre or post tax. The chair of the AAA modeling group stated that would be "very unlikely" that they decide to go back to pre-tax factors for Life RBC so the only question is whether the Health and P/C RBC factors should be post tax. A subgroup member responded that one reason to use pre-tax rates is that companies have different effective tax rates. A trade association representative commented that if company's tax rate is used, it should be the marginal tax rate not the effective tax rate. The chair commented that is obviously a complex issue and that the subgroup is sure to have many lengthy discussions on the issue.

During its New Orleans meeting, the subgroup also discussed potential issues related to gathering sufficient "loss given default" data (i.e. severity of loss data). The subgroup plans to schedule meetings with the NRSROs to discuss their data availability of this information. The subgroup then assigned pairs of subgroup members and industry members to research the assumptions under the current RBC factors for bonds, equities, mortgages, real estate and Schedule BA assets and to recommend potential alternative approaches, if any.

The subgroup plans to hold a full day meeting May 1 at the SVO offices in New York. The subgroup hopes to complete most of its work in 2012 to make a proposal to the Capital Adequacy and Valuation of Securities Task Forces after that.

SMI RBC Subgroup

The subgroup has not met since the Fall National Meeting.

Life Risk-Based Capital Working Group

Having obtained a new chairperson (Kansas), the working group met for the first time in more than a year, via conference call February 22 and at the Spring National Meeting. The goal of both of these meetings was to finalize the group's 2012 Working Agenda. The working group agreed that its two highest priorities for 2012 are to complete the commercial mortgage loan project and consider proposed changes to C-3 Phase 2.

The commercial mortgage update is discussed in the CADTF summary above. With respect to the C-3 Phase 2, a representative from the AAA noted that they had completed significant work on the project but that they need input from the regulators. The C-3 Phase 2 and AG 43 Subgroup plans to begin meeting again in the second quarter.

In adopting the group's 2012 Working Agenda, the chair highlighted a new agenda item, which is to provide input to the Own Solvency and Risk Assessment Subgroup as work on the new model law progresses.

Catastrophe Risk Subgroup

The subgroup is continuing its work in developing a comprehensive catastrophe risk charge, as this peril is considered by the NAIC to be the most significant risk not currently captured by an RBC formula. At its meeting in New Orleans, the subgroup reviewed decisions made during its December 1 and January 26 conference calls. First, value-at-risk (VaR) will be used as a measurement standard. Second, all affiliate reinsurance will be excluded from the contingent credit risk charge. Thirdly, in order to maintain consistency with the overall RBC formula, the catastrophe risk charge will not be tax-effected. Additionally, a 10% charge has been included in the proposal for the catastrophe-related contingent credit risk; however, there is concern that 10% might be too high. The subgroup discussed that efforts are underway by the American Academy of Actuaries to re-evaluate credit risk charges for the Capital Adequacy Task Force, and has asked for this work to be expedited.

The current draft of the catastrophe risk charge reflects a change from "event" to "loss" to indicate that the RBC charge would be for the total modeled loss for the worst year in the specified period and not the modeled loss for the worst event. The subgroup continued discussions on the difficulties related to attempting to remove catastrophe losses from the RBC underwriting risk calculation. Discussion included use of Property Claim Services (PCS) data for estimating historical industry hurricane and earthquake losses but the subgroup acknowledged that because PCS data is not complete and may not represent the majority of the industry, it is not a viable solution. Adding a confidential schedule of insurer data to the confidential RBC report appeared to be the most complete solution but would also add an additional reporting burden to companies. The subgroup agreed to assess the level of detail of data needed; the initial expectation is for Schedule P-type data by annual statement line of business for a limited number of lines. Representatives from two trade associations expressed support for evaluating this approach.

The subgroup also discussed adding a narrative component to the RBC calculation to provide disclosure of a company's assessment of its catastrophe risk. The narrative was proposed as a way to give regulators a tool to use immediately while the subgroup continues to pursue adding a catastrophe risk calculation to the RBC. The subgroup discussed timing in hopes that the narrative disclosure could be made for the 2012 RBC. However, no draft has been exposed to the industry for comment yet. The subgroup agreed to move forward both a change to the RBC calculation to provide Schedule P Part 1 type data for catastrophe amounts and the additional of a narrative disclosure to the RBC report. The subgroup still hopes to have a proposed formula by year-end, and if possible, to start data collection on an informational-only basis for year-end 2012 filings. A conference call will be scheduled in the next few weeks to continue this work.

Property/Casualty Risk-Based Capital Working Group

In discussion of its 2012 Working Agenda, the working group reviewed the appropriate risk credit charge for reinsurance, which is currently 10% but some members think it may be too high. Conclusions on this project could have a significant effect on the catastrophe risk charge. An actuarial subgroup continues to work on this issue.

The working group reported that AAA study of the underlying methodology for updating the underwriting risk factors for the formula continues; some industry representatives believe the current methodology has led to "excessively high" capital requirements for reinsurers. There have been no recent updates to the working group by the Academy on this project.

With respect to the industry proposal to use the same lower factors used by the Life RBC formula for investments in low-income housing tax credits, the CADTF conclude the change will be made the P/C formula for 2013, instead of 2012.

The working group also reviewed a proposal from the Risk Retention Group Task Force to require the P/C RBC formula for RRGs with some modifications. Most of adjustments are proposed because RRGs generally prepare GAAP not SAP financial statements and/or use letters of credit for capital purposes. The working group concluded that additional review of this proposal is required.

Health Risk-Based Capital Working Group

The working group held a conference call February 13 and discussed its 2012 Working Agenda. The working group does not have any new issues on the agenda but monitoring the impact of federal health care reform and identifying missing risks from the formula are high priority items. The working group member from New York noted that there is so much uncertainty with health care reform that regulators should be monitoring their domestic health plans very closely and cannot necessarily wait for the Health RBC formula to be updated to address new risks.

The chair noted that the AAA is currently reviewing the risk of reserve inadequacy for long-duration products, long-term care insurance reserve adequacy risk and disability income reserve adequacy risk. A representative from the Academy noted that the disability reserve and long-term care valuations tables should be completed by the end of 2012.

Solvency Modernization Initiatives Task Force

The task force is developing a new white paper *The U.S. National State-Based System of Insurance Financial Regulation and the Solvency Modernization Initiative.* The white paper is a significant component of the NAIC's self-evaluation to improve the insurance solvency regulatory framework. The task force discussed a preliminary draft of the white paper, which includes the previously adopted US Insurance Financial Solvency Framework (2010) and new sections on "Regulating for Solvency Protects Consumers," "Effective and Efficient Markets Protect Consumer-Analysis of US Markets" and the "Future of US Financial Insurance Regulation."

The paper describes the current US system and the conclusions reached by the task force. The paper will be modified as the task force continues to make decisions this year. The white paper is being revised as requested at the meeting in New Orleans and will be released for comment soon, with responses due April 30. The regulators expect to complete the white paper by the end of this year.

Group Solvency Issues Working Group

The working group met three times December through February via conference call and in New Orleans and discussed the following issues.

Own Risk and Solvency Assessment (ORSA)
Following the adoption of the ORSA Guidance Manual by the working group and the SMI Task Force at the Fall National Meeting (subsequently adopted by Executive Committee and Plenary at the Spring National Meeting), the working group's attention has shifted to the legal mechanism for implementing the new ORSA requirement.

The working group had initially discussed integrating the requirement into Form B of the Insurance Holding Company Model, but received strong objections to the proposal from industry commentators due to confidentiality concerns. During a conference call on December 15, the working group received a proposal from a group of trade associations presenting three alternative approaches: a standalone model law, modifications to the Examination Model Audit Law, or modifications to the Model Audit Rule.

The group presented draft wording for all three proposals to the working group, which agreed to expose the draft model law for comment. The working group discussed concerns about the ability of the NAIC and the states to get a standalone statute in place in advance of the 2014 Financial Sector Assessment Program review by the IMF; however, during a conference call on January 12, it agreed to make a formal request to create a ORSA Model Law, which was adopted at the Spring National Meeting.

During its January conference call and on a further conference call on February 17, the working group continued to discuss the industry's draft model law, focusing on the roles of the lead and non-lead supervisors, confidentiality provisions, including where the NAIC provides central ERM expertise, the size exemption threshold for the application of the

requirements, and the implementation date. A large part of the February discussions revolved around the need for a uniform implementation date across the states, and whether provision should be made for the requirements to come into effect only once a majority of states had adopted it.
During its December call, the working group also discussed the need to require a common group consolidated financial income statement and balance sheet, and agreed to carry out further research. Following the adoption of the request for model law development in New Orleans, the working group will start work on a formal model law proposal. Discussion of other aspects of the implementation of the ORSA, including the 2012 pilot exercise has been moved to the newly created ORSA Subgroup, which is discussed on page 11.

In New Orleans, the working group also received an update from Nebraska on the confidentiality agreement for states' receipt and sharing of the Form F-Enterprise Risk Filing. The agreement is drafted and ready for states to begin signing.

<u>IAIS activities</u>
At the Spring National Meeting, the working group discussed the IAIS's ComFrame (Common Framework for the Supervision of Internationally Active Insurance Groups) project, focusing on Modules 1 and 4, scope of application and supervisory cooperation and interaction, respectively. Key issues discussed by the working group included the scope of ComFrame, reporting requirements, provisions on crisis management, the operation of cross-border colleges of supervisors, and the identification of the group-wide supervisor.

Different measures are being considered to set the scope of the framework, although the NAIC's preference is for it to initially capture a relatively small number of groups, then to be expanded later if considered appropriate. Its application to different operating structures is also being considered, including branch structures and individual companies which operate internationally. The proposed reporting requirements of ComFrame currently require an IAIG to provide an annual reporting package with prescribed elements. The working group discussed the level of prescription in the proposals, and a preference for ComFrame to specify outcomes, with flexibility for Colleges to decide how they should be achieved.

The working group also considered the current proposed requirement for IAIGs to establish a crisis management plan to be inappropriate. The consensus of the working group was that a supervisor is better able to engage in dialogue around crisis management once familiar with the unique risks of a group, and further, that any plan established in advance is unlikely to consider the individual characteristics of a particular crisis, which is by nature unpredictable.

The working group discussed the identification of the group supervisor for ComFrame, and potential regulatory implications where the regulator of the top company in the group is not the most appropriate group supervisor, albeit it recognized that this should be rare in practice.

The working group also discussed the review of ICP 9 (supervisory review and reporting) against ICP 23 (group-wide supervision), by the IAIS's Insurance Groups and Cross-sectoral Subcommittee (IGSC) considering in particular revised requirements on regulator/ insurer communication, corporate governance, independent review of reports and information, and assessment of the fair treatment of customers, conduct of business requirements and consumer regulations.

The working group also reviewed the results of the IGSC's supervisory college roundtables and survey. The working group heard that the results indicated significant progress in the effectiveness of colleges, although best practices for the supervision of international groups continue to be developed.

<u>New Charge</u>
At the Spring National Meeting, the working group also discussed and adopted a new charge: "[i]n collaboration with the National Treatment and Coordination Working Group, develop procedures to implement a consolidated public hearing for acquisitions involving multiple jurisdictions under the NAIC Model Holding Company Act and Regulation."

ORSA Subgroup

Following the Fall National Meeting, the Group Solvency Issues Working Group provided a set of recommendations on the implementation of the new US ORSA requirement to the Financial Condition Committee, which is responsible for implementation. The committee received and discussed the recommendations on a December 19th conference call, and voted to create an ORSA Subgroup to carry out the charges contained in the

recommendations. The new subgroup was therefore created with the following charges:

- Create an ORSA Feedback Pilot Project in 2012 for five to ten undisclosed groups to voluntarily submit an ORSA Summary Report for regulatory review under a confidentiality agreement in order for regulators to be able to provide some high-level (non-group specific) feedback to industry prior to the actual ORSA Summary Report effective date.

- Develop an enterprise risk management education program where regulators will benefit from additional guidance and/or training and then facilitate a delivery method to provide such applicable assistance.

- Develop a glossary to include in the ORSA Guidance Manual to provide clarification of terminology.

- Study the need for the NAIC to hire an ERM expert to provide staff support and future maintenance of the NAIC guidance on ERM and ORSA, and to provide assistance and training to states as they implement examination and analysis of ORSA.

The committee also established new charges for the Financial Analysis Handbook Working Group and Financial Examiners Handbook Technical Group. Both groups were charged to incorporate guidance into their respective handbooks to assist analysts and examiners in reviewing ORSA summary reports.

The implementation of the ORSA requirement is a priority for the Financial Condition Committee during 2012, and the committee plans to monitor progress closely. Once discussions over the legal framework are concluded by the Group Solvency Issues Working Group, the committee intends to establish an effective date, expected to be 2014 or 2015 at the latest. The committee also intends to provide a proposal to the Financial Regulation Standards and Accreditation Committee with respect to ORSA-related accreditation standards.

The new ORSA Subgroup met for the first time by conference call on February 2nd, and subsequently met in person in New Orleans. The subgroup discussed and initiated the planned pilot project for the ORSA, inviting insurers and groups to participate. At the time of the Spring Meeting, 12 insurers had applied to take part in the pilot, with several more expressing interest. While the identity of the volunteers is confidential, the subgroup reported a good mix across life, P&C, title, health and reinsurance companies and noted the inclusion of international groups where US regulators do not carry out a group supervisor role. They also noted that some insurers taking part were slightly below the size exemption threshold. The subgroup heard that the international community is very interested in the outcome of the study, and discussed the importance of continuing to be engaged at the international level.

Insurers participating in the pilot have until June 30th to provide either a partial or complete ORSA, and have the option of providing non-actual numerical information. The subgroup plans to meet to discuss the reports in late July, but did not specify a date when feedback would be released to the industry. One focus for the subgroup will be to identify any areas where the interpretation of the ORSA Guidance Manual is not clear and potentially therefore to make clarifying amendments.

The subgroup also exposed a draft glossary of the terms contained in the ORSA Guidance Manual, prepared by the North American CRO Council for public comment until April 18.

The subgroup also discussed plans for a multi-year Enterprise Risk Management education program for state insurance department staff involved in assessing ERM and the ORSA, and heard presentations from volunteer ERM experts offering to provide assistance. The first phase of the program is due to start in May, and is likely to cover topics including the different models and maturity levels for ERM, proportionality and the assessment of ERM by rating agencies, Finally, the working group discussed the knowledge and skills requirements for a potential state or NAIC ERM specialist.

PBR Working Group

Completion of the PBR project is one of the NAIC's major objectives for 2012, with adoption scheduled for the Fall National Meeting to allow presentation to state legislatures in 2013. Discussions on the project continued at the Spring National Meeting, with the PBR Working Group receiving a summary report on the final results of the VM 20 Impact Study. The results of the Impact Study were provided in full to Life Actuarial Task Force at the Spring National Meeting, and are discussed on page 21. LATF's current target completion date for the Valuation Manual is June 2012.

Corporate Governance Working Group

The working group met at the Spring National Meeting in New Orleans, and continued its discussions on its charges to consider US corporate governance principles, and to identify potential improvements to the US regulatory solvency system.

The majority of the working group's focus at the Spring National Meeting was on its timetable to complete its charge by the end of 2012. The working group had planned to finish identifying any differences between US corporate governance practices and the Insurance Core Principles by the time of the Spring National Meeting. However, given that substantial progress on this task had not been made, the working group decided to divide and assign among the working group members the seven principles of the US Insurance Financial Solvency Framework, and the corporate governance practices identified in relation to each principle in the working group's document on Existing US Corporate Governance Requirements.

The working group discussed its approach to the comparison with the ICPs, and agreed that it would be a "comparative analysis," rather than an assessment of gaps. Where differences are found, the working group agreed to decide whether to make changes or to keep current US practice unchanged despite the difference to the ICPs, because in some cases the current US approach may be a different but equally valid approach to regulation. The working group also discussed the possibility that its review may identify potential improvements to corporate governance regulation that are not included in the ICPs.

Under Principle 1 (Regulatory Reporting, Disclosure and Transparency), these discussions will include a discussion of a referral from the NAIC/AICPA Working Group to consider the incorporation of SEC disclosures on board of director risk management and executive compensation. The NAIC/AICPA Working Group had previously developed an extensive blanks proposal for the reporting of this information, and had received a counterproposal from industry, concerned about the potential reporting burden of the proposed changes. Given the overlap with the work of the Corporate Governance Working Group, the matter was received for future consideration. The working group did not indicate any preliminary thoughts on the referral from the NAIC/AICPA Working Group.

Going forward, the regulators plan to meet regularly by conference call to compare existing practices with the ICPs and to discuss potential differences, in order to recover the previously agreed timetable for the project and to provide its recommendations by the end of the year. The working group also plans to hold an interim in-person meeting, and to keep an open dialogue with North American CRO Council and the industry.

International Solvency and Accounting Standards Working Group

The working group met at the Spring National Meeting, and received updates on the progress of IFRS 9 (financial instruments), the insurance contracts project, and the activities of the IAIS Accounting & Auditing Issues Subcommittee (AAISC) and Solvency & Actuarial Issues Subcommittee (SSC).

Insurance Contracts project

The working group heard that limited progress had been made on the insurance contracts project since the Fall National Meeting, and further that the timing for a revised draft standard had been extended from the second quarter of 2012 to the second half of 2012. The working group discussed the possibility that this may make a joint IASB/FASB exposure draft more likely, and that it may better align with the timetable for the financial instruments standard. However, the working group also recognized that further extensions were possible.

The working group also received an update on the FASB and IASB Boards' current discussions on the use of the premium allocation approach (also referred to as the unearned premium approach). The Boards were in broad agreement about the eligibility criteria for the approach, including the eligibility of contracts with a coverage period of one year or less. However, the Boards were divided on whether the approach should be optional for eligible contracts, with the IASB supporting optional application and the FASB supporting mandatory application.

Financial Instruments Project

The working group heard that the Boards met in February to discuss the contractual cash-flow characteristics assessment, and tentatively decided that a financial asset could be eligible for a measurement category other than fair value through profit and loss. Significantly for the insurance industry, there was explicit recognition that the

Boards would consider the application of fair value through OCI to the insurance industry, which would be considered a positive step to reducing unnecessary volatility in the income statement. The Boards also continued their discussions on the three-bucket impairment model.

ComFrame

The working group received updates on the work of the AAISC and SSC, both of which are involved in the development of the ComFrame. The working group discussed the AAISC's recommendation that IFRS be used as the valuation basis for ComFrame. A significant factor in this recommendation is the working assumption that, by the time ComFrame is in operation, US GAAP and IFRS will have substantially converged, in particular for the large international groups to which ComFrame will apply. However, the working group discussed the fact that the proposed use of IFRS, and the potential additional books and records that will need to be maintained, continues to be a major concern for the industry.

The working group also discussed drafting work carried out by an SSC drafting group on Module 3, Element 5 of ComFrame, covering group capital. The topic of group capital is still subject to ongoing discussion, and the working group heard that the current drafting of Module 3, Element 5 reflects the strategic direction provided by US insurance regulators, and provides for regulators to establish group-wide capital risk measurement taking into account the nature and extent of solvency regulation in the different jurisdictions in which an IAIG operates. The risk measurement must address all material categories of risk.

However, the update stressed to the working group that the current wording is still draft, and remains subject to review by the SSC and Technical Committee, which has asked for the wording to be narrowed. Notwithstanding this, however, in response to an industry request the working group agreed to release the current draft wording of Module 3, Element 5 for public comment until March 23.

International Insurance Relations Committee

The committee met at the Spring National Meeting, and received updates on many international activities and projects. The committee heard that joint technical discussions with the FIO had recently been held with the EU, and that a new steering committee with three members each from the US and EU had been created to guide technical workstreams exploring areas for mutual analysis and discussion. The NAIC also recently held a cross-sector meeting with EU regulators for the insurance, banking and securities industries. The committee heard that discussions with the EU continue to be very productive. The NAIC and FIO also recently participated in a Joint Economic Committee meeting with the China Insurance Regulatory Commission.

The committee also received an update and discussed the Joint Forum's draft Principles for the Supervision of Financial Conglomerates, released for public comment in December 2011. The objective of the principles, which cover supervisory powers and authority, supervisory responsibility, corporate governance, capital adequacy and liquidity, and risk management, is to support consistent and effective supervision of financial conglomerates, in particular those active across borders. The committee heard that the next stage for the principles is not entirely clear at present. However, it is considered not improbable that, following adoption, they will be implemented and potentially enforced through a mechanism such as the Financial Sector Assessment Program.

In its discussion of IAIS activities, the committee discussed Connecticut Insurance Department's recent signing of the IAIS' Multilateral Memo of Understanding (MMoU), and how it has encouraged other states to enter the process. The committee also heard about recent Supervisory Forum discussions on confidentiality, the low interest rate environment, and the current economic environment.

The committee also discussed the IAIS Financial Stability Committee (FSC). The committee heard that the FSC will open its process to public comment soon, and that public consultation is expected in the near term on the FSC's proposed methodology for the identification of insurance G-SIFIs (Global Systemically Important Financial Institutions) and proposed prudential measures. The FSC has been performing data collection and analysis, and expects to issue a new data call in the summer. Based on the data collected, the FSC expects to make recommendations to the Financial Stability Board, who will make a determination of which insurers are considered to be G-SIFIs.

Valuation of Securities Task Force

The task force met twice since the Fall National and in New Orleans and discussed the following issues.

Final Instructions for Structured Securities
During a November 29 conference call, the task force adopted a previously exposed amendment to the SVO Purposes and Procedures Manual that provides final valuation rules and instructions for financially modeled and non-modeled structured securities subject to SSAP 43R. A flowchart which depicts the reporting requirements for modeled and non-modeled structured securities subject to SSAP 43R was also adopted and referred to the Blanks Working Group with a recommendation that it be considered as authoritative guidance.

Consideration of New ARO Policy
During its November 29 conference call, the task force discussed a proposal from the New York State Insurance Department to change the policy and procedures for adding a nationally recognized statistical rating organization (NRSRO) to the NAIC's Acceptable Rating Organization (ARO) list. The proposal would permit any NRSRO that publishes its rating and research reports in English, and that is willing to negotiate a contract with the NAIC specifying the terms under which it will provide its ratings to the NAIC, to become an ARO. The proposal was exposed for a public comment period which ended January 13.

During a January 26th conference call, the task force considered the proposal for adoption. Several task force members expressed concerns that while the proposal is presented as a general change in policy directed to all NRSROs, the immediate result will be the addition of just one or two additional AROs which do not meet the criteria in the current SVO policy. Other regulators believe the new policy will spur competition. After further discussion, the task force adopted the proposal, with Wisconsin, Minnesota and Iowa voting against. In New Orleans, the task force adopted an amendment to Part One, Section 4 of the Purposes and Procedures Manual to eliminate the current threshold requirements to become an ARO and to permit any NRSRO to apply to be added to the NAIC List of Credit Rating Providers. The SVO will now begin contract negotiations with Kroll Bond Rating Agency and with Egan-Jones Rating Company.

Exempt Obligations for AVR and RBC
The task force received and exposed for a thirty-day comment period a proposed amendment to Part Six, Section 2(e) of the Purposes and Procedures Manual. The amendment would conform the list of securities considered “exempt obligations” for purposes of determining the asset valuation reserve and the risk-based capital calculation to recently adopted instructions for government securities in Part Two, Section 4.

Classification Methodology
The task force received and exposed for a sixty-day comment period a proposed amendment to the Purposes and Procedures Manual that would permit the SVO to notch the NAIC designation of a security subject to classification methodology, rather than instructing the insurer to report the investment in a different reporting category. Securities subject to notching would be indicated with an "S" subscript, which would enable regulators to query an insurer's Schedule D for the subscript. This proposal is expected to affect a relatively small number of securities.

Methodology Review for Loan-Backed and Structured Securities
The task forced received a preliminary research report and presentation from SVO staff regarding the implications on capital of mapping the intrinsic price produced by financial modeling to RBC. The research is focused on two aspects: (1) comparing the relative performance of the various RBC approaches (Modeling, FE-ratings based, Modified FE) currently used for structured products, and (2) analyzing the sufficiency of RBC to cover the expected losses.

Per the SVO presentation, RBC as a percentage of book adjusted carry value for RMBS was 2.4% for modeled securities, 11.2% for FE securities and 10.6% for Modified FE securities. The results for CMBS were 1.1%, .9% and .8%, respectively. The consultant to the SVO noted that difference between modeling and FE/MFE is that modeling takes severity of loss into account. The SVO expects to finalize its study shortly, and a task force meeting will be scheduled soon after to review and discuss the final research report.

RMBS/CMBS Mid-Year Review
The task force voted to discontinue the annual requirement to have SVO staff conduct a study of the status and trend of the RMBS and CMBS markets. The task force concluded that the study is no longer necessary.

Derivatives Market Study Working Group
The task force received a request from New York to reconstitute the Derivatives Market Study Working Group in order to consider certain technical issues that have arisen with the Schedule DB reporting instructions and to make recommendations for changes as necessary. New York will develop a scope for the project and the task force will meet to consider the proposal. New York indicated that there are only a few technical issues and hopes that the work can be completed quickly to be effective for 2013 quarterly statement reporting.

Invested Assets Working Group

Working Capital Finance Notes (WCFN)
The working group continued its discussion on WCFN noting that on a February 7 conference call, the working group heard a summary of discussions it had with the FDIC on how trade receivables are regulated followed by a testimony on trade receivable financing in banking by a Citibank representative. The discussion with the FDIC noted that trade receivables are a niche business primarily conducted by larger, sophisticated banks. Trade receivable financing is labor intensive, involving significant recordkeeping. Banks disclose detailed information about each receivable and the applicable valuation procedure and keep detailed payment history that regulators use to drive probability of default and loss given default calculations. Trade receivables are assigned a flat 8% charge under Basel I but effective 2013, higher quality credits will get a lower charge and lower quality credits will get a higher charge.

With working capital finance notes, the insurance company is secured in the sense that it owns the receivable and therefore, is a trade creditor and has the same status as a secured bond holder. The working group discussed a letter received from the trade association ACLI recommending that WCFN programs be prescribed under the same capital treatment as other assets designated NAIC 1 or 2 by the SVO.

The working group discussed a proposal from the Connecticut Insurance Department relating to WCFN treatment as admitted assets incorporating 23 criteria. Key proposed criteria include the following:

- Program documents must be reviewed and approved by the SVO with any amendments to the program documents being re-filed prior to any purchase
- Eligible trade receivables should be limited to those arising from an actual transaction between the seller/vendor and the obligor and purchased within 30 days of the transaction
- Eligible trade receivables must require a confirmation from the obligor that all requirements of the vendor/seller have been fully and completely satisfied, that all rights of set-off have been waived and that a specific payment date has been confirmed
- Programs are subject to an annual SSAE 16 service organization report, which is to be filed with the SVO
- Obligors are restricted to investment grade corporate entities

The working group voted to release the proposal for a 14-day comment period, ending March 18.

Reinsurance Task Force

The task force met in New Orleans and discussed the following projects.

Credit for Reinsurance Models
The task force discussed next steps to assist the states in implementing the revised *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786). The task force is establishing a drafting group to develop an NAIC process to review non-US jurisdictions, identify which jurisdictions will be initially reviewed, and develop a timeline for implementation. The task force also plans to form a second group to provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. The task force hopes to finalize the formation of these two groups within the next few weeks.

The task force also plans to develop instructions for Form CR-F and CR-S, which are annual filings required to be completed by certified reinsurers under the revised Credit for Reinsurance models.

NAIC staff reported on the progress of states adopting the revisions to the Credit for Reinsurance Models. Both Florida and New York have adopted legislation and approved reinsurers for reduced collateral. New Jersey and Indiana adopted revised statutes in 2011; New Jersey is currently working on the corresponding regulation. In 2012 Indiana proposed further revisions to its statute to be consistent with the NAIC models, and is working on

the corresponding regulation. Staff is not aware that either state has approved any reinsurers. Virginia is expected to adopt similar legislation in 2012.

Accreditation Discussion
The task force exposed for a 30-day public comment period proposed key elements for the "reinsurance ceded standard" under the Financial Regulation Standards and Accreditation Program with respect to the revised models. After adoption, the task force will forward the document to F Committee recommending expedited adoption.

There was significant discussion among task force members regarding whether the recently adopted revisions to the two reinsurance models are "voluntary" or not for accreditation purposes. The accreditation process has always been to require states to adopt new standards (after the lengthy exposure period) that are stricter than then current standard. Since these revisions reduce collateral requirements, they are not viewed as more strict. Several regulators expressed the view that uniformity among the states is critical, while others noted that it would be nonsensical for a state to lose its accreditation status merely because it did not adopt the reduced collateral requirements for reinsurance. The task force appeared to conclude that if a state reduces its collateral requirements, then the revised model guidance is mandatory. Otherwise, the reduced collateral standards are voluntary.

Collection of Reinsurance Recoverable Balances
The task force briefly reviewed its referral from the Financial Condition Committee and the Receivership and Insolvency Task Force asking for assistance in providing a recommendation for enforcement of the collection of undisputed balances held by ceding insurers in receivership. This could include consideration of a NAIC Model Law or Guideline so that states have additional authority to collect such balances. NAIC staff is performing additional research on the issue and plan to report to the task force at a later meeting.

Capital and Special Purpose Vehicle Use Subgroup

This newly formed subgroup met via conference call on January 27 and in New Orleans to begin work on its revised charge, which is as follows: "study insurers' use of captives and special purpose vehicles (SPVs) to transfer other than self-insured risk in relation to existing state laws and regulations and establish appropriate regulatory requirements to address concerns identified in this study. The appropriate regulatory requirements may involve modifications to existing NAIC model laws and/or generation of a new NAIC model law." The subgroup clarified that RRGs are also excluded from its review (in additional to self-insured risks). Voting members of the subgroup are representatives from Texas (chair), Missouri, Michigan, New Jersey, New York, South Carolina and Vermont. The subgroup also has two "monitoring non-voting members" from Rhode Island and Vermont.

Thus far, the subgroup has spent most of its time developing and compiling a detailed twenty-question survey sent to all states asking for information on how they regulate captives and SPVs. Responses from thirty-one states were received, which were summarized (with no attribution to specific states' responses) and reviewed in detail in New Orleans. Among the more significant discussions was acknowledgement of the fact by many regulators that there are legitimate uses for captives and SPVs, but that the role of this subgroup is to determine which uses are legitimate. One regulator commented that their recommendations should not reduce the "creativity and flexibility" provided by captives, while another regulator responded that "we are not here to protect the captive industry."

Question 11 of the survey asked what are the differences in solvency standards for captives and SPVs that assume third party risk from insurers as compared to commercial insurers writing a similar product. State responses included lower minimum capital and surplus requirements, not being subject to RBC requirements, more flexibility in reserving and capital requirements and confidential treatment of captive financial information. In response to Question 18 as to whether captives and SPVs should be subject to accreditation standards, fifteen states responded "yes," nine responded "no" and seven responded "not sure" or "not applicable."

The subgroup also distributed an ambitious proposed timeline showing bi-monthly conference calls starting March 30, with the goal of a draft model law/whitepaper to be exposed by June 26, with a public hearing on the draft at the Summer National Meeting. Topics for discussion at these calls include transparency, confidentiality and information sharing, types of business and risks underwritten by captives and SPVs, capitalization, credit for reinsurance, accounting and reporting and holding company analysis.

Blanks Working Group

The working group adopted the following three blanks proposal effective for the 2012 annual statement. The proposals were previously exposed during the Fall National Meeting.

- Instructions to the annual statement Notes were modified to indicate that certain disclosures are captured electronically, and to clarify that certain disclosures must be presented in a format consistent with the illustration to facilitate the data capture. (Agenda item 2011-37BWG)

- New instructions were added for RRGs that report on a GAAP basis, utilizing the P/C blank. The instructions are applicable for the annual and quarterly blanks, and clarify how certain GAAP items that are inconsistent with SAP should be reported. (2011-38BWG)

- The illustration and instructions for Note 9A were modified to reflect the disclosure requirements of the recently adopted SSAP 101, Income Taxes. (2011-39BWG)

The working group discussed a proposal (2012-25BWG) which would require insurers sponsoring separate accounts to file separate statements for insulated separate accounts and non-insulated separate accounts. Concerns have been raised by some regulators regarding the growing trend of life insurers to include non-unit linked (non-insulated) products within the separate account. The proposal is supported by the chair of the Financial Condition Committee as a mechanism to further enhance financial statement disclosures with respect to assets backing separate account products, and specifically, support the effort to clearly differentiate the information in the separate account between insulated and non-insulated products.

Industry representatives expressed significant concerns related to the increased reporting burden. They also suggested that the proposal was premature, noting that other NAIC groups are still evaluating the matter. Following discussion, the proposal was exposed for public comment and referred to the SAP Working Group to consider whether a definition of insulated and non-insulated separate accounts should be included within SSAP 56.

Twenty-four other new proposals were exposed for a public comment period which ends May 14. These proposals will be considered for adoption on a conference call to be scheduled in June. Some of the more significant proposals would:

- Add an illustration for Note 21F (4) to data capture admitted and nonadmitted state tax credits. Other illustrations in Note 21F would be modified to reflect the inclusion of non-transferable state tax credits in the disclosure. (2012-1BWG)

- Modify Question 3.1 of the General Interrogatories to reflect the requirement to report Schedule Y, Part 1 each quarter. The proposal also would add a requirement to provide a brief description of the nature of any changes to the schedule as previously reported. (2012-3BWG)

- Add Exhibit 5 Interrogatory disclosures for contingent deferred annuity contracts and lifetime income benefit contracts. Disclosure requirements already exist for other synthetic products, other types of guaranteed living benefits, and off-balance-sheet risk. (2012-4BWG)

- Add a definition to the Investment Schedules General Instructions for Other Loan-Backed and Structured Securities. The proposal would clarify that those securities subject to the guidance in SSAP 43R but not included in the definition of RMBS or CMBS should be included in Other Loan-Backed and Structured Securities. (2012-5BWG)

- Add a flowchart to the Investment Schedules General Instructions which illustrates the reporting of SSAP 43R relating to the application of the Modified FE process. The proposal would also eliminate reference to the "SM" NAIC designation suffix from the Schedule D instructions, as changes adopted by the SAP Working Group for SSAP 43R eliminated the need for the “SM” suffix. A new “S” suffix would be added to the bond matrix for Schedule D, which would indicate that the SVO has notched the bond as part of its review. (2012-7BWG)

- Revise instructions for the P&C Actuarial Opinion, P&C Actuarial Opinion Summary, and Title Actuarial Opinion. (2012-16BWG) (See further discussion of this proposal on page 25.)

- Add a line to the Five Year Historical Data page(s) to require companies to identify which amounts of investments reported in the current

Investments in Parent, Subsidiary, and Affiliates section are in an immediate or indirect parent. (2012-18BWG)

- Add instructions and modify reinsurance schedules for the reporting of certified reinsurance in the annual and quarterly statements. Separate blanks proposals were exposed for each blank. (2012-19BWG through 2012-23BWG)

- Split the Expatriate Column in the Supplemental Health Care Exhibit into two separate columns for small group and large group plans and add new instructions to clarify the reporting requirements. (2012-24BWG)

All Blanks proposals, including those adopted and exposed for comment, can be viewed at the Blanks Working Group page on the NAIC's website.

Receivership Separate Accounts Working Group

The working group met three times via conference call in January and February and again at the Spring National Meeting. The working group first discussed its new charge from the Financial Condition Committee to consider receivership issues related to the current separate account mix of products and assets, including, but not limited to, issues related to identification and disclosure of insulated and non-insulated assets and products. The working group agreed to form a subgroup chaired by Ohio to draft a document on the expectations of the SEC and insurance receivers related to separate account receivership with registered products and the subgroup will try to arrange a meeting with the SEC to discuss this.

The working group had extensive discussions on several occasions of a proposed Blanks change, which would greatly expand separate account reporting. Industry is strongly opposed to the proposal, but it was exposed by the Blanks Working Group at the Spring National Meeting over their objections. See discussion above in the Blanks Working Group summary.

Financial Regulation Standards and Accreditation Committee

The committee met in New Orleans and took the following actions.

Revisions to Documents Required for Accreditation

Revisions made during 2011 to publications that are required for accreditation purposes (e.g., the Annual Statement Blanks and Instructions; Life and P/C RBC Formulas; the SVO Purposes and Procedures Manual; the Accounting Practices and Procedures Manual; and the Examiners Handbook) were adopted by the committee at the Spring National Meeting as revised accreditation standards. No revisions were deemed to be significant to the accreditation program.

Insurance Holding Company System Regulatory Act and Model Regulation

The committee discussed the 2010 revisions to the Insurance Holding Company System Regulatory Act and the Insurance Holding Company System Model Regulation. A proposal to include these revisions within Part A: Laws and Regulations of accreditation standards was exposed for a thirty-day comment period. The committee will hold a conference call in December to consider comments and vote on the proposal.

Risk-Based Capital for RRGs

The committee received a referral from the Risk Retention Group Task Force which would require states that charter risk retention groups to adopt the Risk-Based Capital for Insurers Model Act for accreditation purposes. The referral was exposed for a thirty-day comment period.

Standard Valuation Law

The 2009 revisions to the Standard Valuation Law were re-exposed for comment until December 31, 2012. The Standard Valuation Law is expected to become a significant element for Part A: Laws and Regulations of the accreditation standards, and was previously exposed at the 2010 Spring National Meeting. However, the committee is awaiting finalization of the PBR Standard Valuation Manual and plans to consider both items for accreditation purposes in 2013.

RBC for Health Organizations Model Act

The committee discussed the possible inclusion of the Risk-Based Capital for Health Organizations Model Act as an accreditation standard. RBC is currently an accreditation standard for both life and property/casualty insurers. As of July 2011, 37 states have adopted a health RBC statute, consistent with or similar to the model act. The committee took no action on the proposal in New Orleans, but is expected to continue this discussion at the Summer National Meeting. If the model act is adopted as an

accreditation standard, it would likely have a January 1, 2015 effective date.

Model Risk Retention Act

The committee received a referred from the Risk Retention Working Group which would require states that charter risk retention groups to adopt the Model Risk Retention Act for accreditation purposes. The corporate governance standards within the model act were developed to ensure that insurers implement and operate within effective risk management and internal control systems, including determining the level of internal economic capital that should be held for solvency purposes. The referral was exposed for a thirty-day comment period.

Risk-Based Capital for Insurers Model Act

Revisions to the Risk-Based Capital for Insurers Model Act were exposed for a thirty-day comment period. The revisions were adopted by the NAIC in November 2011 and changed the level at which the life RBC trend test is triggered to be consistent with the level for health and property/casualty RBC.

Revisions to Review Team Guidelines

A referral from NAIC staff proposing two new review team guidelines for examination was exposed for a thirty-day comment period. The first proposed guideline relates to addressing all risks identified by examiners in a risk-focused examination. The second proposed guideline requires a state insurance department to notify the Examination Oversight Task Force if an exam report has not been issued within 22 months of the examination "as-of" date.

The committee also adopted previously exposed revisions to the timing guidelines for financial analysis. Effectively immediately, state insurance departments are required to analyze supplemental filings from non-priority insurers within 120 days from receipt. These supplement filings include the annual audited financial statements, applicable holding company filings, and Management's Discussion and Analysis.

Life Insurance and Annuities Committee

The committee met in New Orleans and discussed the following issues:

CDA Subgroup

At the conclusion of a lengthy discussion of contingent deferred annuities (CDAs) at the Fall National Meeting, the committee voted to form a group to study the new market of contingent annuities and similarly designed products from an actuarial and policy standpoint, and to discuss how the product should be classified and whether they should be sold under existing statute or model law.

A contingent annuity is essentially a stand-alone guaranteed living withdrawal benefit (GLWB). Parties in support of CDAs as annuities include most insurance companies and an AAA working group formed to address the issue, which had recommended that the NAIC classify a contingent annuity as an annuity and not as a financial guaranty product. Conversely, some insurers and consumer groups believe the product is not an annuity and that the product could lead to reserving and capital issues.

The subgroup met five times via conference call December through February to discuss this contentious issue. The subgroup's summary to the committee noted that 125 parties participated in the calls and "all participants were afforded the opportunity to present views, ask questions and raise concerns." At the Spring National Meeting the chair of the subgroup (New Jersey), presented the conclusions of the subgroup (also presented to interested parties during its February 16th conference call), which include the following:

- CDAs are similar in structure and risk profile to GLWB riders inside variable annuities and many of the same regulations should apply.
- CDAs should be sold by life insurers, not financial guaranty insurers.
- The subgroup's study raised both solvency and consumer protection issues as there has been little discussion of the embedded financial guaranty aspects of the CDAs and GLWB riders, and there have been significant revisions to the basic design of GLWB riders that have changed the risk/reward equation for insurers and consumers.
- The subgroup recommends that a new working group be formed to address the solvency and consumer protection issues identified.

The task force then heard comments from interested parties. A representative from the Center for Economic Justice commented that he disagrees with the subgroup's conclusions due to the risk posed to

consumers of CDAs and that sales of CDAs should be halted until the NAIC adopts "stop gap" guidelines.

The committee then voted to adopt the CDA Subgroup report, which included adopting the subgroup's finding that contingent deferred annuities are annuities and subject to existing state laws and regulations applicable to annuities. The committee also voted to form a Contingent Deferred Annuity Working Group to evaluate the adequacy of existing laws and regulations as applied to CDAs and GLWBs and whether additional solvency and consumer protection standards are required. Wisconsin will chair the new working group.

Viatical Settlements Working Group

The newly re-formed Viatical Settlements Working Group met for the first time at the Spring National Meeting. The working group reviewed its charge, to "review and consider revisions to the *Viatical Settlements Model Regulation* (#698) for consistency with the 2007 revisions to the *Viatical Settlements Model Act* (#697), including reviewing and considering revisions to or replacement of, as appropriate, Appendix A – Informational Brochure."

The working group discussed a list of questions related to the revisions to the Viatical Settlements Model Regulation, which included reports, anti-fraud plans, brochures, and how to take account of developments since the amendments to the Viatical Settlements Model Act, and states which have already updated their regulations. The questions are available for comment until April 2, following which the working group intends to meet by conference call to discuss the comments and decide on potential revisions to the model regulation.

Life Actuarial Task Force

The task force has a new chair (Texas) and vice-chair (Ohio) for 2012. The majority of LATF's day and a half meeting (and its nine interim conference calls since the Fall National Meeting) were spent on finalizing issues related to the Principle-Based Reserves (PBR) project and changes to the working draft of the Valuation Manual, culminating in the exposure of a revised draft of the Valuation Manual. In an unusual move, Insurance Commissioners from Texas and Tennessee (chair of the parent committee of LATF) addressed the task force with remarks stressing the NAIC's commitment to have a proposal for adoption of PBR during the 2013 legislative sessions, at which all states will be participating. To this end, the Life Insurance and Annuities Committee wants to adopt PBR in 2012 and will play a more active role in clarifying expectations, setting deadlines, and providing guidance to ensure LATF is appropriately focused on the items necessary to achieve this objective.

PBR Valuation Manual

Several changes to the Valuation Manual were discussed and adopted during the meeting, while other changes were adopted during conference calls between the Fall National Meeting and this meeting. LATF voted to expose the current working draft of the Valuation Manual for a two-month comment period, with comments due May 1. LATF is targeting mid-June for adoption of the Valuation Manual. Following is a summary of key areas of discussion.

Life Reserves (VM-20)

Changes to VM-20 were primarily focused on mortality assumptions, net premium reserves and investment rate assumptions. During an interim conference call, LATF adopted a modified framework for determining the mortality assumption. The new framework simplifies the approach for determining the mortality assumption and changes the process for grading to industry tables. In finalizing the draft Valuation Manual, the task force spent considerable time discussing the guidance related to setting prudent estimate mortality assumptions, specifically the approach for determining the sufficient data period that will be considered credible for purposes of assigning credibility to a company's own experience in setting anticipated experience assumptions. Several clarifying changes were discussed and approved, although the number of claims used to determine the sufficient data period remains open. LATF anticipates resolving this open item prior to final adoption of the VM. Other changes address the application of mortality improvement factors to industry tables and grading of the anticipated experience assumption to the industry table.

LATF also spent considerable time discussing the Net Premium Reserve (NPR), and the need to evaluate this reserve in the context of the deterministic and stochastic reserves, particularly for ULSG products. The NPR is the minimum reserve under VM-20 and is uniquely defined for Term and ULSG products. The NPR is likely to serve as the tax reserve under PBR. Ideally the NPR should be close to the deterministic model reserve and not overly excessive. Results from the VM-20 Impact Study indicate variation in companies' interpretation of the NPR requirements for ULSG, and overly conservative NPR results stemming from application of a level premium methodology to a product that specifically provides for flexible

premiums. The ACLI is analyzing alternative methods and expects to present proposed changes by late April. Final guidance on the NPR is expected to be completed in time for inclusion in the adopted VM later this year.

Alternatives for determining investment and reinvestment rates had been debated at the Fall National Meeting and a resolution was reached in a January conference call. Alternative 1, originally proposed by New York, is the more simplified approach of the two alternatives and produced the higher reserves of the two alternatives. Alternative 2 is the original approach proposed in VM-20 and has a more complicated structure. A compromise was reached and LATF adopted a version of Alternative 2 that reflects a more conservative credit quality blend in the maximum spread that can be assumed.

Experience Reporting (VM-50 and VM-51)
Discussion regarding experience reporting focused on confidentiality and changes needed to the current language to preserve data confidentiality and clarify accessibility to data. The Standard Valuation Law has very specific and strong provisions for the identification and protection of confidential information, and references in VM-50 and VM-51 were modified to be equally as strong. References to the Society of Actuaries, the AAA, or "professional actuarial organizations" were removed from the Valuation Manual, recognizing that the NAIC will assign resources from the appropriate organizations as needed to perform the necessary data analysis and experience studies. The selection of premium as the metric to determine company size for purposes of the New York pilot project was also discussed, and the second data call for that project is expected shortly. The Policyholder Behavior Data Format of VM-51 will be exposed separately from the Valuation Manual, with the deadline for comments three weeks prior to the Summer National Meeting.

Reporting and Review (VM-30 and VM-31)
The PBR report is intended to be used as the Actuarial Memorandum, or at least comprise a substantial component of the memorandum, and the disclosure requirements are the main elements. Amendments to these sections reflect changes in VM-20 since the last exposure, primarily related to disclosures regarding the impact of margins, including identification of implicit margins in the anticipated experience mortality assumptions. Another change was an option for companies to determine an anticipated experience assumption for prescribed risk factors (e.g. default costs) and disclose margins resulting from use of the prescribed assumptions.

Process and Coordination (VM-00 & VM-01)
The working drafts of these sections were modified to include a requirement that regulators coordinate requests for information through the NAIC as a means of protecting confidentiality. The revised language will be included in the exposed materials.

PBR VM-20 Impact Study on Life Products
Towers Watson presented an overview of the final 351 page report that was released to the NAIC in February (detailed findings and analysis had been previously communicated to the task force).
Phase I of the study was designed to assess the impact of PBR on the US life insurance industry through focus on implementation and comparison of results to formula-based reserves. Phase II was focused on evaluating sensitivities and assumptions. The presentation included observations for all fourteen original study objectives including financial impact, effectiveness of exclusion tests and minimum requirements, bases for assumption setting, reporting and documentation issues, identification of regulatory benchmarks for evaluating results, and implementation challenges.

General conclusions were that VM-20 methodology will have the greatest impact on ULSG and level term products, with term reserves generally lower and ULSG reserves generally higher, relative to current reserve levels. Exclusion tests appear to be effective, and there was little impact from reducing the level of granularity used to define model cells or reducing the number of scenarios used in the stochastic reserve. The results showed significant volatility in the NPR as a percentage of CRVM reserves from company to company, and for term insurance, the NPR was the maximum reserve in a majority of cases, which was not the desired result.

Based on the analysis and observed results, Towers Watson made several recommendations including:

- Clarify whether term gross premiums used in the deterministic reserve exclusion test should be applied over the level term period or over the life of the contract, as this was a source of confusion
- Modify the NPR to be more effective as a floor and not a maximum reserve
- Clarify the intent of the application of margins to YRT reinsurance premium rates, as this was a source of inconsistency between companies

- Review the mortality blending requirement as it appears to be adding a significant margin to the ending PBR reserve
- Increase the corridor for starting assets as a percentage of modeled reserves (deterministic or stochastic) to be 5% instead of 2%, to lessen the number of iterations required to meet the threshold.

LATF is currently evaluating the NPR requirements and mortality blending requirements and will include the other three items noted above as items to be quickly addressed before June for inclusion in the VM when it is adopted by LATF.

Actuarial Guideline XXXIII (AG 33)
The Academy's Annuity Reserve Work Group presented a report on recent activity including compilation of responses to an informal survey on CARVM anomalies, and development of a deterministic reserve for use in PBR for fixed annuities (VM-22). The survey originated from the Academy's awareness of questions and issues related to the application of AG 33 to Guaranteed Living Income Benefits (GLIBs). The results of the survey indicated concern about GLIB reserve levels, as well as questions about the synchronization of calendar year statutory valuation rates with the current economic environment, refreshing of valuation rates for "CD" annuities (that renew subsequent to the initial interest and surrender charge guarantee periods), and proper valuation rates for settlement option elections. Other areas of uncertainty include valuation rates for use with contracts with temporary market value adjustments, treatment of multiple index crediting options with different guarantees, and contingent surrender charges. LATF asked that the work group continue its efforts on VM-22, and to investigate potential issues with AG 33.

Nonforfeiture Improvement
The AAA Nonforfeiture Improvement Working Group reported to the task force on continued discussion of the recommendations presented at the Fall National Meeting (the "Report"). The Academy Working Group, LATF and the ACLI Standard Nonforfeiture Law Modernization Work Group have held conference calls to discuss the Report and specifically the operation of the Gross Premium Nonforfeiture Method (GPNM) that was outlined.

The GPNM is a retrospective approach utilizing actual policy gross premiums and reflecting the funded portion of the risks in the policy. After further review of an example demonstrating the methodology, LATF requested that working group study the actuarial issues associated with the choice of assumptions that would be used and make specific recommendations concerning how the assumptions should be established and any guardrails deemed appropriate from an actuarial perspective. The working group will prepare a report on the considerations in choosing assumptions, but needs resolution of related issues before developing a specific proposal. With the push to get PBR adopted by mid-June, LATF's focus on non-forfeiture improvement will be deferred to late June.

Mortality Tables
LATF received a report from a joint Society of Actuaries and AAA group regarding the status of two separate mortality table projects. For guaranteed issue (GI), simplified issue (SI) and preneed (PN) products, data has been submitted from 15, 33 and 12 companies, respectively. Data cleansing and analysis will be completed this spring, and the goal is to have first draft of the new tables by late 2012.

Work on the 2014 Valuation Basic Table to support PBR is progressing. Data from 2007-2009 is being incorporated with original experience data for 2002-2007. The initial focus is on developing aggregate tables, then smoker/non-smoker splits, followed by preferred tables. Preliminary analysis of selection period, mortality improvement and graduation basis is complete. Originally, experience from 2002 through 2007 was collected for purposes of this study. However, with delays in PBR, data from 2007 through 2009 have been collected from 40 companies and is being included in the analysis. This additional information will greatly increase the amount of preferred underwriting experience data on which the new table will be based.

The joint SOA & Academy group also noted that the 2012 Individual Annuity table has been exposed for several months now but only two comments have been received. This table is a generational table instead of static, as it has been in the past, and there is some concern among regulators that the exposure draft is difficult to find, and that companies are not aware of the potential challenges with implementation of a generational table. LATF approved changes to the Model Regulation to recognize the 2012 Individual Annuity Reserve (2012 IAR) table for use in valuation of annuity contracts and voted to expose the changes for a 45 day comment period. Adoption of the table is planned for Summer National Meeting.

Moody's Corporate Bond Index
Disagreement over the contract terms between Moody's and the NAIC was resolved and the NAIC will continue to publish the Moody's rates for use in establishing dynamic interest assumptions.

Standard Nonforfeiture Law
LATF adopted changes in the Standard Nonforfeiture Law language to make it consistent with PBR requirements and the revised Valuation Manual. These changes tie the applicable mortality table and non-forfeiture interest rates to the Valuation Manual, for policies issued after the effective date of the Valuation Manual. Non-substantive changes included clarifying the mortality table references and the applicability relative to policies issued before or after the operative date of the VM.

IIPRC Report
The Interstate Insurance Product Regulation Commission provided a report of recent activities related to life and annuity product filings, including the issuance of a Filing Information Notice (FIN) regarding separate accounts. This requires companies to disclose whether separate accounts are insulated or not, and establishes filing standards for Group Term and Group Life products. During the summer, the Commission will begin the five-year review of life standards. Product standards are evaluated every five years and the Commission asks staff and interested parties to present proposals and recommendations for consideration, which will determine the need for any changes. If no changes are implemented then the standards are approved for another five year period.

Annuity Sales and Suitability Issues Symposium

As state insurance regulators begin to implement the annuity suitability model regulation, the life insurance industry continues to implement the new processes designed to meet regulatory standards and avoid market conduct action. This was evident on March 2 when the NAIC held a symposium designed to answer questions related to the implementation of the new suitability model. Panelists included Commissioner and Chair of the Life and Annuities Committee, Julie Mix McPeak, Joseph Borg, Director, Alabama Securities Commission, Andrew Favret, FINRA, and Jim Mumford, First Deputy Commissioner and Securities Commissioner of the Iowa Insurance Division.

The symposium was well attended by approximately 100 life industry representatives, regulators, and other interested parties. A healthy dialogue ensued related to several "red flags" regulators would be looking for while conducting a suitability analysis. While the following is not an exhaustive list, regulators will likely note the following when conducting a suitability analysis.

- Were there higher than average surrenders by product or by producer?
- Did the applicant opt not to supply suitability information?
- Did the annuitant make any withdrawals that were close to the issuance date?
- Does the annuitant's age indicate that the product may not have been suitable?

In addition, regulators spoke candidly about their approach when suitability issues arise during a market conduct exam. Specifically, the panel acknowledged there would be challenges associated with implementation of the suitability model and explained that they would be willing to work through them with regulated entities, while ensuring that the consumers' interests are protected.

The symposium also included a Social Media panel lead by Tim Mullen, Director of the Market Regulation Division at the NAIC, Keith Nyhan, Examiner in Charge for the New Hampshire Insurance Department and Donald Walters, President and CEO of CEFLI. The panel focused on the use of social media by insurance producers as a means to build relationships and their professional networks. In addition, the panel discussed a white paper entitled, *The Use of Social Media in Insurance*, which has been adopted by the Social Media Working Group.

The white paper notes the use of social media by the insurance industry is on the rise. While several insurance departments are regulating through market conduct examinations, others are regulating on a case-by-case basis when complaints arise. Currently, there is no plan to develop a model law or regulation about the use of social media in insurance. The panelists noted that the dynamic nature of social media requires regulatory flexibility, which is often difficult with a statute or regulation.

The panels described the nexus between the suitability and social media discussions. First, the actions of those using social media are expected to be supervised and monitored. Second, record keeping requirements need to be considered and enforced. Lastly, insurers need to set clear standards about what their expectations are from their

producers as they relate to both suitability and the use of social media.

Health Actuarial Task Force

Long Term Care
The LTC Actuarial Working Group held its meeting to kick off the task force's session. The primary topic of discussion was continued work on the development of a new LTC valuation table. Data issues delayed the analysis but task force members have begun the tabulation of claims incidence rates and termination rates. Reasonableness checks are targeted for completion by the end of June, with issuance of a draft report by mid-August for presentation at the Summer National Meeting.

Long Term Disability
The task force received an update from a joint Academy & SOA group that is developing a new LTD valuation table to replace the 1987 Commissioners Group Disability Table. The group presented a proposed table and methodology that incorporates a company's own experience into the termination rates used for valuation purposes, taking into account the credibility of the company's data.

The proposed table contains a 15% margin in the termination rates relative to the base table, and limits carriers own experience margins applied in years 1-5 to 5%-15% based on the credibility of the underlying experience. The group plans to finalize the proposal for exposure in the coming months, targeting a complete recommendation by June and Commissioner approval at the Summer National Meeting.

Health Care Reform
Various subgroups of the Health Care Reform Actuarial Working Group presented updates, which included discussion of a recommended approach for establishing state-specific thresholds for annual review of "unreasonable increases in premiums for health insurance coverage," as required by PPACA. The threshold for the initial year of the rate review program (Sept 2011 - August 2012) was set at 10% for all states, and state-specific thresholds are to be established thereafter. Members of the Center for Consumer Information and Insurance Oversight (CCIIO) presented a draft discussion document recommending an approach similar to that used to establish the 10 % threshold, but that would account for state-specific variations in specified data elements and would allow states to propose their own thresholds. The CCIIO plans to finalize the recommendation in March, expose the document in April and adopt a recommendation by June 1, to be effective September 1, 2012.

Casualty Actuarial and Statistical Task Force

At the Spring National Meeting, the task force adopted proposed changes to the Annual Statement instructions for the 2012 Property/Casualty Actuarial Opinion, Property/Casualty Actuarial Opinion Summary, and Title Actuarial Opinion, including improvements to the documentation requirements in the detailed Actuarial Report maintained at the company. Changes to the Actuarial Report are significant and incorporate a description of the appointed actuary's relationship to the company with clear description of the actuary's role in advising the Board and/or management regarding the carried reserves.

The Actuarial Report should identify how and when the appointed actuary presents the analysis to the Board and, where applicable, to the officer of the company responsible for determining the carried reserves. The Report should include an exhibit of reserves which agrees to the annual statement and compares the actuary's conclusions to the carried amounts consistent with the segmentation of exposure or liability groupings used in the analysis, and the actuary's conclusions including the actuary's point estimate, range of reasonable estimates, or both. The Report should also include an exhibit or appendix showing the change in the estimates from the prior actuarial report, including extended discussion of factors underlying any material changes.

The task force discussed two issues related to appointed actuaries who do not write acceptable actuarial opinions. The first is the standards of practice under which actuaries operate (i.e., Actuarial Standards of Practice) are not always drafted to meet the needs of regulators. The second relates to the fact that the commissioner has authority for corrective action when the work of a life company appointed actuary fails to meet regulatory needs or requirements while for P/C companies, the commissioner does not have comparable authority. The task force is considering how best to handle these issues and one option proposed was to revise the *Property and Casualty Actuarial Opinion Model Law* (#745). The task force discussed that approval of both Property and Casualty Insurance Committee and Executive Committees is needed prior to

amending a model law if the task force decides to proceed with this option. The task force discussed the establishment of a subgroup to draft the required paperwork to amend the model law.

The task force also discussed the need to consider ways to improve financial reporting to make it more meaningful. It was noted that some information within the annual statement is more useful than others. Additionally, some requirements may be more obscure. Thus, a request was made to hold a conference call and invite the industry (i.e. appointed actuaries) to provide feedback to improve the usefulness of financial statement reporting and to discuss industry concerns. The task force then adopted modifications to the NAIC Statistical Handbook to insert information about the *Medical Professional Liability Closed Claim Reporting Model Law* (#77).

Examination Oversight Task Force

The task force discussed a survey of the states regarding progress toward adopting the revised *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition*. Of the 35 states that responded to the survey, 17 states have adopted the revised model, 12 states plan to adopt, and 1 state plans to adopt with changes. Three states are unsure and two states are not planning to adopt as they feel the revisions are already covered by other statute. For states planning to adopt, 6 are adopting in 2012, 4 in 2013, and remaining 3 have no timeline.

The task force heard a presentation of the risk-focused exam industry survey results from the Risk Focused Surveillance Working Group, which asked for "constructive comments that can be used to make positive changes to improve the overall effectiveness and efficiency of risk focused exams." A total of 26 responses were received from 22 companies, 1 trade organization, and 3 contractors.

The survey results revealed general concerns from the industry that risk-focused examinations are not being consistently applied among the states. Specific comments related to the number of examiners, number of interviews, increased examination fees, lack of utilization of SOX/MAR work, and unsecured data transmittal. The most common challenge noted was the examiner's lack of understanding of the company which was evident during interviews with top level management. Response on the use of contract examiners was mixed, ranging from contract examiners being more organized with better workflow management to a perceived lack of understanding of state laws and risk-focused approach along with lack of communication between the contractor and state examiners. The three most common responses to increase efficiency were more reliance on work performed by internal/external auditors and SOX/MAR documentation, more reliance on other state's work or prior exams, and better management of the planning phase.

The task force plans to address issues noted in the survey results. The task force also discussed a need to request that the Financial Regulation Standards and Accreditation Committee announce publicly that the states will not be subject to accreditation sanctions for doing less work in conjunction with performing a risk-based audit.

A member of the task force expressed disappointment with the lack of responses and suggested a re-survey. A request to reconcile the number of responses was raised, in particular those related to feedback received from trade organizations in order to ascertain an accurate number of responses since the 26 responses do not appear to be indicative of the number of entities actually responding. NAIC staff will coordinate work on this.

Climate Change and Global Warming Working Group

The working group received a presentation on the United Nations Environment Programme Finance Initiative Principles for Sustainable Insurance (PSI) Initiative. The presentation included information on the objectives, development and implementation of the global principals of the PSI.

Impact of Climate Exam Subgroup

The subgroup is charged with reviewing risk-focused examination questions for possible inclusion of specific questions regarding the impact of climate for inclusion in the 2013 Financial Condition Examiners Handbook. The subgroup has identified four areas (Exhibit Y–Examination Interviews, Exhibit B-Examination Planning Questionnaire, Exhibit V, and the applicable risk repositories) for possible inclusion of questions addressing the impact of climate change. The subgroup requested NAIC staff to draft proposed updates to these areas.

Impact of Climate Disclosure Survey Subgroup

The subgroup is charged with modifying the NAIC Climate Risk Disclosure Survey to have greater financial emphasis. The subgroup considered the results of United Nations Environment Programme Finance Initiative Global Survey, "Advancing the

Role of the Insurance Industry in Climate Change Adaptation." The subgroup plans to meet monthly following the Spring National Meeting to address potential changes to the NAIC Climate Risk Disclosure Survey.

Title Insurance Task Force

At the Spring National Meeting, the task force received an update on projects as follows.

Modernize the solvency regulation of title insurance
A joint subgroup of members from the task force and the Capital Adequacy Task Force (CADTF) will be established to identify major risks for title insurance and how those risks might be addressed and to see whether it makes sense to develop a risk-based capital formula for title insurers or modify the current P/C RBC formula to add risks associated with title insurance. Some regulators believe the solvency risk of title insurers does not warrant the resources to develop an RBC tool for title insurers, but the task force is generally supportive of forming a subgroup to study the issues further.

Develop risk-focused financial examination guidelines for title insurers - The Financial Examiners Handbook Technical Group agreed to consider what type of guidance related to title insurance should be added to the Examiners Handbook.

Develop early warning tools for title insurers - The Financial Analysis Research and Development Working Group has made substantial progress over the last few years in developing regulatory financial tools for title insurers. The early warning tools are for regulators only. The task force will consider if additional early warning tools for title insurers are necessary.

Revive work on Title Insurance Guaranty Fund Model Act and promote the use of blanket lenders' policies and individual owners' policies to replace policies issued by insolvent insurers - At the Receivership and Insolvency Task Force meeting, a subgroup was formed, chaired by Texas, to review and provide recommendations to address these two referrals.

A subgroup was formed whereby Kansas and Ohio will work with other regulators in determining the feasibility of promoting effective consumer shopping for title agents and insurers without delaying real estate closing schedules, and in developing best practices for the design and implementation of title cost comparison guides for consumers.

Title Insurance Market Conduct and Mortgage Fraud Working Group - The working group convened in a two-part session of meetings. In the first session, the working group heard from interested parties, the American Land Title Association and a large title agent in Colorado regarding concerns over mortgage fraud (e.g. defalcation, embezzlement, and escrow theft). The working group agreed that action is needed to limit escrow theft in order to protect consumers. The working group also agreed to develop a white paper to identify issues concerning escrow theft and develop solutions that the industry and regulators can implement. A subgroup was formed, chaired by Nebraska, to develop the outline of the white paper.

Risk Retention Group Task Force

The task force discussed a December 2011 report on RRGs published by the Government Accountability Office (GAO). The report examined the current financial condition of the RRG industry, noting that it has remained profitable. The report also discussed the regulation of RRGs, which it noted often varies among states, in particular given that the Liability Risk Retention Act (LRRA) is silent on certain issues including registration requirements, fees, and the types of insurance coverage that RRGs can write. In some cases this has led to litigation between state insurance regulators and RRGs.

The report also highlighted the unique provisions of the LRRA which allow RRGs to be supervised by their domiciliary state regulator, and to write business across other states without being subject to supervision by the non-domiciliary state regulator. The report noted that this has resulted in RRGs being concentrated in a small number of states, and cited evidence that this may be because of lower minimum capitalization requirements and other comparative financial and regulatory advantages.

The report also referenced an earlier 2005 GAO report, which recommended the establishment of more uniform, baseline standards for RRGs, and discussed subsequent changes made by the NAIC, including the extension of risk-focused examinations and RBC to RRGs.

The report recommended that Congress consider clarifying certain provisions of the LRRA regarding registration requirements, fees and coverage, a conclusion with which the NAIC concurred. However, both working group members and industry commentators agreed that a focus on minimum capitalization standards for RRGs, which

can be low, was misleading, as lead state regulators consistently require RRGs to hold capital above the minimum required standard. The working group also discussed the importance of communication between domiciliary and non-domiciliary state regulators, to provide confidence to the non-domiciliary state regulator that the RRG is being supervised effectively.

Risk Retention Working Group

The working group met via conference call on December 14; however because the working group did not have a quorum, items discussed on the conference call were taken via response to an electronic vote on December 21. The working group approved a response letter to the National Treatment and Coordination Working Group regarding the draft Form 16b, Statement of Voluntary Dissolution for RRGs to recommend that completion of the form and notification of non-chartering states be made mandatory. The purpose of the form is to notify the registered states when an RRG voluntarily dissolves its corporate status in its chartering state. The task force requested that the working group consider whether Form 16b should be mandatory, and if so, whether the chartering state should be required to communicate the information to all other states in which the RRG is registered.

The working group also discussed a referral from the Financial Regulation Standards and Accreditation Committee regarding the exemption of RRGs from the Business Transacted with Producer Controlled Property/Casualty Insurer Act for accreditation purposes. The working group voted to respond to the Property and Casualty Committee that it agrees with the recommendation of the task force that the Act be applicable to RRGs.

The working group also received a report from the Risk Retention Handbook Subgroup. The subgroup has approved revisions to Sections II and II of the Risk Retention and Purchasing Group Handbook and continues to consider revisions to the remainder of the handbook.

***

The next National Meeting of the NAIC will be held in Atlanta August 11-14. We welcome your comments regarding issues raised in this newsletter. Please give your comments or email address changes to your PricewaterhouseCoopers LLP engagement team, or directly to the NAIC Meeting Notes editor at jean.connolly@us.pwc.com.

Disclaimer

Since a variety of viewpoints and issues are discussed at task force and committee meetings taking place at the NAIC meetings, and because not all task forces and committees provide copies of agenda material to industry observers at the meetings, it is often difficult to characterize all of the conclusions reached. The items included in this Newsletter may differ from the formal task force or committee meeting minutes.

In addition, the NAIC operates through a hierarchy of subcommittees, task forces and committees. Decisions of a task force may be modified or overturned at a later meeting of the appropriate higher-level committee. Although we make every effort to accurately report the results of meetings we observe and to follow issues through to their conclusion at senior committee level, no assurance can be given that the items reported on in this Newsletter represent the ultimate decisions of the NAIC. Final actions of the NAIC are taken only by the entire membership of the NAIC meeting in Plenary session.

Additional information

If you would like additional information, please contact:

Jean Connolly
Managing Director, National
Professional Services Group
Tel: 1 440 893 0010
jean.connolly@us.pwc.com

PwC's Insurance Practice Leaders

Jim Scanlan
Insurance Practice Leader
Tel: 1 267 330 2110
james.j.scanlan@us.pwc.com

Paul McDonnell
Insurance Advisory Co-leader
Tel: 1 646 471 2072
paul.h.mcdonnell@us.pwc.com

James Yoder
Insurance Advisory Co-leader
Tel: 1 312 298 3462
james.r.yoder@us.pwc.com

Sue Leonard
Insurance Tax Leader
Tel: 1 213 830 8248
susan.leonard@us.pwc.com

www.pwc.com/us/en/insurance

© 2010 PricewaterhouseCoopers LLP. All rights reserved. "PwC" refers to PricewaterhouseCoopers LLP, a Delaware limited liability partnership, or, as the context requires, the PricewaterhouseCoopers global network or other member firms of the network, each of which is a separate and independent legal entity. This document is for general information purposes only, and should not be used as a substitute for consultation with professional advisors.

Mark Your Calendars | Upcoming SOFE Career Development Seminars

2012

July 29–August 1
Dallas, Texas

Omni Mandalay Hotel at Las Colinas

Registration Opens in April
Visit: www.sofe.org

2013

July 21–24
Henderson Lake, Nevada

Red Rock Resort

2014

July 27–30
Philadelphia, Pennsylvania

Loews Philadelphia Hotel

We are a nation of symbols. For the Society of Financial Examiners, the symbol is a simple check mark in a circle: a symbol of execution, a task is complete.

The check mark in a circle identifies a group of professionals who are dedicated to the preservation of the public's trust in the field of financial examination.

Our symbol will continue to represent nationwide the high ethical standards as well as the professional competence of the members of the **Society of Financial Examiners.®**

Society of Financial Examiners
12100 Sunset Hills Road | Suite 130
Reston, Virginia 20190

703.234.4140
800.787.SOFE (7633)
Fax 703.435.4390