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CRE READING PROGRAM INSTRUCTIONS

The Society of Financial Examiners has a Reading Program for Earning Continuing Regulator 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. There will be a total of 9-20 questions depending on 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 username and password to access it. If you experience any difficulty logging into the Members section, please contact **sofe@sofe.org**.

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The questions are on the following page. Good luck!

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CRE Reading Program Questions

All quizzes MUST be taken online.

*Questions will be **available online Monday, June 18, 2018.***

Why States Should Perform Commercial Medical Loss Ratio Exams and What Do I need to Know?

Multiple Choice Questions — Submit Answers Online

1. Earned premiums are reported on the MLR Form on what basis?
   a. Direct written premium generally after reinsurance amounts
   b. Direct earned premium generally after reinsurance amounts
   c. Direct written premium generally before reinsurance amounts
   d. Direct earned premium generally before reinsurance amounts

2. What types of taxes are allowed to be reported in the tax section on Part 1 of the MLR Form?
   a. PCORI fees, capital gains taxes, premium taxes
   b. 9010 fees, PCORI fees, state income taxes
   c. Federal income taxes, payroll taxes, investment income taxes
   d. Guaranty fund assessments, sales tax, federal and state employment taxes

3. The Federal definition to determine MLR group size market classification is:
   a. Total average number of eligible employees of the preceding calendar year
   b. Total average number of current full-time employees
   c. Total average number of employees in the preceding calendar year
   d. Total eligible employees per the State counting method

4. Beginning with the 2017 MLR reporting year, issuers have the option to report which of the following as a single fixed amount of 0.8 percent of earned premium for each state and market?
   a. Quality improvement activities (QIA) expenses
   b. Experience rating refunds
   c. Federal income taxes
   d. Cost-sharing reduction (CSR) payments

5. Which of the following federal premium stabilization programs <u>does not</u> expire at the end of 2016?
   a. Federal Transitional Reinsurance Program
   b. Federal Risk Adjustment Program
   c. Federal Risk Corridor Program
   d. All of the above

The Model Audit Rule: Requirements, Misconceptions, Industry Trends, and Value Added Recommendations for Examiner Consideration

Multiple Choice/True or False Questions — Submit Answers Online

1. Which of the following is not a purpose for the NAIC's Annual Financial Reporting Model Regulation #205, Model Audit Rule ("MAR").
    a. Provide regulators with confidence that insurers have effective controls for mitigating the risk of inaccurate annual statements.
    b. Increase efficiency of the risk focused examinations by allowing Examiner reliance on MAR control testing performed.
    c. Ensure that the CEO and CFO of insurers subject to the regulation are financially liable to stakeholders in the event of an insolvency.
    d. Enhance corporate governance by increasing management confidence in their internal controls environment.
2. The Annual Financial Reporting Model Regulation Implementation Guide defines diligent inquiry as "conducting a search and thorough review of relevant documents which are reasonably likely to contain significant information with regards to internal control over financial reporting."
    a. True
    b. False
3. The authors indicate that all of the following are industry common misconceptions related to MAR, except:
    a. If an insurer is required to file an Own Risk Solvency Assessment ("ORSA") report they are also required to file MAR, and vice versa.
    b. Materiality and scoping can be completed without regards to risks.
    c. IT systems are not significant unless they relate to the general ledger.
    d. All of the above are included in the article as common misconceptions.
4. The alignment trends within MAR implementation and improvement aims to ensure the timing of MAR procedures are aligned to periods in management's schedule when it is most convenient to assess the operating effectiveness of controls.
    a. True
    b. False
5. Which of the following is not one of the authors listed value added recommendations for increasing an insurers overall MAR process.
    a. Making no changes to the risk assessment and materiality scoping year-to-year to ensure uniform MAR procedures.
    b. Implementing effective project management including, but not limited to, a MAR calendar of kickoff meetings, testing timelines, and deliverables.
    c. Conducting rotational auditing which is determined based on the areas inherent risk assessment.
    d. Incorporating MAR testing as part of other planned operational / compliance audits to increase efficiency.

A Review of Root Cause in Insurer Insolvencies and Impairments

True or False Questions — Submit Answers Online

1. Based on the case study conducted and documented in the article, relative to Canadian insurer insolvencies, the rate of U.S. insolvencies is much lower.

   a. True
   b. False

2. Premium growth was not identified as one of the key risks as a potential insolvency driver for U.S. based insurance companies.

   a. True
   b. False

3. Based on case studies reviewed, the majority of insurer insolvencies have evolved from a multiple number of risk factors.

   a. True
   b. False

4. Relative to the U.S. based view, Canadian based studies also did not show that growth and profitability (pricing) were leading factors in insolvency.

   a. True
   b. False

PWC NAIC Newsletter

True or False Questions — Submit Answers Online

1. The Blanks Working Group voted to combine the annual and quarterly statement blanks for life companies and fraternal companies into one blank by making changes to the life blank. All life companies and all fraternal companies will now file this newly combined blank.

   a. True
   b. False

2. After extensive comments and feedback, the Reinsurance Task Force determined no changes are needed to the Credit for Reinsurance Model Law and Regulation as a result of the adoption of the Covered Agreement by the U.S. and EU.

   a. True
   b. False

3. The Financial Regulation Standards and Accreditation Committee determined that the December 2017 significant revisions to the Life and Health Guaranty Association Model Act (which were made to address guaranty fund assessment and coverage issues of long-term care insolvencies) will not be required to be adopted by States for purposes of accreditation.

   a. True
   b. False

4. The Group Solvency Issues Working Group determined that an exemption could be granted from filing a Form F if an Insurance Holding Company System has filed an annual report with the SEC disclosing its material risks.

   a. True
   b. False

5. The Executive Committee and Plenary adopted the Corporate Governance Disclosure Model Act and Model Regulation as a Part A accreditation standard effective January 1, 2020.

   a. True
   b. False

Why States Should Perform Commercial Medical Loss Ratio Exams and What Do I Need to Know?

By Paul Alaimo, Barbara A, Bartlett and Christopher Rushford

The Medical Loss Ratio (MLR) ensures that policyholders receive value for the premium they pay for their health insurance coverage. The MLR exams are about validating that health insurance issuers (issuers) offering commercial individual or group health insurance coverage are complying with the MLR requirements established by the Affordable Care Act (ACA).

Why Perform MLR Exams?

The purpose of a MLR exam is to assess compliance with state MLR regulations, if applicable, and the requirements of Title 45 of the Code of Federal Regulations (CFR), Part 158, which implements section 2718 of the Public Health Service Act (PHS Act). Section 2718 of the PHS Act was added by the ACA and generally requires issuers offering individual or group health insurance coverage to submit an MLR Annual Reporting Form (MLR Form) to the Secretary of the U.S. Department of Health and Human Services (HHS) for each state in which the issuer has written direct health insurance coverage.

The MLR is the proportion of direct premium revenue expended by an issuer on clinical services and activities that improve health care quality in a given state and market (e.g., individual, small group, large group, etc.). Section 2718 of the PHS Act also requires an issuer to provide rebates to the subscriber, policyholder, and/or government agency that paid the premium if it does not meet the MLR standards established by the law for the relevant market. The MLR Form is used by issuers to report the MLR data elements, calculate the MLR ratio and determine the amount of rebates, if applicable.

In order to assess compliance with the federal requirements, a MLR examination should be conducted in accordance with the NAIC's 24 MLR Agreed Upon Procedures (MLR AUPs). The MLR AUPs set forth the procedures to evaluate the validity and accuracy of the data elements and calculated amounts reported on the MLR Form, and the accuracy and timeliness of any rebate payments. The examination includes assessing the accuracy of reported premiums, claims, quality improvement activities (QIA), etc., the principles used and significant estimates made by the issuer, evaluating the reasonableness of expense allocations, evaluating the accuracy and timeliness of rebate payments, if applicable, and determining compliance with relevant statutory accounting principles, MLR regulations and guidance, and the MLR Annual Reporting Form Filing Instructions.

What Do I Need to Know?

There are several components to the MLR calculation along, with some new changes that will start with the 2017 MLR Form filing due July 31, 2018. The MLR is calculated on Part 3 of the MLR Form for each market and contains a numerator, denominator, credibility adjustment and credibility-adjusted MLR. However, the calculation cannot be performed without all of the underlying information that is reported on Parts 1 and 2 of the MLR Form as the information from Part 2 flows into Part 1, and then ultimately to Part 3.

MLR Numerator
The numerator calculation includes reported amounts for incurred claims, QIA, federal premium stabilization program adjustments, and until October 2017, cost-sharing reduction payments from the Federal Government.

There are several key items which must not be included in claims for MLR purposes. Title 45 CFR §158.140(b)(3) details the adjustments that cannot be reported within incurred claims. These include amounts paid to third party vendors for secondary network savings, network development, administrative fees, claim processing and utilization management, as well as amounts paid for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, including amounts paid to a provider. Generally, based upon our MLR examination experience, when reporting issues arise related to improper inclusion of these types of items, it is in connection with claim amounts reported for capitation arrangements, pharmacy benefit manager contracts and intercompany agreements. In these instances, the issuer is compensating the affiliate or non-affiliated third party vendors for administrative and overhead type expenses and incorrectly reporting these amounts with the claims reimbursement portion of the payment. It is important to understand how transactions related to these type of agreements are recorded and reported by the issuer within the MLR Form to ensure they are properly excluded in accordance with the regulation.

Historically, one of the most significant risk areas with regard to the MLR Form has been the reporting of QIA expenses. Title 45 CFR §158.150 and Title 45 CFR §158.151 provide the guidelines and reporting requirements for QIA expenses. There are five categories of QIA activities: 1) improving health outcomes, 2) preventing hospital readmissions, 3) improving patient safety and reducing medical errors, 4) implementing, promoting and increasing wellness and health activities, and 5) enhancing the use of health care data to support these objectives.

The reporting of QIA expenses generally requires significant judgment on behalf of the issuer, not only regarding the determination of which expenses qualify as QIA expenses, but also the quantification of those activities. In addition, reporting of QIA often involves a complex and detailed cost aggregation and allocation process, which varies by issuer. Issuers may outsource certain QIA programs, which creates additional challenges in the determination and reporting of QIA expenses. For all of these reasons, the frequency of issuers misreporting QIA and the number of issues noted in this area are generally higher than other MLR reporting areas, at least based upon our experience.

A recent change issued by the Centers for Medicare & Medicaid Services (CMS) may significantly change the QIA reporting requirements in the MLR

Form. In the HHS Notice of Benefit and Payment Parameters for 2019 Final Rule, CMS amended Title 45 CFR §158.221 by adding a new paragraph (b)(8), which provides issuers with the option to report QIA expenses as a single fixed percentage of 0.8 percent of earned premium beginning with the 2017 MLR reporting year, in lieu of determining and reporting actual QIA expenses.

The objective of the simplified fixed percentage QIA option is to alleviate the administrative cost and substantial effort required by issuers to identify, track and report actual QIA expenses. This change is optional and issuers can continue to report actual QIA expenses if they undertake the effort to identify, track and document actual QIA expenses. In the final ruling, CMS included specific conditions which must be adhered to by those issuers who elect the option to report QIA as a single fixed percentage. These conditions apply to issuers and their affiliates and are as follows: 1) apply the option consistently across all of the states and markets subject to the MLR requirements, 2) apply the reporting method for a minimum of three consecutive MLR reporting years, and 3) elect the option for all affiliated issuers. If an issuer decides to use the fixed percentage option, it does not have to prove that it has actual QIA expenditures.

For the 2014 through 2016 MLR reporting years, the numerator of the MLR calculation included the impact of amounts received and paid by the issuer in connection with the federal premium stabilization programs. The federal premium stabilization programs were comprised of amounts reported by the issuer for the Federal Transitional Reinsurance Program payments expected from HHS, Federal Risk Adjustment Program receivables or additional payables, and Federal Risk Corridor Program receivables or additional payables. However, regulations covering the Federal Transitional Reinsurance Program and the Federal Risk Corridor Program expired at the end of 2016, which will impact not only the amounts reported in the MLR numerator, but will also impact the reporting of taxes in Part 1, Section 3 of the MLR Form as contributions related to the Federal Transitional Reinsurance Program are no longer required of issuers. In addition, for the 2017 MLR Form, there will no longer be reporting in the Risk Corridor columns on Parts 1, 2 and 3 of the MLR Form. As a result, the Federal Risk Adjustment Program, which is a permanent program, will be the only remaining premium stabilization program that will impact the amounts reported on the 2017 MLR Form and beyond.

In addition, there has been other recent regulatory actions that will impact issuers' reporting of cost-sharing reduction (CSR) payments reported on Part 3 of the numerator calculation on the MLR Form. In October 2017, President Trump issued an executive order which effectively ended the payment of CSR to issuers selling qualified individual health plans. Prior to this executive order, the Federal Government made CSR payments to issuers to compensate them for complying with the ACA requirements to ease the patient's share of

costs in Silver plans on the Exchange through the reduction of deductibles and co-pays of enrollees. Unless there is a change to the current executive order or additional legislation enacted through Congress to fund the CSR payments, issuers will no longer receive or report CSR payments on Part 3, Line 1.4 of the MLR Form. The elimination of the CSR payments, which is accounted for as a reduction to incurred claims in the MLR Form, will cause an increase in incurred claims as issuers will still be responsible for the CSR payments with no reimbursement from the Federal Government. The potential exists that the elimination of CSR payments may cause increases in premium rates charged by issuers in order to offset the loss of the reimbursement of these payments. The status of CSR payments should be monitored for any changes as they will directly impact the MLR calculation.

Beginning in 2015, the MLR Form Filing Instructions included a key change to the reporting of experience rating refund reserves. The instructions explicitly state that premium stabilization reserves must be excluded from the amounts reported for experience rating refund reserves in Part 2. Given that this exclusion was added in 2015, there is a risk that an issuer many not have properly captured this reporting change and, as a result, is improperly including premium stabilization reserves within incurred claims. Improper inclusion of these reserves would result in an overstatement of incurred claims, which increases the MLR numerator as well as the issuer's MLR, leading to a potential inappropriate reduction or elimination of rebates.

MLR Denominator

The denominator calculation includes earned premium reported on a direct basis less taxes, which are comprised of federal income tax, state income tax and other taxes, along with licensing and regulatory fees.

Title 45 CFR §158.130 defines direct earned premium as all the monies paid by a policyholder or subscriber as a condition of receiving coverage from an issuer. These monies are to include any fees or other contributions associated with the health policy. These fees and contributions include all monies received by an issuer under advanced payment tax credits (APTC) for on-exchange subscribers, any administrative fees charged to a policyholder, the 9010 fee that is charged with premium, and agent/broker commissions that are a part of the premium charged to a policyholder. The impact of assumed and ceded reinsurance is not included in the premium or claims reported in the MLR Form unless 1) it is a 100% assumption with novation, or 2) a 100% indemnity reinsurance and an administrative agreement effective prior to March 23, 2010. If either of these two criteria are met, then only the assuming reinsurer reports the experience for the entire year, regardless of the date of the assumption.

A key objective in the testing of premiums is to ensure a policy is reported in the proper market on the MLR Form. There are four types of commercial markets: individual, small group, large group and student health. Whereas the individual, small group and large group markets are reported according to the situs state of the policy (the state the policy was issued), student health insurance is reported only in the Grand Total page of the MLR Form and the situs state is not applicable. This is due to the fact that student health is considered national coverage and not determined by the specific state in which the policy was issued. The issues that arise in determining the market classification involve sole proprietors, partners in partnerships and the size of the group. Section (c) of Title 29 CFR §2510.3-3 defines single business owners, whether incorporated or unincorporated, and partners in a partnership as individuals and not employees. Although some states allow sole proprietors and partners to be reported as a small group, the federal definition states that unless a sole proprietor or partnership provides health coverage for one or more unrelated employees, it is to be reported in the individual market.

Issuers are allowed to use the state definition of a small group for market classification purposes. Prior to 2016, if the state defined a small group as up to 50 employees, an issuer could classify groups having up to 50 total average employees in the preceding calendar year as a small group, but the federal definition of small group was 100 total average employees for the preceding calendar year. Issuers were allowed to use the state definition of the situs state until 2016, when issuers were required to use the federal definition. As many states already defined a small group as one that has 50 employees, and there was state support for keeping that, CMS lowered the total average employees for the preceding calendar year from 100 to 50 for purposes of determining group size. Approximately 15 states had already changed their small group definitions to 100 in anticipation of the required change, effective as of January 1, 2016. Issuers writing policies in states that changed the small group definition to 100 must now use the state definition of 100 and not the federal definition of 50 for small group classification purposes. Additionally, issuers are allowed the option of restating the prior two years' experience (PY1 and PY2 columns) reported on the MLR Form, if the situs state defines small group as 100 instead of the previous definition of 50. If an issuer chooses to restate the prior two years' experience, the restatement must also include all of the related claims, QIA, taxes, life years, etc., related to the restated experience.

In addition to the changes related to MLR group size market classification above, there was also recently issued guidance regarding the requirements for how issuers count and define employees in the determination of market size. For the 2016 MLR reporting year and prior, the federal definition for determining the number of employees for market classification purposes must be used, which is the total average number of employees in the preceding calendar year. The total average number of employees includes all employees in the preceding calendar year, i.e., full time, part-time and seasonal

employees, not just eligible employees. However, the Center for Consumer Information and Insurance Oversight (CCIIO) recently issued new guidance in an Insurance Standards Bulletin dated April 9, 2018 with regard to counting employees for the determination of group size for MLR reporting. Based on this guidance, beginning with the 2017 MLR reporting year, an issuer may elect to use either the federal definition described above or the counting method used in the HHS operated Risk Adjustment Program for determining market classification, which defers to the applicable state counting method subject to certain criteria as more fully described in the issued bulletin.

Recently, there have been discussions concerning allowing the formation of Association Health Plans (AHP) to help individuals and small groups obtain more affordable health coverage. On October 12, 2017, President Trump issued Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States". The Executive Order proposes to accomplish this by prioritizing three areas for improvement in the near future, as follows: 1) use of AHPs; 2) short-term limited duration insurance, and 3) health reimbursement accounts (HRAs). Regarding the AHPs, the Executive Order directed the Secretary of Labor to, within 60 days of the Order, consider proposing regulations or revising guidance consistent with the law to expand access to health coverage by allowing more employers to form AHPs. One of the major issues with AHPs is that, under section 3(5) of Employee Retirement Income Security Act (ERISA), associations must have a bona fide purpose to form other than just offering health coverage. The United States Department of Labor (DOL) has issued proposed rules to modify the ERISA guidance regarding associations, allowing associations to form solely for the purpose of offering health care coverage. Qualifications to this rule would be the association could form only if there is commonality between the employers in the group, such as industry or geography. As for geography commonality, the proposed rule requires that the region the association would cover not exceed the boundaries of the same state or metropolitan area if that metropolitan area includes more than one state. The proposed rules would require that only employees and former employees of employer members (and family/beneficiaries of those employees and former employees) may participate in a group health plan sponsored by the association and does not allow the association to make coverage available to anyone other than as previously described. The purpose of the proposed rule is to provide affordable healthcare for small groups, which would also include sole proprietors and partnerships. The change is based on the assumption that associations would have economies of scale that would translate to lower cost health insurance. The proposed rule was issued for comment in January 2018 with the comment period ending on March 6, 2018, with a final rule anticipated to be issued in the summer of 2018. If the proposed rule passes, it will require the Associations' market to be classified in the MLR Form according to the number of total subscribers.

Taxes are reported in Part 1, Section 3 of the MLR Form and flow into the Part 3 denominator section. As premiums are also part of the denominator, the two sections are usually associated with each other. Total taxes reported in Part 1 are subtracted from premium in Part 3. An increase or decrease in taxes has an inverse effect on the denominator. Therefore, the overstatement of taxes is the risk on which to focus, as higher taxes lead to a lower denominator, which improves the issuer's MLR and potentially lowers or eliminates a rebate liability.

Taxes include federal and state income taxes, Patient Centered Outcomes Research Institute (PCORI) fees, 9010 fees, other federal taxes and assessments, state excise, business and other taxes, state premium taxes, community benefit expenditures, Federal Transitional Reinsurance Program Contributions (not applicable after 2016) and other federal and state regulatory authority licensing and other fees.

The reporting of federal and state income taxes is generally self-explanatory, except that not only are tax expenses reported, but tax benefits are to be reported as negative values. Federal and state income taxes that are expressly excluded from reporting on the MLR Form are taxes related to investment income and capital gains. These taxes are reported in Part 1, Section 9 of the MLR Form, but only for informational purposes.

PCORI fees are based on covered lives and assessed to health plan sponsors and issuers by the Internal Revenue Service (IRS) code. They are designed to assist patients, clinicians and policymakers in making informed health decisions by advancing the quality and relevance of evidence-based medicine. PCORI fees are paid by both health insurance issuers and self-funded employer health plans, which are not subject to MLR reporting and which report their PCORI fees through the issuer that administers the claims of the self-funded plan.

The ACA 9010 fees are imposed on issuers generally with net written premiums exceeding $25 million, and charged to policyholders as part of premium. There are some exceptions, but they are complex and beyond the scope of this article. An issuer acts as a pass-through for collection of the 9010 fee, much in the same way sales taxes are handled through a retailer. The 9010 fees are due to the government by September 30th, called the fee year, in which the fees are payable. The actual fees, however, were collected for the previous calendar year. For example, fees that were paid on September 30, 2017, were actually the fees collected in the 2016 calendar year. The government declared a moratorium on the 2017 and 2019 calendar years, therefore, no 9010 fees were collected in 2017 and will not be collected in the 2019 calendar year. Fees start to be collected again in 2018 and will be remitted to the Federal Government by September 30, 2019.

Other federal taxes and assessments are those that are not specifically excluded by regulation. However, this does not include fines, penalties or examination fees. If an issuer underwent an IRS audit and had to pay penalties and interest, those penalties and interest are not treated as a deduction from earned premium on this line in the MLR Form.

State excise, business and other taxes do not include sales tax or real estate/property taxes. Although these taxes are not expressly excluded under the regulation, they are not included as a specific state tax. Real estate/property taxes are not state taxes and CCIIO has determined that sales taxes are not includable as 'other taxes' or business taxes. Examples of allowable taxes are industry-wide assessments paid to the state directly, but surcharges directly related to claims are not includable; premium subsidies designed to cover the cost of providing indigent care or other access to health care, as long as they are directly related to indigent care or improving health access; and, guaranty fund assessments, which also may be deferred if the assessments will be offset in future years through reductions in state taxes or premium surcharges by state law. If these are deferred, the assessments are reported in the year of offset. Assessments of state boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes and advertising required by law, regulation or ruling, except advertising associated with investments are also considered allowable taxes.

Payroll taxes were specifically not allowed as a deduction from premium on Part 1 of the MLR Form, starting with the 2016 MLR reporting year; however, in CMS's proposed 2019 changes issued for comment, it is reevaluating allowing issuers to report federal and state employment taxes in the tax section once again.

Credibility Adjustment

The credibility adjustment consists of the base credibility factor and the deductible factor, which are multiplied by each other to determine the total credibility adjustment. Each factor is calculated separately for each market on the MLR Form. The ACA requires the MLR calculation to include methodologies to account for special circumstances, such as smaller or newer plans and, as a result, these two adjustments were adopted. The base credibility factor exists to address the statistical unreliability of experience of plans with low enrollment and which may have more variability in claims experience from year to year. The deductible factor exists for issuers that have a large share of high deductible plans, which generally have more variability in claims experience from year to year. An issuer that reports a deductible factor other than 1.0 tends to have an extremely high error rate based upon past examination experience, due to issuers incorrectly calculating the average deductible, which results in an incorrect deductible factor and thus an incorrect credibility adjustment.

Credibility-Adjusted MLR

The credibility-adjusted MLR is the calculation of the numerator to the denominator, plus the credibility adjustment, and is calculated for each market. The credibility-adjusted MLR by market is compared to the MLR standard (generally 80% for the individual and small group markets and 85% for large group market). If the credibility-adjusted MLR is below the standard, then rebates are required to be paid to enrollees.

Conclusion

The regulations and reporting requirements for the MLR Form can be complex, so understanding the different components and staying well informed about the evolving changes to the MLR Form and updates to existing guidance or the issuance of new guidance is essential to conducting a quality and efficient MLR examination.

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The Model Audit Rule: Requirements, Misconceptions, Industry Trends, and Value Added Recommendations for Examiner Consideration

By John Romano and Rachel Myslinski

Management's required reporting and filing requirements

The National Association of Insurance Commissioners' (NAIC) Annual Financial Reporting Model Regulation #205, commonly known as the Model Audit Rule (MAR) was enacted for three primary purposes:

1. Provide regulators with greater confidence that their domiciled insurance entities have effective controls in place to mitigate the risk of that they are publishing inaccurate annual statements
2. Increase efficiency of the risk focused examinations by allowing the examination teams to rely on the control testing performed by the insurer regarding their financial reporting risks
3. Enhance corporate governance by increasing management's confidence in their internal controls environment

Effective threshold: $500 million in premiums written

Section 16/17 Management's Report of Internal Control over Financial Reporting – Annual Attestation on Internal Control mandates that every insurer having annual, direct-written and assumed premiums of $500 million or more (i.e., the act provides a calculation for life and health entities) shall prepare a report, for the prior calendar year's year-end, attesting to the insurer's, or the group of insurer's, internal controls over financial reporting.

Timing requirements

The report is to be filed with state commissioner 60 days after the audited financial report is filed, with a cutoff and requirement to file by Aug. 1, with the exception of the state of New York which requires the report to be filed by May 31.

The act provides the insurer with a two-year grace period, which starts the date that the threshold is breached, to formalize the company's internal controls and to prepare for filing the attestation report (e.g., if an insurer has breached the $500 million direct written and assumed premium threshold on May 1, 2018, the company is not required to file until August 2020).

Hardship exemption

Under Section 17/(18), MAR has granted insurers the ability to file with the commissioner for hardship, which will allow the insurer to be exempt from MAR compliance. Hardship is granted under the discretion of the commissioner and is usually approved if it can be determined that the act will cause the insurer financial/organizational hardship.

Attestation key statements

If an insurer meets the requirements, and is not granted hardship, MAR mandates the attestation be completed and be signed by the chief executive officer (CEO) and chief financial officer (CFO), inclusive of the following key statements:

- Management is responsible for establishing and maintaining internal controls
- Internal controls have been established and are operating effectively
- Brief description regarding the scope, any controls excluded, and the overall approach utilized to evaluate effectiveness
- Disclosure of any unremediated material weaknesses of internal controls
- Statement regarding any inherent limitations of internal control

SOX compliance expedient for MAR compliance

If the Insurance Company, group of insurers, or parent company is/are already compliant with the Sarbanes-Oxley Act (SOX), Section 16/17 states that the insurer may file its, or their parent's, Section 404 SOX report, including an MAR addendum, to satisfy the section 16/17 requirement. However, an insurer, or group of insurers, can only take advantage of this if their internal controls, that have a material impact on the preparation of the audited statutory financial statements, were included within the scope of the Section 404 SOX report.

Management's responsibility for diligent inquiry

A common question insurers have regarding MAR implementation is in regards to the amount of testing that is generally required. When reviewing the insurer's MAR documentation, the examination team should keep in mind Section 16D(2)/17D(2), which states that management's assertion regarding the effectiveness of the insurer's financial reporting controls must be made to their best of their knowledge after diligent inquiry. To define diligent inquiry, refer to the Annual Financial Reporting Model Regulation Implementation Guide, which defines it as "conducting a search and thorough review of relevant documents which are reasonably likely to contain significant information with regards to internal control over financial reporting" (i.e., further discussion regarding testing requirements is discussed below under common misconceptions).

Additional consideration should be taken regarding Section 16D(5)/17D(5), which requires the insurer to identify all material weaknesses in internal control over financial reporting that exist as of the balance sheet date. If the insurer has identified unremediated material weaknesses, the company will be required to disclose the material weaknesses within its required reporting to the commissioner of their domiciled state. Material weaknesses can often

be determined by identifying the significance of an internal control failure, and if it is reasonable to concur that the probability of a material error in future financial statements, which would not be detected by other controls (i.e., compensating controls), ranges from 5 percent to 10 percent. Examination team should be aware of any material weaknesses prior to completing Phase 2, to ensure risks are appropriately included within the applicable area's risk matrix.

Industry common misconceptions

Below are common misconceptions by insurance companies, as it relates to MAR, based on our work with our outsourced internal audit clients, as well as review of MAR programs during examinations, as well as feedback received at industry conferences and events:

Reporting requirements	
Misconception: If an insurer is required to file an Own Risk Solvency Assessment (ORSA) report they are also required to file MAR, and vice versa	The misconception is due to the differences in the threshold requirements. MAR requires the report to be filed once the insurer reaches the $500-million-dollar threshold based on their direct written premium on the audited financial statements, while the own risk and solvency assessment (ORSA) has a $500 million or $1 billion for the group threshold on either the audited or annual statement. For example, if an insurer records on their annual statement $478 million in total direct written premium, but records on the audited financial statement, $475 million in premiums earned, $23 million in change in unearned and $2 million in reinsurance ceded, the insurer may be required to file the MAR attestation report but not ORSA.
Materiality and scoping	
Misconception: Materiality and scoping can be completed without regards to risks	Materiality and annual risk assessments should drive the MAR program's overall scope and plan. Ensuring that a formalized risk assessment is completed annually by obtaining business owner and management input is key to ensuring that internal audit is testing/focusing on the appropriate key areas.
Misconception: Materiality and scoping can be completed without regards to risks	Materiality and annual risk assessments should drive the MAR program's overall scope and plan. Ensuring that a formalized risk assessment is completed annually by obtaining business owner and management input is key to ensuring that internal audit is testing/focusing on the appropriate key areas.

Misconception: All general sub ledger accounts need to be in scope	This is generally not the case as it largely is impacted by materiality, areas that are not material can be excluded from the scope to increase efficiency and keep costs down.
Misconception: Entity level controls can be ignored	Entity level controls should be included within the scoping if it materially effects the subsidiaries (i.e., insurer) audited financial statements. As aforementioned, if the parent is SOX compliant, the insurer can file the SOX 404 report to cover entity level controls and reduce duplication of efforts.
Misconception: Management cannot elect their own framework	The Committee of Sponsoring Organizations (COSO) 1992 was superseded, and MAR does allow management to utilize their own control framework, however, COSO 2013 is recommended.
Misconception: IT systems are not significant unless they relate to the general ledger	IT systems including the general ledger system, policy and claims administration systems, as well as data warehouses and overall network, should be included within scope as it all relates to data integrity. Remember the term “garbage in, garbage out.” If IT systems are not appropriately coded or mapped, the data being extracted will be inaccurate and lead to misstated financial statements.
Control testing	
Misconception: All key controls should be independently tested annually	In order to remain efficient and cost effective, insurers can consider rotation of formal independent testing by supplementing with management self-assessments. The MAR guidance allows management to determine the nature, scope and timing of testing suitable to their environment.
Misconception: A walkthrough alone is sufficient to determine operation effectiveness, and diligent inquiry, for key control testing	Although for IT automated controls, where a walkthrough alone is sufficient, testing a population or a frequency (i.e., daily/monthly/quarterly) requires a formal sample selection, and cannot be determined based on a sample of one. Internal audit/management should reference the American Institute of Certified Public Accountants (AICPA)/ Institute of Internal Auditors (IIA) standards to determine appropriate sample sizes.
Misconception: All supporting documentation should be obtained and stored centrally	MAR does not require the insurer to centrally house all supporting documentation, rather the insurer can reference where the documentation can be found (i.e., claims administration system, policy administration system, etc.) From an NAIC state examination efficiency perspective, all supporting documentation should be readily available, specifically documentation related to the last scope year (i.e., unless the company plans to give the examination team access to the where documentation is maintained).

Trends in MAR

Insurers in the process of implementing, or that have implemented, MAR programs are consistently revitalizing processes to better increase alignment, effectiveness and efficiency. Regulators should be aware of such trends and how they may impact the insurer. Regulators can consider these trends in providing domiciled companies under supervision with value added recommendations to improve their MAR programs.

Alignment trends

Alignment trends include utilizing risk analytics and materiality scoping to ensure the MAR key areas are appropriate to address identified financial reporting risk. Enhancing an insurer's alignment with its MAR program can be realized by:

- Taking a risk, instead of control, based approach
- Revisiting the financial statements to determine materiality through a combination of the following methods:
    - Utilizing the NAIC's benchmark (e.g., 5 percent of surplus for planning materiality)
    - Applying sub ledger materiality (i.e., percent of the general ledger account greater than or equal to the dollar amount)
    - Utilizing management judgement based on qualitative judgement scores, areas of audit weaknesses or strengths, or areas of emerging risks
- Aligning the key risks identified to management assertions
- Having management (not internal audit) own and attest to the key controls, resulting in the company continuing to remove/add controls based on its changing control environment to ensure the risks are inherently mitigated

Efficiency trends

Management should ensure the appropriate amount of key controls are identified to mitigate the financial reporting risk without being duplicative or not substantially covering the risk. By reducing the number of key controls while still maintaining adequate coverage over the risk, organizations will realize a more efficient MAR process. Additional efficiency trends include:

- Rotational auditing and supplementing with management self-assessments for low-risk areas that are on rotation
- Company would be consistent with the State examination/NAIC risk matrix approach

Effectiveness trends

Effectiveness trends include:

- Reviewing key control and compensating control assessments
- Completing a deficiency evaluation for each control failure identified to determine if the control is a material deficiency/weakness
- Dashboards to understand the boarder impact of the results. Results should be tabulated based on overall function and a trend assessment over time conducted
- Utilizing state examination language and building the testing lead sheets to include the risk, management assertion(s), overall inherent risk assessment, control and control testing results

Trends in implementation

The aforementioned trends are holistic and can be applied to current and implementing MAR programs. Some additional trends and best practices that insurers should consider and regulators should understand as it relates to new implementers that apply specifically to the implementation process, including:

- Discussing internally, and with the board of directors, management's planned approach to executing MAR
- Performing a high-level assessment of the insurer's current control state versus the requirements of MAR
- Taking time to perform a thorough risk assessment including addressing accounts and assertions
- Preparing a comprehensive road map for execution, including resource management
- Recruiting or contracting with experienced MAR professions, and delegating an internally dedicated liaison (i.e., MAR champion) to manage the MAR program
- Developing a sustainable program for ongoing reliance by either external audit or the state examiners

IT trends

Information technology (IT) is a key component in MAR implementation and testing. Similar to above, there are multiple ways an insurer could improve the overall efficiency and effectiveness, including:

Efficiency trends/best practices

- Taking a risk-based approach and identifying the volume of transactions, the level of automation and any compensating downstream detective controls
- Leveraging other assessments completed such as System and Organization Controls (SOC) examinations, Health Information Trust Alliance (HITRUST), International Organization for Standardization (ISO), National Institute of Standards and Technology Cybersecurity Framework (NIST CSF), etc.
- Obtaining an understanding of the control framework and identifying ideas where controls have already been tested, appropriately determined reliance will aid in increasing the overall efficiency of the program

Effectiveness trends

- Identifying automated controls within the business process which reduce manual intervention and the potential for human error
    - Automated controls generally only require a sample of one to determine operational effectiveness and can increase efficiency of the program overall
- Obtaining a further understanding of completeness and accuracy including data mapping, when data can be manually input or edited, etc. (i.e., garbage in, garbage out)

Closing Summary and Examiner Considerations for Value Added Recommendations:

MAR can be a significant undertaking for most insurers; taking action to understand the controls and identifying weaknesses is crucial to ensure the insurer is prepared when the threshold is reached. For insurers that have already reached the threshold, the examination team can play a crucial role in providing value added recommendations, or further clarifications, to improve the overall program and ensure its continued compliance and "buy-in" from the Company.

Some ways an insurer can improve their organization's existing program include:

- Increasing corporate governance unity and control confidence
    - Providing and obtaining senior management and audit committee understanding, training, and buy-in to the program
    - Implementing a MAR steering committee to ensure significant financial reporting areas are addressed

- Incorporating functional area certifications to provide to the CEO and CFO prior to certifying to help them gain comfort over their control environment

- Increasing organizational unity
  - Identifying a MAR champion for each functional area (i.e., does not have to be the key process owner)
  - Providing training annually and request feedback from the business owners/key personnel of each area to determine training needs are met
  - Increasing leverage of departmental testing through self-assessments, ensuring that the process is guided by someone independent of the function

- Increasing overall process
  - Revisiting the risk assessments and materiality scoping annually to determine that areas under review are appropriate
  - Incorporating a subledger materiality to reduce accounts in scope, including clear explanations for the exclusion
  - Implementing effective project management including, but not limited to, a MAR calendar of kickoff meetings, testing timeline and deliverables and making all affected parties aware
  - Conducting rotational auditing which is determined based the areas inherent risk assessment
  - Incorporating MAR testing as part of other planned operational/compliance internal audits to increase efficiency

- Increasing the use of technology
  - Incorporating dashboards and analysis of key controls and deficiencies
  - Utilizing SharePoint of other workflow functions for signoffs and version control and to create an audit trail
  - Conducting cost analysis of MAR compliance including opportunity costs, identifying bottlenecks and cost drivers, and replacing with automation, computer assisted audit techniques (CAAT) or a third party software

Regulators/examiners can benefit from understanding the MAR program, and how it can be utilized to increase overall efficiency in the examination process, and where best practices/common trends can be included as value added recommendations.

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A Review of Root Cause in Insurer Insolvencies and Impairments

By Dave Heppen and Veronika Cooper

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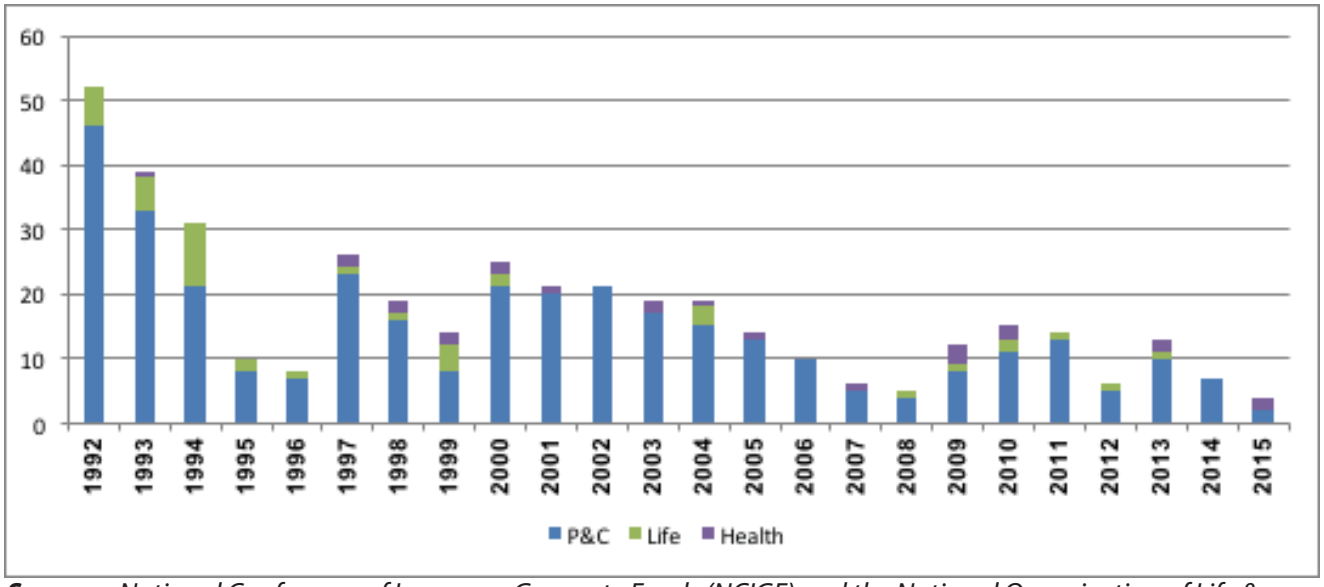
In 2016 and 2017, we conducted a study of root causes in insurer insolvencies and impairments, with the focus on analyzing potential risk factors and prevention measures. The study was sponsored by the Canadian Institute of Actuaries, Casualty Actuarial Society and Society of Actuaries (collectively the sponsoring organizations). It looked at causes of insolvency and decisions made by management, regulators and policyholders over the life cycle of the insolvency. In addition, the study considered ways the actuarial profession can be equipped to help prevent or mitigate future insolvencies. It was also intended to assist other insurance industry practitioners in understanding the complexities of insurance company solvency and the benefits of keeping the actuarial profession in the forefront of company management, operations and regulatory communication. This article provides a summary of our study. The complete report and case studies can be found on the SOA's website.

The study considered insurer insolvencies in both the United States and Canada. In Canada, the insolvency rates are very low, and detailed studies have previously been conducted on both individual company insolvencies as well as insolvency from an industry-wide perspective. Our analysis used available studies and insights from previous research on Canadian insolvencies to draw comparisons and contrasts to observations on risk drivers in the United States.

Figures 1 and 2 illustrate the historical number of U.S. and Canadian insurer insolvencies by year and by product type:

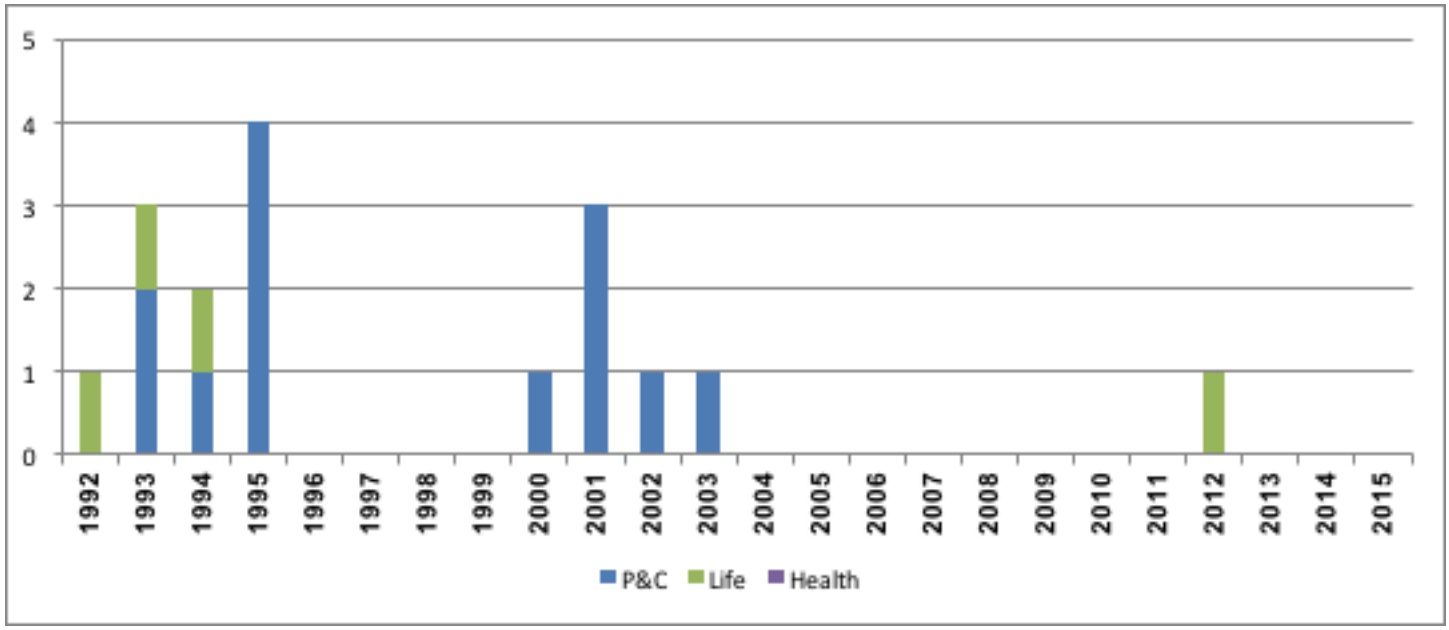
(Please note that there were no Health insurer insolvencies in Canada for the period from 1992 to 2015.)

Figure 1
Number Of U.S. Insurer Insolvencies



Sources: *National Conference of Insurance Guaranty Funds (NCIGF) and the National Organization of Life & Health Insurance Guaranty Associations (NOLHGA).*

Figure 2
Number Of Canadian Insurer Insolvencies



Sources: *Assuris and Property and Casualty Insurance Compensation Corporation (PACICC).*

A key aspect of our study was the review of insolvency risk factors by cohort. The use of cohorts allowed us to compare insolvency risk factors across life, health and P&C companies. The cohorts included P&C personal auto; P&C homeowners; P&C workers' compensation; P&C commercial liability; Life & Annuity, Health including long-term care (LTC); and Health cooperatives.

RISK DRIVERS

During the course of the study, we developed two comparative views of risk drivers when performing the analysis of U.S. insolvencies. The first view was based on a review of a sample of U.S. companies' insolvencies by risk factor and cohort. The risk factors considered in the study were grouped into two major categories—financial and demographic. This view allowed for comparisons of the potential importance of particular risk factors for each company and cohort within the study, relative to all insolvent companies and cohorts included in the study.

The financial risk factors were:

- Premium growth,
- profitability,
- liquidity,
- investment,
- leverage and
- risk-based capital.

The demographic risk factors were:

- Company size,
- number of years in operation,
- geographic concentration and
- product concentration.

The second view was a comparison of the insolvent sample to the corresponding industry sample for each cohort, which allows for perspective on the extent to which the risk factors help distinguish insolvent companies from a broader industry sample with the same product focus. Risk factors are likely to be less useful in identifying potential insolvencies if they manifest the same way for insolvent companies as they do for similar going concern companies. They are more useful if they manifest differently, e.g., displaying higher risk characteristics for companies that ultimately experienced insolvency relative to similar going concern companies.

For example, one of the key risks identified as a potential insolvency driver for the U.S. companies was premium growth, and the charts below represent two main views (described above) for that risk. The first view includes only the insolvent sample of companies by cohort. Based on financial information for the companies in the study, we defined those companies showing low, medium or high premium growth (and therefore low, medium or high risk) in the years prior to the insolvency. It can be seen from the first view in Figure 3 that, among the insolvent insurers included in the study, high growth and high risk was present predominately in the P&C cohorts as well as the health cooperatives. In other words, the P&C companies and health cooperatives exhibited more risk associated with premium growth than the life or other health companies. The second view provides an industry overlay, in which the insolvent cohorts are compared to the full industry set of companies in terms of premium growth and risk. This is shown in Figure 4 in which the insolvent sample and the industry sample are compared side by side with the industry shown in a lighter shade. The comparison shows a higher risk associated with premium growth for nearly all cohorts in the insolvent sample, which suggests this risk is a strong indicator of insolvency.

Figure 3
View 1: Insolvent Sample

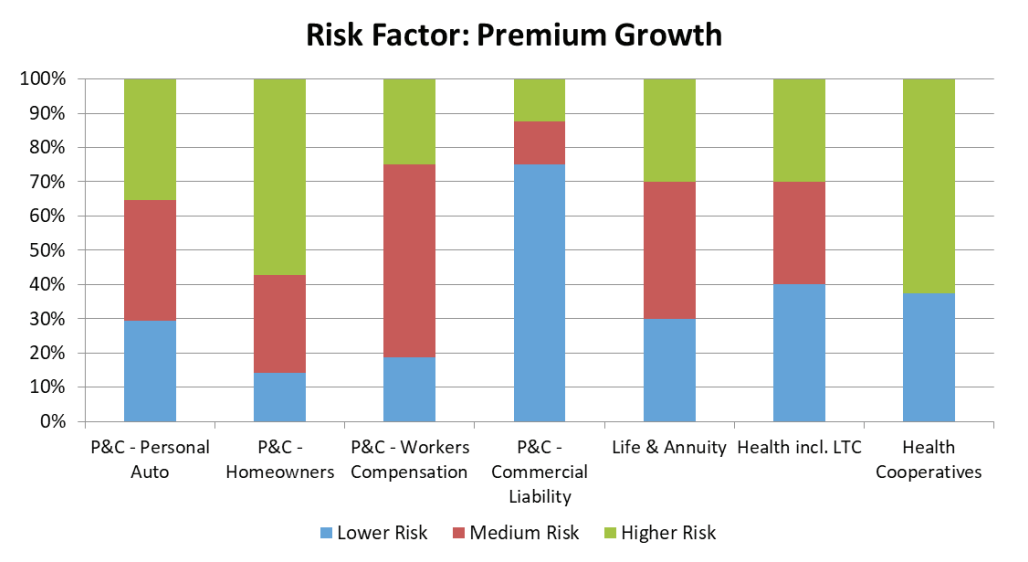
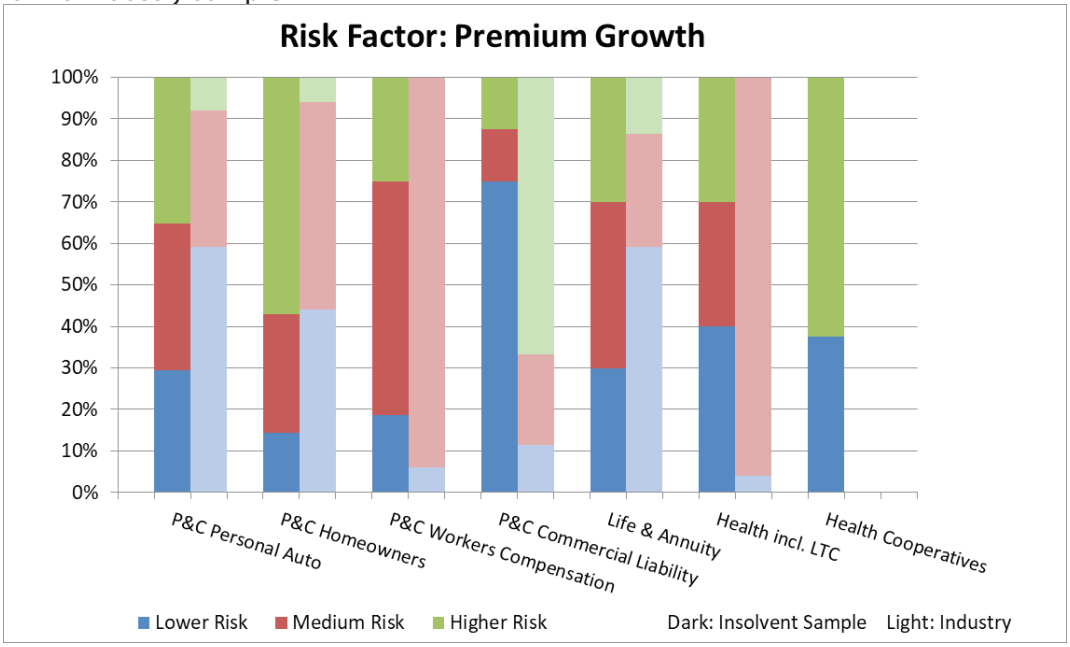


Figure 4
View 2: Insolvent And Industry Sample



We used data derived from SNL Financial to develop these results for the U.S. companies, both for the insolvent cohorts and their industry counterparts.

CASE STUDIES

In the earlier phases of the review, the focus was on analyzing the root causes of insurer impairment and insolvency across property and casualty, life and annuity, and health insurance in the United States and Canada with emphasis on potential indicators which may facilitate earlier intervention for companies at risk of becoming impaired or insolvent. In the later phases of the analysis, the focus shifted to specific case studies, where each case study targeted in-depth research on "what went wrong" for a life, health, and P&C insurance company. The goal of the case studies was to provide insight into potential actions that could be taken by actuaries and other insurance industry practitioners to help prevent or mitigate future insolvencies arising from similar circumstances.

Some insurer insolvencies point to one primary causal driver, such as fraud. However, a majority of the insolvencies evolved from multiple risk factors. The most significant of those were identified as financial risk factors. We also identified some of the key regulatory activities that now exist (or are under development) that may help detect issues that were present in some of the case studies under review. The regulatory activities include (but are not limited to) risk-focused examinations, regulatory stance on rate increases, reserve increase requirements, requirements for corporate governance, NAIC filing requirements for LTC on stand-alone basis, changes in opining actuary, and morbidity risk in capital.

KEY FINDINGS

During the course of the study, we found that financial risk factors were better indicators of insolvency when compared to the industry, while demographic risk factors showed a weaker relationship between the insolvent sample and the industry.

Here are a few examples of our analysis of financial and demographic risk factors:

For purposes of this study, we considered negative operating cash flow as indicative of **liquidity risk**. The companies were ranked by the number of years within the last five during which negative operating cash flow occurred. A review of liquidity in the insolvent sample as compared to the industry sample showed a higher risk mix in the insolvent sample, with the exception of commercial liability insurers. This suggested that liquidity challenges may be a significant indicator of insolvency risk.

Significant **premium growth** in short time frames may be problematic for any insurer. Industry studies from the PACICC found that rapid growth was a primary cause of 17 percent and a contributing cause to 43 percent of P&C insolvencies in Canada. The review of premium growth as a risk factor among cohorts within the insolvent sample shows a varied risk mix. The homeowners and health cooperative cohorts have the largest proportion of high-growth companies within the insolvent companies. A review of premium growth in the insolvent sample relative to the industry sample shows a higher risk mix in the insolvent sample, with the exception of commercial liability insurers. This suggests that growth is a strong indicator of insolvency risk.

Company size was based on the largest net written premium amount observed in the last five full years of company operations for the insolvent sample. The study **did not** categorize small companies as indicative of higher risk from an insolvency perspective. The analysis also indicated that when comparing to the broader industry results, company size did not appear to clearly indicate relative insolvency risk as there was no observable pattern of small or large companies predominating the insolvent cohorts relative to the industry counterparts. Company size may, therefore, be less predictive of future insolvency as compared to other financial risk factors.

Figure 5 provides a summary of the risk factors for which we observed noticeable differences in the insolvent cohorts relative to their industry counterparts.

Figure 5
Risk Factors Noticeable In Insolvencies

	P&C Personal Auto	P&C Homeowners	P&C Workers Compensation	P&C Commercial Liability	Life & Annuity	Health incl. LTC	Health Cooperatives
Premium Growth	X	X	X	X	X	X	X
Profitability		X	X	X		X	X
Liquidity	X	X	X		X	X	X
Investment	X	X	X	X	X		
Leverage			X		X	X	
Risk-Based Capital	X	X		X	X	X	X
Company Size (S/M/L)	X				X		
Number Of Years In Operation		X					X
Geographic Concentration			X				X
Product Concentration		X	X	X			

Consistent with the U.S. review, Canadian studies by the PACICC showed growth and profitability (pricing) as leading factors in insolvency. They also highlighted foreign parent as a significant factor, which was less evident in the review of the U.S. companies.

As a result of the study, including the case studies, we observed key areas in which increased actuarial involvement may support earlier identification of some of the challenges that lead to insurer insolvencies:

- Increased involvement of actuaries in the surveillance process, which includes (but is not limited to) identifying issues such as underpricing and aggressive rate increase assumptions used in reserve adequacy analysis.
- Improved practices and disclosures regarding the assumptions used in assessing reserve adequacy, which includes providing enhancements to Actuarial Standards of Practice, developing educational materials and updating practice notes.
- Increased coordination and consistency of actuarial requirements across states, including items such as additional disclosures to consumers, additional requirements for rate filings, experience tracking and additional requirements for testing adequacy of LTC reserves.

Conclusion

The study was intended to educate insurance professionals on historical insurer impairments and insolvencies and possible future prevention indicators. It explored potential risk factors insurance professionals can monitor to mitigate future insolvent situations.

Overall, the analysis suggested that the financial risk factors (premium growth, profitability, liquidity, investment, leverage and risk-based capital) were useful indicators for insolvency. The financial risk factors in the insolvent sample analyzed generally showed a greater proportion in higher risk brackets when compared to the industry. The demographic risk factors analyzed (company size, number of years in operation, geographic concentration and product concentration) showed a less significant relationship between risk levels within the insolvent sample and the industry.

We would like to thank the sponsoring organizations and the project oversight group for their contributions and support throughout this research process.

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PwC NAIC Newsletter

April 2018

The National Association of Insurance Commissioners held its Spring National Meeting in Milwaukee March 23-27. This newsletter contains information on activities that occurred in some of the committees, task forces and working groups that met there and includes subsequent conference calls through April 5. For questions or comments concerning any of the items reported, please feel free to contact us at the address given on the last page.

In this issue

pwc

Executive Summary

- The Big Data Working Group adopted charges for projects to assist states in their regulator review of complex models used to support personal auto and homeowner insurance rate filings.
- The Statutory Accounting Principles Working Group issued in February INT 18-01, Updated Tax Estimates under the Tax Cuts and Jobs Act, and re-exposed proposed changes to SSAP 101 related to tax reform at the Spring National Meeting. The working group also exposed issue papers on hedging variable annuity contracts and statutory considerations of ASU 2016-20, Credit Losses, and ASU 2017-12, Derivatives and Hedging.
- The Operational Risk Subgroup finalized its operational risk proposal, which is expected to be effective for 2018 RBC filings. The Life RBC Working group began discussion of revisions to the life RBC formula to reflect the effect of tax reform; the working group is meeting weekly in April with the objective of adopting changes for 2018 RBC (which the chair acknowledges is an aggressive goal).
- The Valuation of Securities Task Force finalized its blanks proposal to implement reporting of new designations for private letter ratings in quarterly and annual statements, which is expected to be effective for year-end 2018.
- The Group Capital Calculation Working Group continued progress on the calculation, focusing on discussion of the treatment of captives, surplus notes and subordinated debt and non-regulated entities in the group capital calculation.
- The Reinsurance Task Force held a public hearing to receive comments as to how the credit for reinsurance models should be revised to reflect adoption of the U.S/EU Covered Agreement and have developed recommendations to achieve this.
- The Variable Annuities Issues Working Group heard extensive comments on its recommendations related to the second Quantitative Impact Study.
- The Financial Stability Task Force adopted its final proposal for extensive new liquidity disclosures for the annual statement, but the effective date was pushed back to year-end 2019. The Blanks Working Group will coordinate future exposures and implementation into the annual statement.
- Various NAIC long-term care insurance groups continued discussion of LTC rate reviews by regulators, including work on an LTC rate increase checklist.
- The Group Solvency Issues Working Group adopted its Form F Implementation Guide to make enterprise risk filings more useful to regulators.

PwC NAIC Newsletter

April 2018

All documents referenced can be found on the NAIC website naic.org.

Executive Committee and Plenary

The commissioners ratified adoption of the NAIC's three year strategic plan State Ahead.

Cybersecurity

Insurance Data Security Model Law adoption
South Carolina and Rhode Island provided updates on the legislation they have introduced in 2018 to adopt the NAIC's model. Discussion was held to consider coordinated reporting and the use of a centralized reporting system as additional states begin to address implementation.

The Innovation and Technology Task Force will consider what, if any, additional consumer disclosures related to cybersecurity might be necessary and, if appropriate, develop model consumer disclosure guidance by December 2018.

The NYDFS updated its FAQ document related to its cybersecurity regulation in December 2017 and February 2018, which includes guidance on vulnerability assessments and third party provider due diligence requirements.

Innovation and Technology Task Force

Regulatory sandbox
The task force heard a presentation from the trade association AIA as a continuation of its discussion at the Fall National Meeting. The association is asking that state insurance regulators adopt legislation that would create "sandboxes" wherein certain regulatory requirements would be waived for insurers looking to develop innovative insurance products, services and technologies.

The AIA believes a regulatory sandbox could be structured to promote innovation while including measures for a level playing field. A consumer representative noted that such a construct could promote innovation but would require appropriate transparency and public accountability. Several task force members commented they believe it is already within their state authority to allow for innovation while providing customer protections. The task force agreed to discuss the regulatory sandbox concept with other state insurance commissioners to determine how to proceed.

Big data

Following the Fall National Meeting, the Big Data Working Group exposed for comment through early 2018 the following draft documents: 1) Background Information for Discussion of Regulatory Framework; 2) Background Information for Assessment of Regulatory Data Needs; and 3) a listing of principles and structure to aid state regulatory review of complex models used in support of personal auto and homeowner insurance rate filings. A number of comments were received on each of the exposures. While all three matters were on the agenda at the Spring National Meeting, the discussion largely focused on the proposed charges of the Casualty Actuarial and Statistical Task Force to appoint a Predictive Analytics Working Group (PAWG) with the following 2018 charges:

- draft potential changes to the Product Filing Examiners Handbook to address best practices for review of predictive analytics and models used by insurers to justify rates,
- recommend filing requirements for rate filings that are based on complex predictive models,
- facilitate discussion among regulators regarding rate filing issues of common interest across states (while ensuring state confidentiality protections apply),
- facilitate training and the sharing of expertise through predictive analytics webinars, and
- work with NAIC technical staff to identify software, databases, and other technology that could be purchased or developed to assist analysis of predictive models.

Certain interested parties continued to express concern that the review of models would be centralized to NAIC Staff, rather than domiciliary state-led reviews. Several working group members countered that each state would not relinquish their responsibility, and this should be seen no differently than engaging an outside consultant to perform a review. The principles exposed for comment include the concept that the state regulators will maintain their current rate regulatory authority.

The motion to request the CASTF appoint the PAWG with the charges passed unanimously. The Property and Casualty Committee also adopted charges for the CASTF to develop best practices for the review of

predictive models and propose state guidance for the rate filings based on that modeling. The Innovation and Technology Task Force subsequently adopted a request for the NAIC to conduct research as to the appropriate skills and resources required to conduct the reviews of predictive models.

Statutory Accounting Principles Working Group

The working group met via conference call in February and at the Spring National Meeting; significant actions include the following. (Appendix A to this Newsletter summarizes all actions taken by the working group since the Fall National Meeting.)

INT 18-01 – Tax Estimates under Tax Reform (agenda item #2018-02) – On February 8, the working group adopted INT 18-01, Updated Tax Estimates under the Tax Cuts and Jobs Act, which provides guidance in three areas:

Reporting and updating estimates – The guidance adopts concepts from SEC Staff Accounting Bulletin 118 related to "complete" and "incomplete" tax estimates and those items for which a reasonable estimate cannot be determined; it also provides a limited time exception to SSAP 9, Subsequent Events (one year from the enactment date), which allows companies not to be required to adjust the audited statutory financial statements when there is a change in estimate of year-end 2017 amounts after the annual statement has been filed.

Reporting changes to deferred tax assets and liabilities – Companies will be required to allocate the remeasurement of DTAs and DTLs due to the change in the tax rate to three components of surplus: change in net unrealized capital gain/loss, change in net deferred income tax and change in nonadmitted assets. The change in the nonadmitted asset component is computed by comparing beginning-of-year nonadmitted assets at the old rate to end-of-year nonadmitteds at the new rate.

Footnote disclosure – Companies will be required to disclose in narrative format to the annual statement note 9C tax disclosure table and the audited financial statements the change in DTAs and DTLs as a result of the tax rate change.

SSAP 101, Federal Income Tax Reform (#2018-01) In February the working group exposed for comment proposed changes to SSAP 101 to address additional accounting issues created by tax reform; the proposal also asked for feedback on ASU 2018-02, Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income.

At the Spring National Meeting, the working group re-exposed for a short comment period (April 23) revisions to the proposed guidance. The most significant proposed conclusions include the following:

- Consistent with ASU 2018-02, tax amounts are not discounted (e.g. tax liability on deemed repatriation and AMT credit), and
- The AMT credit carryforward may be classified as either a current receivable or deferred tax asset

Issues related to base erosion anti-abuse tax (BEAT) and the global intangible low-taxed income (GILTI) will be addressed as separate agenda items and will not be adopted as part of issue #2018-01. The chair of the working group also requested that interested parties provide specific comments related to the "assessment of reversal patterns of deferred tax items under the new federal Act." This issue was raised as an initial topic in INT 18-01 but was not included in the final guidance as consensus could not be reached during the very short comment period.

SSAP 86 – Special Accounting Treatment for Derivatives Hedging VA Contracts (#2016-03) – The working group exposed for comment a significantly revised issue paper, which is the first new proposal in a year on this topic. NAIC staff worked with the ACLI during the past year to resolve outstanding issues including change in hedging strategy/hedging target, termination guidance/expired derivatives, calculation of deferred asset/deferred liability and related amortization period, and transition.

The proposed guidance would allow recognition of deferred assets and liabilities related to the portion of the fair value fluctuation in the hedging instruments that is attributed to the hedged risk and does not immediately offset changes in the hedged item. Industry had requested allowing amortization over 20 years to remove most of the non-economic accounting volatility from the statutory financial statements; the issue paper limitation is a 10 year maximum.

With respect to transition for insurers which currently have a permitted or state prescribed practice for hedging VAs, the issue paper suggests three alternatives: continue application of the prior program as a permitted or prescribed practice with SSAP 1 disclosures, adjust the prior program to

comply with the standard, or discontinue the prior program and apply the new guidance prospectively. The working group directed NAIC staff to discuss the issue paper with states which have provided permitted or state prescribed practices that deviate from SSAP 86.

The proposed effective date is January 1, 2019; some insurers want the ability to early adopt for year-end 2018. However, the regulators have stated that they want both the hedging guidance and the AG 43 and RBC guidance for the VA liabilities to be implemented at the same time, and that project may likely not be ready for implementation by December 31, 2018. (See further discussion in the summary of the VA Issues Working Group below.)

ASU 2016-13 - Credit Losses (#2016-20)
The working group exposed for comment a discussion document that includes U.S. GAAP concepts on expected credit losses and provides possible concepts for statutory accounting consideration. For example, the discussion paper suggests the use of a "fair value floor" for investments valued at amortized cost, i.e. no expected credit loss would be required when fair value exceeds amortized cost at the reporting date. For investments valued at fair value, the discussion paper suggests adopting the ASU guidance for recognizing credit losses through an allowance for credit losses. The exposure document does not include discussion of how AVR and RBC would be adjusted to reflect the potential change from an incurred loss model to an expected loss model.

Reinsurance risk transfer for short duration contracts (#2017-28) – In 2017, the working group exposed for comment proposed revisions to life, health and property/casualty reinsurance guidance to address issues identified by regulators (which resulted from reviews of certain reinsurance agreements of short duration health contracts). Industry expressed significant concern that the proposed changes could have negative unintended consequences, and the working group agreed to have informal drafting groups of life and P/C representatives (comprised of companies, trade associations, AIPCA representatives and NAIC staff) explore potential solutions.

At the Spring National Meeting, staff provided an update on discussions held on the three calls each group had. The P/C Drafting Group is focusing on which GAAP guidance should be added into SSAP 62R (vs incorporation by reference), which could include wording from EITF 93-6 on multi-year retrospectively rated reinsurance contracts. The Life and Health Drafting Group is working to recommend improvements to Appendix A-791 and provide more explicit guidance for contracts which are scoped out of the appendix. The Life/Health issues appear to be more complex such as which specific types of nonproportionate reinsurance contracts were intended to be scoped out of Appendix A-791 and how the guidance should be applied to short duration heath contracts. The chair of the working group noted that he thinks this issue is mainly one of the appropriate reinsurance credit versus reinsurance risk transfer issues.

Reconsideration of goodwill limitations (#2017-18)
In lieu of adopting guidance to reduce the amount of statutory goodwill that could be admitted by insurers, the working group adopted additional disclosures for goodwill, including the original amount of goodwill, admitted goodwill at the reporting date and admitted goodwill as a percentage of the acquired entity's book adjusted carrying value. The working group will also recommend to the Blanks Working Group that this information be data captured beginning with year-end 2018.

SSAP 86 - ASU 2017-12, Derivatives and Hedging (#2017-33) – The working group exposed for comment its initial draft Issue Paper 15X considering adoption of this recent GAAP guidance. The issue paper addresses the same seven topics as the ASU, (risk component hedging/hedges of nonfinancial assets/benchmark interest rates, accounting for the hedged item in fair value hedges of interest rate risk, recognition and presentation of the effects of hedging instruments, amounts excluded from hedge effectiveness, improvements in assessing hedge effectiveness, etc.) and generally recommends adoption of the GAAP guidance.

However, the issue paper does note that the statutory guidance for fair value hedges is "inherently different from U.S. GAAP, and the existing differences allow for fair value hedges under SAP that would not be permitted under U.S. GAAP. If the ASU revisions were incorporated into SAP, NAIC staff expects the provisions would create confusion and exacerbate the reporting issues when a hedged item is reported at amortized cost. Although revisions may be ultimately considered, NAIC staff believes discussion on the existing guidance for fair value hedges should concurrently occur." No proposed effective date is yet suggested; the working group is also looking for input on that topic. The exposure draft has an extended comment period to June 22.

SSAP 30-Investment Classification Project (#2017-32) – The working group directed NAIC staff to draft an issue paper for exposure to address three specific SSAP 30 issues: 1) clarify the definition of "common stock" and identify investments in scope but not considered legally to be common stock, such as mutual funds and non-bond ETFs, 2) include closed-ended funds and unit investment trusts within the scope of SSAP 30, and 3) recommend reporting enhancements to Schedule D Part 2 Section 2 to allow NAIC designations for certain SSAP 30 investments, which could provide look-through treatment for RBC purposes (if agreed to by the VOS Task Force and Capital Adequacy Task Force).

The working group, however, did not support a comment letter proposal from Vanguard to extend to all bond mutual funds the new bond-like accounting guidance for certain ETF investments.

SSAPs 21 & 56 – private placement variable annuities (#2018 -08) –The working group began discussion of a new issue raised by NAIC staff related to private place variable annuities and private placement life insurance. The working group voted to expose for comment proposed new disclosures for the separate account annual statement to data capture information on insurer issuance of private placement life insurance and private placement variable annuities starting with year-end 2018.

At the request of interested parties, the working group agreed to modify the exposure document to not require non-admission of assets related to PPVA and PPLI "realizable amounts." An ACLI comment letter noted that PPVAs (investment contracts) and PPLI (life insurance contracts) are not interchangeable terms and that the exposure document was already causing market disruptions for COLI/BOLI/keyman life and PPLI products.

In response, the working group requested comments on characteristics differentiating private placement products that are investment-focused and the traditional life products intended to be captured under SSAP 21 when the insurer holds the product as owner and beneficiary. The intent of this will be to exclude investment products from the SSAP 21 admitted asset guidance.

Blanks Working Group

At the Spring National Meeting, the Blanks Working Group adopted six new proposals, including a requirement to file a merger history date file with the NAIC in any year a company has been a party to a statutory merger or consolidation (2017-21BWG).

The working group also exposed for comment 18 new proposals with a comment deadline of May 4. Significant exposures include proposals to:

- Align the life and annuities types of reinsurance to be consistent between ceding and assuming schedules and revise the health types of reinsurance to be consistent with more common terminology. (2018-04BWG)

- Revise the P/C Statement of Actuarial Opinion instructions to incorporate AG 51 requirements and increase disclosures for accident and health business reported on a P/C blank. (2018-05BWG)

- Combine the annual and quarterly reporting of life and fraternal companies into one blank by making changes to the life blank, effective for the first quarter of 2019. (2018-18BWG)

Risk-based capital

The regulators made the following significant progress on RBC projects. (Appendix B summarizes other actions taken by the various RBC Working Groups since the Fall National Meeting.)

Operational risk (2017-13-O)
During its January 25 conference call, the Operational Risk Subgroup adopted the revised proposal for the basic operational risk charge to be implemented in all formulas for 2018 RBC filings. The revisions were a fix to the "double counting issue" identified in 2017; no change was made to the 3% add-on factor. Some industry representatives asked that the charge be phased in over two years using 1.5% for 2018. The regulators pointed out that due to the last minute deferral in 2017, the charge had already been effectively phased in over 2 years, i.e. 2017 and 2018, and no change was made. At the Spring National Meeting, the Capital Adequacy Task Force also adopted the proposal.

During its March 5 meeting, the subgroup re-exposed the RBC instructional changes for operational risk and plans to adopt the guidance during its April 12 conference call. The subgroup also had a discussion about a possible voluntary operational risk data collection database so that the regulators can test whether the 3% charge is appropriate. Similar to the response for a proposed mandatory data collection exercise for operational risk discussed previously, industry representatives expressed concerns due to cost and lack of specifics on what data would be collected. The chair noted that without any data to support a different factor, the 3% charge will likely end up being used for years into the future.

Investment RBC

Bond factors - The Investment RBC Working Group reconfirmed its commitment to implement revised bond factors for 2019 RBC filings for all three formulas and reiterated that they have ample time to meet that goal. All parties (regulators and industry) are in agreement with the move from 6 rating classes to 20 rating classes. The working group then discussed the ACLI's lengthy comment letter (January 22) and that the ACLI does not support the AAA's revised proposed factors. The regulators agreed to discuss the spread adjustment concept proposed by the ACLI, i.e. the amount of credit losses already included in policy reserve assumptions (also called the "statutory reserve offset"). Even with possibly revising the AAA's model for the spread adjustment, the regulators are confident they can meet the 2019 deadline.

At the Spring National Meeting, the working group heard a report from the AAA Joint P&C/Health Bond Factors Analysis Work Group; the work group is currently suggesting a 4 year time horizon for modeling for P/C bond factors and 1 year for health, based on the respective liability run off time horizons. Consistent with prior comments, the chair responded that the ten year time horizon for life bond factors is based on a complete credit cycle, not average life reserve duration; two other working group members agreed that these shorter time periods don't seem appropriate. The AAA Work Group anticipates submitting its report by the Summer National Meeting.

Life RBC

Effect of tax reform on life RBC – The Life RBC Working Group had an extensive discussion at the Spring National Meeting of the effect of tax reform on RBC, both the numerator (total adjusted RBC) and the denominator (required capital). The working group reviewed letters received from the ACLI and the AAA, both of which discuss parts of the formula affected by the change in the tax rate, which includes C-1 and C-2 components. The ACLI letter strongly encourages the NAIC to implement factor and other changes in 2019 due to 1) the complexities of the changes, i.e. significant modeling work will likely be necessary, and 2) some changes will increase required capital and some will decrease required capital, and both should be implemented together. (The ACLI estimates that the net effect of all changes could decrease RBC ratios for the life industry by "possibly by as much as 20%.")

The working group noted that changes to total capital as a result of adjustments to deferred tax assets were reflected in 2017 RBC, and as a result, the regulators should attempt to implement all the denominator changes in 2018, if possible. The working group has scheduled five weekly calls in March and April, with a goal of meeting the April 30 deadline of adoption of structural changes to RBC for 2018 filings. The chair acknowledged that this goal may not be achievable. During the first weekly conference call, the working group discussed whether the DTA effectiveness factor (currently 75% and anticipated to be revised to 81.5% for 2019 RBC as part of the Investment RBC Working Group's bond factor project) should be considered for implementation with other 2018 tax reform changes. The second call focused on reviewing specific parts of the formula and instructions to make sure the working group has a complete inventory of items that are affected by tax rates; the chair noted that they are making "slow but significant progress."

FHLB collateral RBC (2017-03-L) – After several years of discussion, the Life RBC Working Group adopted a revised ACLI proposal related to the RBC treatment of Federal Home Loan Bank collateral and advances. Under the adopted guidance, FHLB advances subject to C3P1 cash flow testing will have no RBC charge for the collateral up to the amount of the advance, and a factor for the excess collateral equal to the C-1 Bond factor (.4%). For advances not subject to cash flow testing, the .4% charge will be applied to the entire amount of pledged collateral supporting the advance. In the event a life insurer has FHLB funded advance liabilities associated with funding agreement activities in excess of 5% of total net admitted assets, a factor of 1.3% will be applied to the excess. The final proposal removed the provision allowing the domiciliary regulator to authorize collateral amounts in excess of 5% of admitted assets not to be assessed the higher charge; the term "spread lending activities" was also replaced with "funding agreement activities."

The Capital Adequacy Task Force also adopted the proposal, which is effective for 2018 RBC filings.

Longevity risk – The AAA's Longevity Risk Task Force provided an update on the field study they plan to conduct to inform their proposed methodology for developing longevity risk factors to be applied to reserves in the RBC calculation. Requests for data for the field study will be sent out in April with an expected two to three week turnaround. AAA expects to send requests to approximately 120 companies with material blocks of individual and group annuities. The request will be for December 31, 2017 statutory CARVM reserve balances calculated using current and stressed assumptions under a range of valuation interest rate, issue age, duration since issue and gender combinations. The stress scenarios will include a 95th percentile stress on mortality rates assuming both high and low credibility and a 95th percentile stress on mortality improvement. No updated was given on when the task force anticipates completing their work; however, they were previously targeting 2019.

Schedule BA investments
Both the P/C and Health RBC Working Groups agreed to consider the effect on RBC if Schedule BA investments are assigned NAIC designations, which would allow the "look-through" treatment for RBC that is currently permitted by life RBC filers.

Health RBC
The Capital Adequacy Task Force approved four proposals related to health business for 2018 RBC filings. The revisions are being implemented in all three formulas; see Appendix B for a summary of the specific changes.

Valuation of Securities Task Force

The task force has made progress on the following projects.

FE enhancements project and private letter ratings
After reaching agreement on changes to the P&P Manual in November 2017 to adopt new procedures for private placement securities (and other policy changes), the task force finalized the related Blanks Working Group proposal in February.

Those changes proposed include the following:

- Would add PL and PLGI symbols to Schedule D to represent securities where, respectively, the private letter rating has been filed with the SVO or the security is grandfathered (i.e. rating was received before January 1, 2018 and cannot be filed with the SVO due to confidentiality).
- Would add a new General Interrogatory for insurance entities to verify that all securities designated as PLGI have ratings that cannot be shared and that the insurer is holding capital commensurate with the NAIC designation rating.
- Would introduce two new symbols, YE and IF, to identify properly filed securities that the SVO has been unable to designate by year-end. YE would be assigned to annually updated securities, and IF relates to the initial filing of a security.
- Would eliminate the R and RP symbols for preferred stocks, replacing them with specific line categories
- Would remove the reference to "Life and Fraternal Only" in the Schedule BA instructions for investments with the underlying characteristics of bonds; this will allow P/C and health entities to do look-through treatment for Schedule BA investments (if adopted by the Capital Adequacy Task Force).

The Blanks Working Group also exposed this proposal (#2018-07BWG) for comment; if adopted as expected, the revisions are effective for year-end 2018 reporting.

P&P Manual amendment adoptions and exposures
RBC granularity – The task force exposed for comment the proposed 20 NAIC Designation Categories for securities for RBC purposes, scheduled to be implemented for 2019 filings: NAIC 1 would include 7 categories (1A-1G), NAIC 2-5 would include 3 categories (A-C), one category for 6 and Not Rated category.

SVO assessment of affiliated transactions - The task force adopted final guidance for the P&P Manual to address issues regarding the credit assessment and rating of insurance entity related party investments/ debt transactions. The revisions describe the formal process to be followed if the SVO reaches a conclusion that a related party transaction is unlike a transaction that unaffiliated parties would enter into.

P&P Manual reorganization - The task force adopted revisions to the manual to include filing instructions, documentation requirements and

analytical methodologies in one place in the Manual (versus separate sections for each) for seven topics, e.g. credit tenant loans, structured transactions etc. The task force exposed for comment a proposal to combine six other topics.

Fund investments – Proposed guidance was exposed to ensure that all funds that hold bonds are subject to the same principles in the P&P Manual regardless of which investment schedule the fund is reported on.

Regulatory transactions
The Reinsurance Task Force has asked the VOS Task Force to define the term "regulatory transaction" and to provide guidance to regulators to assess such transactions. The task force recognized there are concerns about the request, including that the SVO "is not a source of expertise on regulatory transactions." Before forming preliminary conclusions, the task voted to expose the referral from the Reinsurance Task Force for comment until April 9.

Group capital calculation

The working group is continuing progress on its project to construct a U.S. group capital calculation using an RBC aggregation methodology.

Captive insurers
The working group exposed in October 2017 an updated proposal on the treatment of captives in the group capital calculation, which attempts to overcome differences in opinion among states and find consensus. The revised proposal suggests looking through the transaction, i.e. unwinding the captive. This could include requiring the XXX/AXXX captives to report liabilities consistent with the valuation by the direct writer and the use of SAP for captive assets. Another alternative would be to require on-top adjustments to arrive at a similar net capital valuation of the XXX/AXXX business.

The working group discussed the six comment letters on the proposal on two conference calls; there are insurance departments and life insurers on both sides of the issue of requiring adjustment or allowing the framework permitted by the domiciliary state to continue in the group capital calculation. During the April 5 call, the chair acknowledged that no consensus has been reached and there is no obvious compromise. However, as a next step, the chair instructed NAIC staff to develop a calculation based on the ACLI/AIA Aggregation and Calibration proposal first discussed in 2016, which the chair believes would be consistent with the "adjusted calculation" discussed above. In addition, an informational data request would also be done during field testing to allow the NAIC to assess the difference between the two calculations. The ACLI representative noted they don't support the A&C approach for the captive calculation; that presentation in 2016 was done for a different purpose.

Non-regulated entities
The working group had originally suggested that a flat 22.5% charge be assessed for non-regulated entities but is now working on a more risk-sensitive proposal. At the Spring National Meeting, the working group discussed comment letters received related to the staff's October 30 memo which recommended for field testing that all asset managers and registered investment advisors be assessed a 12% charge on three year average revenue or another basis such as assets under management. For other entities material to the group from a risk perspective, additional discussion is needed but the memo suggested use of a 22.5% charge applied to book adjusted carrying value or a similar or higher revenue-based percentage compared to that of asset managers to reflect credit risk. All other entities would be assessed a charge of 12% of revenue scaled based on ACLI/AIA's suggestion to 2%, or 22.5% of BACV.

The ten comment letters included significant suggestions and objections; the non-regulated entity proposal will be revised based on feedback received and re-exposed at a later date.

Surplus Notes and Senior Debt
The working group discussed an NAIC staff memorandum that proposes treatment of surplus notes and senior debt in the group capital calculation, and considers limitations on including such amounts as group capital. Based on feedback from a March 13 call, the working group re-exposed the document for comment with the following proposed conclusions:

- "In all cases," assets transferred to the issuer of surplus note would be classified as available capital. Adjustments would be necessary for group capital purposes if the purchaser of the note is an affiliated regulated entity.

- Subordinated senior debt would be classified as available capital when certain criteria are met, e.g. the instrument has a fixed term and supervisory approval is required for any repurchase or redemption of the instrument.

There was significant discussion of whether subordinated senior debt as capital should be limited to 20% of available group capital. A large health insurer commented that S&P allows up to 40% for health insurers because of their short reserve liability tail and lack of catastrophe risk. NAIC staff will follow up with S&P this spring to learn more about exemptions to the 20% limitation for health insurers.

The working group has scheduled a conference call April 19 to continue/conclude discussions on the treatment of surplus notes and subordinated debt.

Scope of the group capital calculation
At the Spring National Meeting, the working group exposed for comment the first "official" scope document proposing that the "default starting point" of the group capital calculation would be the ultimate controlling person, but would allow the lead state to define the scope differently based on facts and circumstances. The exposure document asks for feedback on this conclusion and other questions including:

- To the extent a lead state makes a determination on the scope of the group that differs from the ultimate controlling person, should the calculation still include information on (any of) the entity(ies) excluded from the calculation either individually or in total?

- To the extent a lead state makes a determination on the scope of the group that differs from the ultimate controlling person, what type of communication may be appropriate to the other licensed states? Should such communication occur before or after a determination is made by the lead state with input of the domestic states and international regulators?

The memo was exposed for comment until May 8.

Baseline exercise and field testing of draft formula
NAIC staff has been working on the baseline exercise, which involves data submission by volunteer groups and their preferred alternatives on scalars, permitted practice adjustments and treatment of non-insurance and non-U.S. insurance affiliates. Round two of the baseline exercise is nearly complete, with staff developing tentative conclusions. Field testing could start later in 2018 but could get pushed into 2019; volunteers for field testing will include more than those involved in the baseline exercise.

Reinsurance Task Force

Covered Agreement
The task force held a nearly five hour public hearing in New York City February 20 to hear comments from regulators and interested parties on potential approaches to address the adoption of the Covered Agreement by the U.S. and EU. The task force received 174 pages of comments in 20 letters from insurers, trade associations, and U.S. and international regulators.

Most of the comment letters agreed that amending the Credit for Reinsurance Model Law (#785) and Model Regulation (#786) to eliminate reinsurance collateral requirements for EU-based reinsurers meeting the conditions of the Covered Agreement is a necessary first step and to provide reinsurers domiciled in NAIC Qualified Jurisdictions with similar reinsurance collateral requirements as EU reinsurers. There was also consensus among U.S entities that non-EU qualified jurisdictions reinsurers must provide the same treatment and recognition afforded under the Covered Agreement including the U.S. approach to group supervision and group capital. No comment letters supported additional "guardrails" for U.S. ceding companies to address the increased financial solvency risks caused by the elimination of reinsurance collateral.

Using feedback from the comment letters, the task force developed the following recommendations, which was also adopted by Financial Condition Committee at the Spring National Meeting. The task force will develop revisions to the Credit for Reinsurance Model Law and Regulation to:

- Conform the models to the Covered Agreement

- Allow reinsurers domiciled in NAIC non-EU qualified jurisdictions to have reinsurance collateral requirements similar to EU-domiciled reinsurers when specific conditions are met (as discussed above), and

- Address the effect of a breach of the Covered Agreement and the effect of a non-EU qualified jurisdiction to meet agreed-upon standards.

The task force hopes to have a "good draft" of proposed changes to the models by the Summer National Meeting, with possible adoption at the Fall National Meeting in mid-November. The task force chair acknowledged that this is an aggressive timetable.

Other related charges adopted include 1) review of the life and health RBC formulas to determine whether a reinsurance credit risk charge based on the financial strength of the reinsurer should be adopted, consistent with what is already done for P/C RBC, and 2) consider revisions to Schedule F to reflect changes to the credit for reinsurance models, including study of whether an allowance for doubtful accounts methodology (vs a Schedule F penalty) is appropriate. Those charges have a completion goal of year-end 2020.

Principles-based reserving

Valuation Manual amendment proposals
Since the Fall National Meeting LATF adopted several Amendment Proposal Forms; the most significant of these is one that removes volatility in grading of company experience toward an industry table by making the credibility grading scales more granular. At the meeting in Milwaukee LATF exposed or re-exposed several amendments related to the PBR Actuarial Report (VM-31) and Experience Reporting (VM-50 and VM-51).

An APF discussed at this meeting proposes clarifications to the aggregation of mortality segments determining credibility under VM-20. Passionate discussion ensued around the pros and cons of alternative ways to align mortality (and hence reserves) with underwriting criteria and marketing characteristics. The proposed revisions allow aggregation if three conditions are met: i) the company based its mortality on aggregate experience and then segmented the aggregate class, ii) all aggregated segments were subject to the same or similar underwriting processes, and iii) all aggregated segments were marketed similarly. The APF was exposed for comment until May 28. An ACLI representative noted that the proposed changes are clarifications and the expectation is that the changes would not be substantive.

VM-22 fixed annuity PBR
LATF heard an update from the VM-22 Subgroup on activity following the initial effective date of VM-22 Statutory Maximum Valuation Interest Rates for Income Annuities, which became effective for all applicable annuities on January 1, 2018. Under the adopted methodology, valuation rates for income annuities are adjusted quarterly or daily depending on contract size, are based on treasury rates plus a spread less default costs and expenses, and are established based on the expected duration of the payout period.

In response to questions raised by interested parties about the applicability of VM-22 in specific situations, the subgroup exposed a Q&A document to address the questions but has now re-drafted VM-22 to incorporate "significant clarifications." One item of note is the proposed inclusion of annuitizations commencing after 12/31/18 that arise from host contracts issued prior to 1/1/18; commenters are asked to weigh in on this change. In response to requests from interested parties to publish the weights used to develop the VM-22 valuation rates, the re-draft includes appendices with sample calculations. The VM-22 re-draft is exposed for comment until May 3.

Work continues on development of maximum valuation interest rates for other fixed income annuity (i.e. non-VA/non-SPIA) contracts and valuation methodologies. The subgroup expects to present a summary of their work at the Summer National Meeting.

Variable annuities framework

The Variable Annuity Issues Working Group met for a full day at Spring National Meeting to continue its discussion around the recommendations issued by the working group, together with its consultant on the project, Oliver Wyman (OW), resulting from the second Quantitative Impact Study. The current recommendations were provided by OW in December 2017. In March OW issued its responses to the comment letters it received.

OW's updated recommendations were developed with the purpose of enhancing the robustness of total balance sheet funding requirements, incentivizing risk management, and promoting comparability amongst insurers while preserving the existing statutory construct and minimizing implementation complexity. In its response to the comment letters, OW addressed the concerns expressed in each letter, but maintained its support for the majority of the recommendations included in the December report.

During the meeting, the working group reached a general agreement on several recommendations issued by OW, including the following:

1) The removal of the Working Reserve.

2) Greatest Present Value of Accumulated Deficiencies will be discounted at the asset earned rate on general account assets not explicitly included in the projection.

3) Asset projection will follow the guidance of VM-20 with an additional restraint on borrowing cost.

4) Interest rate scenarios will be generated using the VM-20 scenario generator.

5) Regulators reached a general agreement to proceed with the current equity calibration, rather than following OW's recommendation to lengthen the calibration period to 1926-2016.

While these recommendations were supported in concept by the majority of regulators, several regulators expressed the desire to refine some of the language.

Several other recommendations discussed at length were not resolved and will remain the focus of future discussions. These items include the following:

1) The American Academy of Actuaries proposed that companies reflect all hedge assets regardless of the current Clearly Defined Hedging Strategy (CDHS) designation, or that the criteria for CDHS be refined such that management cannot "opt out" of reflecting a hedge program which would typically qualify. OW maintained its support of the CDHS designation and questioned the ability of companies to meaningfully and accurately reflect management action in discretionary risk management programs which do not qualify for CDHS.

2) The working group proposed several variations to OW's recommendation regarding the reflection of non-guaranteed revenue sharing agreements. While no proposal was agreed upon, the majority of regulators expressed comfort with allowing companies to reflect a greater percentage of their non-guaranteed revenue sharing agreements for both affiliated and non-affiliated funds than the current proposal.

3) The ACLI and several industry representatives proposed that the Standard Scenario Amount be made a disclosure-only item, rather than a binding minimum reserve. OW and several regulators expressed a lack of comfort with the removal of the SSA as a required minimum reserve.

The working group will continue to hold joint conference calls with the C-3 Phase II/AG 43 Subgroup to discuss the list of issues developed by regulators related to potential changes to AG43/C3 Phase II. The working group also proposed scheduling another in-person meeting due to the significant number of outstanding recommendations and issues at a date to be determined. The earliest date on which the revised guidance could realistically be implemented appears to be December 31, 2019, due to the amount of work necessary to complete the project.

Proposed derivative accounting for hedging VAs
The SAP Working Group exposed for a comment a revised issue paper on hedging variable annuities. See discussion in the SAPWG summary above.

Life Actuarial Task Force

In addition to progress on PBR initiatives, the task force continued work on the following projects.

Valuation mortality tables – AG 42
During the interim period LATF members adopted revisions to Actuarial Guideline 42, Application of the Model Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities, and the revisions were adopted by the commissioners at the Plenary session in Milwaukee, making the guideline effective as provided by a state's requirement. The revisions provide guidance for purposes of the certification requirements related to the selection of the appropriate preferred class structure mortality table, and incorporate use of the 2017 CSO Preferred Class Structure Mortality Table, (the existing guidance already provides for use of the corresponding 2001 CSO table), and include application to business subject to PBR. The revised AG 42 effectively provides the necessary guidance for application of the 2017 CSO table before changes can be incorporated into the Valuation Manual; corresponding changes will be incorporated in the 2019 Valuation Manual.

Accelerated underwriting mortality
In Milwaukee, the Joint Academy/SOA Preferred Mortality Project Oversight Group (POG, or joint committee) provided an update on activity to support data collection for accelerated underwriting

(AUW) mortality and to understand implications for mortality table development and reserve valuation under VM-20. During the interim period, LATF exposed for comment the joint committee's AUW Questions and Commentary Document pertaining to AUW data elements and feasibility of gathering such data. At this meeting the ACLI presented results from a survey of its member companies regarding their ability to provide additional data fields.

A total of 195 data fields were considered with respect to experience reporting value, current data availability and time to report. The ACLI also noted items needing clarification as well as concerns. The joint committee provided responses to the ACLI comments and noted they are currently working to refine and prioritize data elements, including consideration of a phased-in approach. The joint committee noted the importance of identifying the necessary data requirements with sufficient lead-time to allow companies to modify their systems to facilitate data collection on a timely basis to inform development of the corresponding mortality tables. The joint committee will come back to LATF with a revised recommendation for discussion.

Guaranteed issue mortality
At this meeting, LATF heard an update from the AAA Life Experience Committee and the Society of Actuaries Preferred Mortality Oversight Group's (joint committee) on the topic of guaranteed issue (GI) mortality. During the interim period, LATF voted to exclude GI business from PBR at this time, to allow the joint committee to expedite determination of the appropriate GI mortality levels for valuation and ultimately facilitate adoption of the amendment proposal once this work is complete. LATF then focused attention on determining the percentage loads to apply to the 2017 CSO table to reflect GI mortality, and evaluate differences between reserves based on loaded 2017 CSO tables relative to reserves based on the 2001 CSO and 1980 CSO tables. At this meeting, following a presentation from the joint committee on potential results under various mortality table options, the task force voted to exposed reserve comparisons under four loaded 2017 GI mortality tables and a corresponding APF for incorporating the GI mortality tables into the Valuation Manual for comment period ending April 25.

Simplified issue mortality
The joint committee gave LATF an update on the charge to develop simplified issue (SI) mortality tables. The SI mortality tables and report, including a definition of SI, were exposed for comment in September 2017. Review of comments and significant changes in the marketplace since the tables were developed (based on 2005-2009 experience) has indicated challenges with establishing a definition of SI that has sufficient longevity and with establishing an appropriate mortality table considering variations in market practices and mortality profiles. The joint committee requested more direction and the matter will be discussed further on a future conference call.

Individual annuity nonforfeiture
At the Spring National Meeting, the Model #805 (Standard Nonforfeiture Law for Individual Deferred Annuities) Drafting Group provided an update on its work to address determination of individual annuity nonforfeiture values in compliance with the Model #805 prospective test. The drafting group held several calls during the interim period to discuss specific approaches, culminating with a draft guideline that addresses treatment of common annuity features like bonuses, charges, market value adjustments, treatment of optional maturity dates, and testing required to certify compliance with the law. The guideline in its initial form emphasizes gradual convergence of cash surrender benefits to the paid-up annuity benefit available at maturity. The proposed guideline was exposed for comment until May 28.

Long-term care issues

Presentation on "current state of LTC insurance"
At the Spring National Meeting of the joint LTC Task Force, the trade associations AHIP and ACLI together presented on long-term care insurance (LTCI) in response to the Financial Analysis Working Group presentation in September which noted concerns about the state of the industry. The joint presentation proposed timely, predictable, and consistent approvals of actuarially justified LTCI rate increases across jurisdictions. It noted that rate increases are critical to the financial health of the companies writing the business and the continued ability to market and retain LTCI business. The AHIP/ACLI position is that denial of rate increases could result in several negative consequences including higher ultimate rate increases, fewer policyholder mitigation options, market contraction and subsidization of LTCI by other lines of business.

AHIP/ACLI requested that industry and regulators begin immediately working together to propose common principles and methodologies for a LTCI rate increase process nationwide and requested this be driven by top regulators and industry executives.

At the conclusion of the presentation, the task force asked the two trade associations to provide a plan in writing outlining the steps to achieve their proposal, to which they agreed. The task force scheduled a regulator to regulator (closed) meeting April 17 to hear a proposal from Utah on a pilot project for state coordination of LTC rate reviews.

Guaranty Association Model implementation
Significant revisions to the Life and Health Insurance Guaranty Association Model Act (#520) to address guaranty fund assessment and coverage issues of LTC insolvencies were adopted in December. The NAIC reported that ten states are currently in the process of adopting the newly revised model: AZ, CO, CT, HI, IN, IL, MO, UT and WV. At the meeting of the Financial Regulation Standards and Accreditation Committee, the regulators concluded that these revisions to the model will be considered "acceptable but not required" for purposes of accreditation.

LTC reserving and rate reviews
The LTC Actuarial Working Group heard an update on Academy activities from Warren Jones (PwC). The update addressed issue briefs being developed by the AAA's LTC Reform Subcommittee including a brief on "Recouping Past Losses," which is currently in review. The regulators also heard an update on the work of three Academy groups. The AAA LTC Combo Valuation Work Group is developing a Practice Note on LTC "combo products" to address statutory, GAAP and tax valuation methods and assumptions due to the range of practices for valuation. The LTC Valuation Work Group is developing mortality and lapse tables as possible bases for statutory minimum reserve requirements, and has separate subgroups addressing mortality and lapse. The LTC Practice Note Work Group is developing an update to LTC Practice Note, which is currently in review by the Academy.

The working group's LTC Pricing Subgroup has developed a LTC Rate Increase Checklist. During its March 1 call, the subgroup voted unanimously to adopt the checklist as the final product in response to the LTC Task Force's request for a consolidated LTCI rate review checklist that moves the states toward uniformity in requesting information and data, without preventing a state from asking additional or fewer questions. The checklist will be considered for adoption by the LTC Actuarial Working Group during its April 11 call. The subgroup will be meeting weekly in April and May to discuss LTC rate review methodologies.

The Valuation Subgroup has been considering changes to the Long-Term Care Experience Exhibit Forms 1 through 5. The subgroup informally surveyed states regarding the use of the Exhibit in monitoring reserve adequacy and half of the states responded that they use Forms 1 and 2. The chair of the subgroup recommended postponing any changes to the Exhibit for a year while the first filings under AG 51 are reviewed.

The LTCAWG heard an update on SOA activities, which is preparing to start its next LTC Experience Study. Responses from companies are expected in April. A working group member raised the issue of mandatory LTC data collection under the Valuation Manual. The chair of the working group responded that a mandatory data collection will not needed if there is good response to the SOA data call.

Financial Stability Task Force

Proposed liquidity disclosures
The task force adopted significant new liquidity disclosures for consideration by the Blanks Working Group later this spring. The proposals were extensively revised as a result of the two exposure periods in 2018 and include the following changes:

- The task force adopted nearly all of industry proposed changes to the new "baseline liquidity" proposal which adds columns to the Life and Fraternal Analysis of Operations and Analysis of Reserves for expanded categories of types of life insurance and annuities. Industry noted areas where systems changes would be necessary to capture the requested data and suggested that certain definitions be added and that references to specific products be made consistent throughout the 68 page proposal.

- Note 32, Analysis of Annuity Actuarial Reserves and Deposit Type Liabilities by Withdrawal Characteristics now divides the tabular disclosures into separate individual annuity and group annuity, and deposit-type contract sections.

- For proposed new Note 33, Analysis of Life Actuarial Reserves by Withdrawal Characteristics, the task force removed the disclosure requirements for deposit-type contracts and provided additional discussion of account value and cash value.

The task force agreed to the industry's request to defer the implementation date from year-end 2018 to year-end 2019. In exchange, industry agreed to submit information for a data call in April 2019 for 2018 premium, reserves, cash surrender ending balances and available policy loans for individual life, group life, individual annuity, group annuity and deposit-type contracts, along with the new Note 33 disclosures.

Liquidity stress testing
The Liquidity Assessment Subgroup has continued to hold regulator only meetings to discuss company specific stress testing methodologies. Once that work is complete, the subgroup will conduct open calls to begin deliberating a baseline proposal for a liquidity stress testing framework for large life insurers. This will likely include constructing regulatory stress scenarios that still allow flexibility for company-specific situations to ensure the tests are meaningful to both regulators and the industry participants.

ORSA and enterprise risk (Form F) filings

The Group Solvency Issues Working Group continued discussion of the Form F Implementation Guide, for which extensive proposed revisions had been exposed in November 2017. The goals of the revisions were to: 1) reduce redundancy in the reporting requirements for ORSA filers, particularly in relation to insurance risk exposures; 2) clarify that the purpose of the Form F Implementation Guide is to outline best practice recommendations for reducing potential follow-up questions and the scope of additional analysis and exam activities; and 3) provide more guidance regarding the regulator's interest in information on risk management practices for those insurance groups not subject to ORSA reporting requirements.

Comments received were not extensive. The ACLI did request an exemption to filing a Form F if an Insurance Holding Company System has filed an annual report with the SEC disclosing its materials risks. Ultimately the working group concluded that SEC filers could reference specific pages within their filings to the extent information can be leveraged; however, the guidance would not include an exemption. The working group adopted the implementation guide and comparison chart in Milwaukee.

In an update from the ORSA Implementation Subgroup, a comment letter response was submitted related to the exposure of the ASOP on Capital Adequacy Assessment developed by the Actuarial Standards Board's ERM Committee. The comment letter was overall supportive, but included proposed edits and clarifications. An open conference call will be scheduled prior to the Summer National Meeting to discuss possible proposed revisions to the ORSA Guidance Manual.

International Insurance Relations Committee

IAIS Comment Letters
Since the Fall National Meeting, the International Insurance Regulations Committee met five times to approve various comment letters. Comments on the Financial Stability Board's consultative document on the key attributes for the insurance sector noted concerns, although improved from the previous version, that the some of the methodology is better suited for other non-insurance financial services companies. Comments on the International Association of Insurance Supervisors' revised Insurance Core Principle 15 (Investments), ICP 16 (ERM for Solvency Purposes) and related ComFrame material noted that the consultation documents represent a general improvement over the current version; however, there are still some areas where clarification is needed. Additional comment letters were also approved for ICP 8 (Risk Management and Internal Controls) and related ComFrame material, the IAIS activities-based approach to systematic risk and the IAIS application paper on the use of digital technology in inclusive insurance.

Update on IAIS activities
The committee reported that the IAIS is currently revising ICP 6, Change in Control, and ICP 20, Disclosure. In addition, field testing is planned to start during the second quarter of 2018 relating to the insurance capital standard version 2.0. Regarding macroprudential and financial stability, the IAIS continues to work through the activities-based approach to systemic risk and on identifying the list of G-SIIs for 2018.

Financial Regulation Standards and Accreditation Committee

Corporate Governance Models
At the Spring National Meeting, Executive Committee and Plenary adopted the Corporate Governance Annual Disclosure Model Act (#305) and Model Regulation (#306) as Part A accreditation standards effective January 1, 2020.

Insurance Holding Company System Regulatory Act
The committee adopted the 2014 revisions to the holding company model (#440) that provides states with "clear legal authority" to act as the group-wide supervisor for an internationally active insurance group. The changes will be required for accreditation purposes as of January 1, 2020 for states that have a domestic IAIG. The committee did not adopt any changes to require that the confidentiality protections adopted by a state as part of the #440 revisions be "functionally equivalent" to the model #305 language as requested by the joint trade groups.

Revisions to Review Team Guidelines
The committee adopted revisions to the accreditation Review Team Guidelines to provide guidance on ORSA filings and to incorporate the new risk-focused analysis process that became effective January 1, 2018. At the Spring National Meeting, the committee exposed for comment to require the use of a credentialed actuary on financial exams of companies that have a substantial amount of business subject to PBR calculations or exclusion tests.

P/C Appointed Actuary attestation

The Casualty Actuarial Task Force has been tasked with the development of an actuarial attestation form that would be completed and signed annually to verify that the actuary is qualified to sign a statutory P&C Statement of Actuarial Opinion. The attestation exposed for comment in February would require the actuary to respond whether 1) he or she meets the basic education, experience and continuing education requirements of the Specific Qualification Standard for Statements of Actuarial Opinion and NAIC P&C Annual Statement, 2) has the "knowledges" necessary to sign the actuarial opinion appropriate for the company's lines of business and activities and 3) is a member of the American Academy of Actuaries. The "knowledges" includes a list of over 100 broad topics (e.g. key elements of tort law, tort trends and reforms and policy forms and coverages, underwriting, and marketing).

The task force received 60 pages of comment letters from 17 respondents, expressing very significant opposition to the attestation proposal. Subsequent to the Spring National Meeting, the task force released a revised "working definition" of qualified actuary, noting that the "knowledges" will be used only to assess educational syllabi rather than an individual actuary's qualifications. The task force has a goal of completing this "standards and assessments" project, which includes the definition of qualified actuary and revised instructions for the Statement of Actuarial Opinion, for the 2019 annual statement.

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The next National Meeting of the NAIC will be held in Boston August 4-7.

We welcome your comments regarding issues raised in this newsletter. Please provide your comments or email address changes to your PwC LLP engagement team, or directly to the NAIC Meeting Notes editor at jean.connolly@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 meeting materials to industry observers at the meetings, it can be 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.

Appendix A

This table summarizes actions taken by the SAP Working Group since the PwC NAIC January 2018 Meeting Newsletter on all open agenda items. Items exposed for comment are due May 18, 2018 unless otherwise noted. For full proposals exposed and other documents see the SAP Working Group webpage.

Issue/ Reference #	Status	Action Taken/Discussion	Proposed Effective Date
Quarterly Reporting of Investment Schedules (#2015-27)	Referred*	The Financial Condition Committee is still considering various proposals for the NAIC to receive quarterly investment data (in lieu of the proposal for industry to file data electronically with the NAIC every June 30). The committee has asked for a comparison of the cost to purchase the data from A.M. Best or modify NAIC systems to generate the data in-house.	June 30, 2019
SSAP 22 - ASU 2016-02 - Leases (#2016-02)	Re-exposure expected at the Summer National Meeting	A "full re-write" of SSAP 22 was exposed for comment at 2017 Summer National Meeting, which proposes adoption of ASU 2016-02 with significant modifications to continue the current approach for statutory accounting in all areas, including operating leases, sale/leaseback and leveraged leases. Staff is working with industry to finalize a revised issue paper for exposure this summer.	Years ending December 31, 2019 with early adoption permitted
SSAP 86 - Special Accounting Treatment for Limited Derivatives (#2016-03)	Re-exposed	A significantly revised issue paper was re-exposed for comment at the Spring National Meeting. See additional discussion in the SAPWG summary above.	January 1, 2019
ASU 2016-13 - Credit Losses (#2016-20)	Exposed	The working group exposed for comment a "discussion document" of possible GAAP credit loss concepts that could be considered for statutory accounting. Additional discussion of this topic is included in the SAPWG summary above.	TBD
Appendix C Introduction (#2016-42)	Deferred*	The working group had previously exposed revisions to Appendix C – Actuarial Guidelines in the AP&P Manual to promote consistent application of the Actuarial Guidelines which highlights that insurers which depart from actuarial guidelines should disclose those differences. In comments from interested parties, they suggest that disclosure not be required when insurers hold reserves in excess of the required minimums. The working group asked NAIC staff to work with interested parties to refine the wording of the proposed guidance. Renewed discussion is expected in 2018.	TBD
SSAP 86 – Derivatives with Future Settled Premiums (#2016-48)	Adopted and referred	The working group adopted proposed revisions to SSAP 86 for extensive individual contract disclosures for derivatives with financing premiums, which will be implemented via electronic-only columns in Schedule DB. For each derivative contract with future settled premiums, an insurer will disclose whether premium cost is paid throughout the contract or at derivative maturity, the next premium payment date, total premium, premium cost paid in prior years and in the current year, future unpaid premium cost, fair value of the derivative, excluding impact of financing premiums, and unrealized gain/loss, excluding impact of financing premiums.	Year-end 2018 for Schedule DB revisions if adopted by the Blanks Working Group (2018-12BWG)

Appendix A

Appendix D – ASU 2017-06 Master Trust Reporting (#2017-03)	Adopted	The working group rejected this ASU as not applicable to statutory accounting.	March 24, 2018
SSAP 41 – Surplus Note Amortization and Accretion (#2017-12)	Re-exposure expected at the Summer National Meeting	NAIC staff continues to work with industry to resolve issues and propose related accounting for surplus notes issued at a discount.	TBD
SSAP 68 & 97 – Goodwill Limitation (#2017-18)	Adopted	After initially considering possible additional limitations on statutory goodwill, the working group adopted revised new disclosures without new limitations on admitted goodwill; see the SAPWG summary for additional detail.	December 31, 2018
SSAPs 41R and 97– Double Counting of Surplus Notes (#2017-21)	Adopted	The working group adopted proposed SSAP 41R and 97 revisions to prohibit "double counting" of all surplus notes, either directly or indirectly acquired by a parent insurer and regardless of how acquired.	March 24, 2018
SSAP 48/SSAP 26R – Look-through for LLCs (#2017-25)	Rejected and referred	The working group rejected a proposal from industry to allow a "look-through" approach for underlying bond investments in an LLC. The working group concluded the more appropriate action, since the issue is RBC treatment of these LLCs, is referral to the VOS Task Force and CADTF to consider NAIC designations for Schedule BA assets. (The VOS Task Force exposed the referral at its Spring National Meeting.)	N/A
SSAP 61R – Reinsurance Risk Transfer for Short Duration (#2017-28)	Report on informal drafting groups' discussion	In November 2017, the working group created informal drafting groups with industry to discuss SSAP 61R and 62R issues. See additional discussion in the SAPWG summary.	TBD
SSAP 92 & SSAP 102 - Plan Asset Disclosures (#2017-30)	Adopted	The employee benefits SSAPs were revised to remove the Level 3 reconciliation disclosure for plan assets as this disclosure is viewed as unnecessary since plan assets are not recorded in the statutory balance sheet.	March 24, 2018
SSAP 103R – Wash Sale Disclosures (#2017-31)	Adopted	The working group adopted revisions to SSAP 103R to eliminate cash equivalents, all derivative instruments and short-term investments with credit assessments equivalent to an NAIC 1 or NAIC 2 designation from the wash sale disclosure.	March 24, 2018
SSAP 30 – Investment Classification Project (#2017-32)	Exposed	The working group directed staff to draft an issue paper to propose guidance related to three common stock issues. See detail in the SAPWG summary above.	TBD
SSAP 86 - ASU 2017-12, Derivatives and Hedging (#2017-33)	Exposed until June 22	The SAP Working Group exposed a proposed issue paper to consider adoption of this ASU. See the SAPWG summary above for additional discussion.	TBD

Appendix A

APP Manual Appendix D – FASB Codification References (#2017-34)	Disposed	Based on feedback from industry, the working group decided not to undertake a comprehensive project to "better identify the FASB Codification references for U.S. GAAP reflected in statutory accounting." The working group may reconsider this project after the review of ASU 2016-13 on credit losses is complete.	N/A
SSAPs 49 & 56 – Policy Loans (#2017-35)	Re-exposed	NAIC staff had raised concerns that guidance for policy loans held in separate accounts is not clear. At the Spring National Meeting, the working group exposed for comment proposed guidance for SSAPs 49 and 56 to clarify that a transfer of assets from the separate account to the general account must occur to fund the policy loan issuance; otherwise the policy loan is nonadmitted in the general account. The guidance also includes sample journal entries for the separate account.	TBD
INT 02-22 & INT 09-08 Updates (#2017-36)	Adopted	INT 02-22, Accounting for the U.S. Terrorism Risk Insurance Program, was updated to clarify that the Interpretation will be effective as long as the TRIA program is in existence. INT 09-08 was nullified as there are no longer any loans outstanding under the Federal Reserve's Term Asset-Backed Securities Loan Facility program.	March 24, 2018
SSAP 47 – Uninsured Plans (#2017-37 and #2016-19)	Exposed	The working group adopted guidance to reject all FASB revenue recognition standards recently issued: ASUs 2014-09, 2015-14, 2016-08, 2016-10 and 2016-12.	March 24, 2018
SSAP 101, Federal Income Tax Reform (#2018-01)	Re-exposed until April 23	The working group re-exposed guidance related to its consideration of FASB's ASU 2018-02 on federal tax reform. See additional discussion in the SAPWG summary above.	June 2018
INT 18-01 – Tax Estimates Under Tax Reform (#2018-02)	Adopted	Guidance was adopted in three areas including consideration of SEC SAB 118 on tax estimates. See discussion in the SAPWG summary.	February 8, 2018
SSAP 43R – Reporting NAIC Designations as Weighted Averages (#2018-03)	Exposed	The working group exposed revisions to SSAP 43R Implementation Questions 8 and 10 to require that for SSAP 43R securities with different NAIC designations by lot, the reporting entity shall either report the entire investment in a single reporting line at the lowest NAIC designation that would apply to a lot or report the investments individually by purchase lot in the investment schedules. The guidance applies separately to lots in the general and separate account.	TBD
SSAPs 21 & 26 – Bank Loan Referral (#2018-04)	Exposed	The working group exposed for comment a proposed recommendation to the VOS Task Force that "borrowing base loans" and "DIP financing loans" be classified as collateral loans as opposed to bank loans under SSAP 26R.	TBD
SSAPs 1 & 32 – Security Symbol Changes (#2018-05)	Exposed	As a result of changes adopted by the VOS Task Force related to 5* securities and perpetual preferred and redeemable preferred stock symbols, the working group exposed proposed revisions to SSAP 1 and SSAP 32 to reflect those changes. See the VOS Task Force summary for additional discussion.	TBD

Appendix A

Regulatory Transactions Referral from the Reinsurance Task Force (#2018-06)	Exposed	The working group exposed for comment proposed new wording for SSAP 4 to address assets acquired in connection with "regulatory transactions" (which had been discussed in detail by Reinsurance Task Force). Such assets would admitted only to the extent that the regulatory transaction had been approved for admittance by the domiciliary regulator. Such transactions would also be subject to disclosure as a permitted or state prescribed accounting practice that differs from NAIC prescribed.	TBD
SSAP 41R – Surplus Notes Linked to Other Structures (#2018-07)	Exposed	In connection with a referral from the Reinsurance Task Force, the SAP Working Group exposed for comment proposed revisions to SSAP 41R to disallow capital treatment for surplus notes which are linked to other products that are not subordinate. Assets linked to issued surplus notes that are not subordinate that are not available for policyholder claims would also be nonadmitted.	TBD
SSAPs 21 & 56 – Private Placement Variable Annuities (#2018 -08)	Exposed	The working group exposed for comment proposed new disclosures related to private place variable annuities and private placement life insurance. See the SAP Working Group summary for additional discussion.	December 31, 2018
SSAP 97 – SCA Cumulative Losses (#2018-09)	Exposed	The working group exposed proposed revisions to SSAP 97 to require tracking and disclosure by reporting entities whose share of losses in an SCA exceed the investment in the SCA. This would be required regardless of whether a guarantee or commitment of future financial support to the SCA exists.	December 31, 2018
INT 18-02T – 2019 ACA Section 9010 Moratorium (#2018-10)	Exposed	As a result of adoption of a 2019 moratorium on the health insurance provider fee (similar to 2017 moratorium), the working group released for comment INT 18-02, which is modeled after INT 16-01 on the same topic. The interpretation also provides general guidance in the event of any future moratoriums of the provider fee.	TBD
Appendix D – ASU 2017-15 (#2018-11)	Exposed	The working group has proposed rejection of this ASU related to U.S steamship entities as not applicable to statutory accounting.	TBD
Various SSAPs – ASU 2018-13 (#2018-12)	Exposed	The regulators are proposing to reject ASU 2018-03, Recognition and Measurement of Financial Assets and Financial Liabilities within SSAPs 26R, 30, 32, 43R, 86 and 100R.	TBD
Editorial Updates to Various SSAPs – (#2018-13EP)	Exposed	The working group exposed several NAIC staff proposed editorial revisions such as deletion of disclosure illustrations and an outdated footnote.	TBD
SSAPs 47, 54, 66, & 84 – Guidance for Covered GAP Discount Program (#2018-14)	Exposed	The working group proposed revisions to INT 05-05, Medicare Part D Definitions, to provide guidance for the Coverage GAP discount program. The proposal is similar to the existing accounting guidance for the low-income subsidies.	Prior to year-end 2018
*No additional action was taken on this topic/issue since the 2017 Fall National Meeting.			

Appendix B

This chart summarizes action on other proposals of the RBC Working Groups since the 2017 Fall National Meeting, i.e. those not discussed on pages 4-5 of this Newsletter. The detail of all proposals adopted for 2018 RBC are posted to the Capital Adequacy Task Force's webpage (under Related Documents).

RBC Formula	Action taken/discussion	Effective Date/ Proposed Effective Date
All formulas		
Remove Unaffiliated Common Stock for MMMFs (2017-07-CA)	The Capital Adequacy Task Force **re-exposed** a proposal to remove the common stock charge for money market mutual funds for all formulas as these investments are now classified as cash equivalents.	2018 RBC Filings
Medicaid Pass-Through Payments (2017-08-H)	The CADTF **adopted** a proposal to apply a 2% factor to Medicaid pass-through payments that are reported as premium to reflect that these risks are more similar to ASO and ASC business, which also receive a 2% charge.	2018 RBC Filings
Risk Adjustment and Risk Corridor Sensitivity Test (2017-09-CA)	The Capital Adequacy Task Force **adopted** a proposal to remove the risk corridor portion from the sensitivity test for all formulas since the temporary program ended in 2016.	2018 RBC Filings
ACA Reinsurance (2017-10-H)	The CADT **adopted** a proposal which removes lines from Recoverables on Paid and Unpaid Losses for ACA and non-affiliates since the program ended in 2016.	2018 RBC Filings
Stop loss interrogatories (2018-01-CA)	In connection with the adoption of revisions to the stop loss factors in 2017, the Health RBC Working Group agreed to gather information (via an electronic only table) and continue to review the factors with more current information. The interrogatories provide information needed to review the factors, which will be aggregated and analyzed. At the Spring National Meeting the interrogatories were **re-exposed** for comment until April 4 to address technical issues identified by industry representatives. The Capital Adequacy Task Force hopes to receive any final comments and adopt the proposal for 2018 RBC filings during its April 30 conference call.	2018 RBC Filings
Deletion of Underwriting Risk Experience Fluctuation Risk page (2018-02-CA)	The Capital Adequacy Task Force **approved** deletion of the Underwriting Risk Experience Fluctuation Risk – Informational Only Page from all formulas due to the continued changes of the ACA making the information less meaningful.	2018 RBC Filings

Appendix B

P/C RBC		
Internal Modeling (2016-12-CR)	The Catastrophe Risk Subgroup agreed to **re-expose** later in 2018 a proposal to allow catastrophe models other than the five approved commercially available models to reflect comments received from interested parties.	2018 RBC Filings
Affiliated Bonds (2017-14-P)	The P/C RBC Working Group **adopted** its proposal to remove affiliated bonds from the affiliated investment pages and include those bonds with unaffiliated bonds on PR006. This results in a change in RBC factor from a flat 22.5% to a charge based on the credit quality of the individual bonds and updates the P/C formula to be consistent with the life and health RBC formulas and their treatment of bonds.	2018 RBC Filings
PR027 Interrogatory Instruction (2018-08-CR)	The Catastrophe RBC Subgroup **exposed** for comment until April 22 a clarification to the P/C RBC instructions that all filers must complete this interrogatory, which supports the exemption from filing the catastrophe risk charge.	2018 RBC Filings
Health RBC	All exposures are until April 24	
Stand-Alone Medicare Part D Instructions (2018-04-H)	The Health RBC Working Group **exposed** for comment additional language in the instructions for Lines 1 and 6 on page XR012 that beneficiary premium and incurred claims for stand-alone Medicare Part D coverage should be excluded.	2018 RBC Filings
Business Risk (2018-06-H)	The Health RBC Working Group **exposed** for comment additional language in the instructions for Lines 8 and 9 on page XR021 to include ASC and ASO broker commissions.	2018 RBC Filings
All Other Low Income Housing Tax Credit factor (2018-07-H)	The Health RBC Working Group **exposed** for comment a correction to a factor error, updating the factor from .015 to .15 to align with the intended factor, as well as the PC and Life factors.	2018 RBC Filings

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