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CRE READING PROGRAM INSTRUCTIONS

The Society of Financial Examiners has a Reading Program for Earning Continuing Regulatory Education Credit by Reading the Articles in The Examiner.

You can earn **2 CRE credits** for each of the 4 quarterly issues by taking a simple, online test after reading each issue. There will be a total of 15-30 questions depending on the number of articles in the issue. The passing grade is 70%. 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**.

NOTE: Each new test will be available online as soon as possible within a week of the publication release. The Reading Program online tests are free. Scoring is immediate upon submission of the online test. Retain a copy of your online test score in the event you are audited or you need the documentation for any other organization's CE requirements. Each test will remain active for one year or until there is a fifth test ready to be made available. In other words, there will only be tests available for credit for four quarters at any given time.

Earn Continuing Regulatory Education Credits by Reading The Examiner!

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 April 12, 2021.***

Examination Considerations in the Pandemic

True and False Questions — Submit Answers Online

1. COVID-19 has not generated logistical challenges that interfere with the examiner's ability to perform certain steps of the examination.
   a. True
   b. False

2. Video conferencing can be used to facilitate C-Level interviews, meetings with the analyst and status updates with other regulators.
   a. True
   b. False

3. Examiners are no longer required to obtain CPA workpapers due to COVID-19 as per the Financial Condition Examiner's Handbook.
   a. True
   b. False

4. In the event that current year workpapers from the CPAs are not available during planning or the beginning of fieldwork, prior year workpapers can be reviewed in the interim.
   a. True
   b. False

5. In most cases, the impact of COVID-19 will warrant a subsequent events disclosure within the exam report.
   a. True
   b. False

Windfall for Insurers from Recovery of Unpaid Risk Corridor Payments May Lead to Payment of MLR Rebates to Enrollees

True and False Questions — Submit Answers Online

6. HHS indicated that RC collections from the 2016 program year would be used first to offset the shortfall from the 2014 program year, before applying to any payments due to insurers for the 2015 program year.

    a. True
    b. False

7. At of the beginning of 2021, there were only three CO-OPS remaining, operating in five states.

    a. True
    b. False

8. According to SSAP No. 103 – Risk Sharing Provisions of the Affordable Care Act, the determination of collectability of receivables from the RC program was required to be made each reporting period. Although the 90-day past due rule to treat such receivables as non-admitted assets still applied because the amounts were due from a governmental agency, impairment testing was not required be applied each year.

    a. True
    b. False

9. The HHS guidance requires insurers to refile their MLR forms for years 2015 through 2018, regardless if inclusion of the RC recovery amounts results in a higher rebate liability to its enrollees than the liability in each respective year it initially filed.

    a. True
    b. False

10. For those that recovered risk corridor payment amounts in 2020, disclosure of the recovery amounts, as well as the initial amounts previously written off, should be included in the notes to the 2020 Annual Statement, most likely in Note 24E – Risk Sharing Provisions of the ACA.

    a. True
    b. False

Property Insurance: The Intersection of Reinsurance, Catastrophe Modeling and Exposure Management

Multiple Choice and True or False Questions — Submit Answers Online

11. Which of the following can be goals of a reinsurance program?
    a. Increase capacity to write larger accounts
    b. Mitigate earnings volatility
    c. Provide surplus relief
    d. All of the above

12. The risk tolerance of an insurance company is largely a management decision.
    a. True
    b. False

13. For large reinsurance programs, it is desirable to have a single, highly rated reinsurer as opposed to a diversified panel of reinsurers
    a. True
    b. False

14. Common PML's protected by catastrophe reinsurance programs are:
    a. 100 year to 250 year PML
    b. 250 year to 500 year PML
    c. 500 year to 1000 year PML
    d. Greater than 1000 year PML

15. A 100-year PML event is estimated to occur with what probability?
    a. ½% probability)
    b. 1% probability
    c. 5% probability
    d. 10% probability

True or False Questions — Submit Answers Online

16. The Health RBC Working Group adopted a proposal to require entities writing predominately health business and currently filing on the life or P/C blanks to begin filing on the health blank.
    a. True
    b. False

17. The Blanks Working Group exposed for comment a proposal to add a new Schedule Y, Part 3 to the 2021 annual statement blanks.
    a. True
    b. False

18. Due to delays in state legislative activity caused by COVID-19, the September 1, 2022 deadline for all states to adopt the 2019 revisions to the Credit for Reinsurance Model Law and Regulation to comply with the EU and UK Covered Agreements has been extended to September 1, 2023.
    a. True
    b. False

19. The final version of the group capital calculation (GCC) revisions to the Holding Company System Model Act were adopted in late 2020 by the NAIC Commissioners. The revisions will require insurance groups to file a group-level capital calculation, which will be in addition to the capital calculation currently required at the insurance entity level.
    a. True
    b. False

20. The Restructuring Mechanisms Working Group adopted its final white paper, which recommends adoption by all states of uniform restricting statutes.
    a. True
    b. False

Examination Considerations in the Pandemic

By Elise Klebba, CPA and Bailey Henning, CFE (Fraud), NAIC

We have just passed the one-year anniversary of COVID-19 being declared a worldwide pandemic. Although we may be starting to see the light at the end of the tunnel, many state insurance regulators and company personnel continue to be operating under a work-from-home environment. While many examiners have largely adapted to the complexities of conducting examinations remotely, there continues to be a greater focus on the unique challenges of conducting exams during a pandemic, with an emphasis on working in a more efficient and effective manner. Throughout this article, we will walk through various strategies to help examiners overcome certain logistical challenges, ways to enhance exam efficiencies, tips for leveraging technology, and other considerations for conducting examinations in the midst of a pandemic.

Figure 1 below highlights potential ways to gain efficiencies throughout the examination.

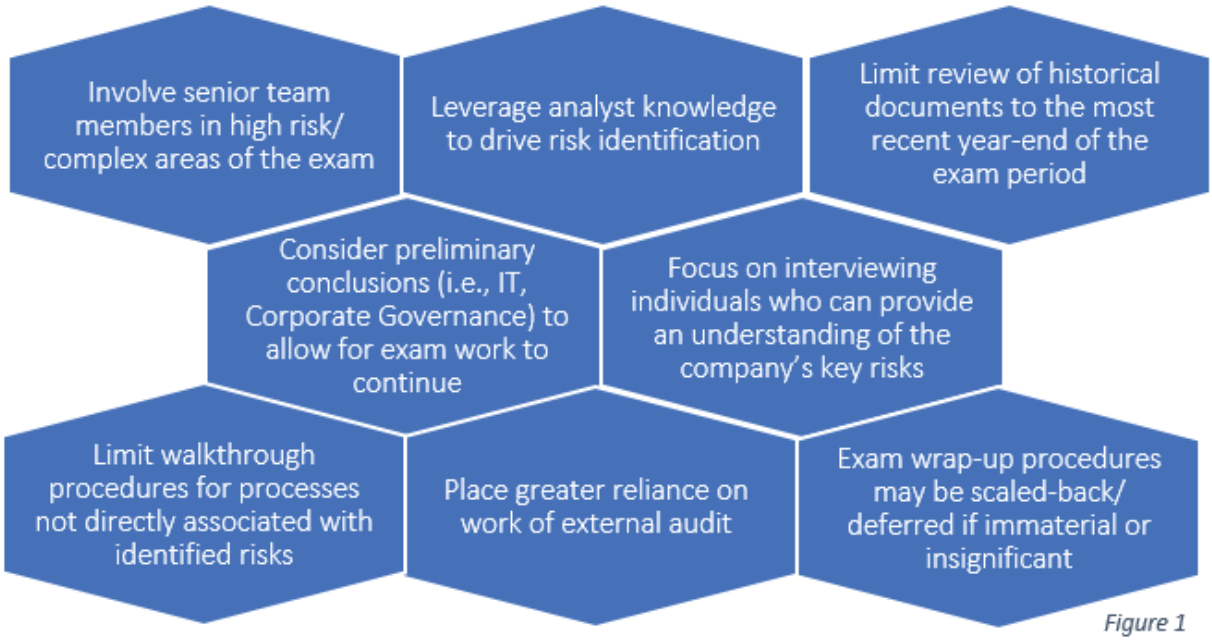

Figure 1

Exam Efficiency

It is safe to say that exam efficiency is an enduring concept that all examiners strive for, even in normal circumstances. However, it has become even more important due to the decentralized remote work arrangement that most companies and states are working under. The flexibility to work from home is likely appreciated by staff across a variety of sectors, but that arrangement may result in disruptions to the normal course of an examination. For example, intermittent staff availability may result in delays in correspondence between the company and the DOI and/or obtaining requested documentation. As always, the exam team should carefully consider where, and if, it makes sense to implement these suggestions, based on the specific complexities of the company under examination.

Logistical Considerations

The COVID-19 pandemic has also generated logistical challenges that may interfere with the examiner's ability to perform certain steps of the examination, which will likely be completed virtually. There may be circumstances in which the audit workpapers are not available when needed by the exam team, or when the exam team encounters a situation in which the company has altered its processes and controls to allow for continued operations while its staff works from home. These challenges require professionals to rethink the traditional testing approach and brainstorm how to effectively utilize technology to complete testing work and documentation.

Use of Technology

Having been thrust into a remote work environment over a year ago, examiners across the country had to quickly adapt and integrate the use of various technology—that at the time may have been completely foreign to them—into their day-to-day activities. Fortunately, these technologies have made it possible for exam teams to continue conducting high quality examinations, even while off-site. Exam teams can use these technologies to facilitate virtual collaboration and to complete multiple areas of an examination remotely. For example, examiners can utilize videoconferencing programs to facilitate C-Level interviews, meetings with the DOI analyst and status updates with other regulators who may be participating in a coordinated examination. Examiners may also utilize programs with screen-sharing capabilities (e.g., Skype for Business or Microsoft Teams) during walk-throughs to see certain processes and documents as they are being discussed. Using these programs, examiners may be able to test controls through observation and reperformance or even conduct an IT server room walk-through.

While utilizing these technologies has advantages, it is important to ensure that the integrity of the virtual review remains intact. The examiner should provide specific instructions/requests to the company in order to obtain and inspect all necessary support for the review procedures. Simultaneously, the examiner should ask questions as they arise to ensure a complete understanding of the company's IT systems and processes. Further, much of the guidance provided in Figure 1 on page 8 can be extended to the IT review portion of the financial examination to increase efficiencies, particularly in placing greater reliance on work of external audit, when appropriate.

Before applying these options, it is important to consider security implications of sharing sensitive information through these channels. Both the DOI and insurance companies should agree to the programs' usage and ensure transmission of data as securely as possible.

Availability of Audit Workpapers

Another logistical challenge that exam teams may encounter is availability of audit workpapers. Examiners are required to obtain and review workpapers and reports associated with the audit conducted for the examination's as-of date, according to the NAIC's *Financial Condition Examiners Handbook* [Handbook]. Any workpapers from audits after this date are not required to be reviewed; however, examiners may find it worthwhile to see if any findings could potentially affect the conclusions reached in the exam report. This is especially true given the potential impact of the COVID-19 pandemic.

In the event that current year audit workpapers are unavailable during planning or the beginning of fieldwork, the examiner may review the prior year workpapers in the interim. Before utilizing an auditor's prior period workpapers to test the effectiveness of internal controls, the examiner should verify that the controls have not changed since prior period testing. Should there be any issues identified that warrant further investigation or disclosure based on the audit report findings or through discussions with the external auditor, the section related to Subsequent Events can help the examiner to determine their next steps

Utilize evidence that is different in nature or form	Utilize draft document vs. finalized document
	Digital copies and/or signatures
Adjust for altered control processes	A monthly control temporarily being performed every other month to accommodate staff availability
Other control considerations	Establish an encrypted/secure transfer site for receiving sensitive documentation
	Consider whether current staff accommodations affect segregation of duties and/or increase potential for management override

Figure 2

Potentially Altered Control Environment

The ongoing work-from-home environment may have also affected the company's internal control environment. For example, due to company personnel working remotely, it is possible that the company altered the nature, timing, and/or extent of its controls to accommodate changes in staffing. Considerations that may assist examiners in handling other logistical challenges that arise have been included within Figure 2.

Considerations for Coordinated Examinations

Exam coordination and collaboration are also likely to be impacted by the current pandemic. As such, communication between participants throughout the examination is crucial to the success of the exam through frequent status updates and whether the pandemic will affect the states' ability to participate in the coordinated exam on an ongoing basis. States should also be understanding of possible disruptions to the exam schedule due to the pandemic and variances in government-issued mandates across states. Depending on the specific circumstances surrounding the examination and participating states, the lead state may need to assume a larger role in the completion of the exam work with limited travel opportunities and work-from-home policies of the participating states. Conversely, the lack of time required for travel and the opportunity to conduct more work off-site might increase opportunities to share work with participating states in other situations.

Subsequent Events

The impact of COVID-19 on a company's operations will continue to change as time passes, with the severity being dependent on the company's mix of business and exposure. In most cases, the impact of COVID-19 will likely warrant a subsequent events disclosure within the exam report. Given the continued uncertainty of the pandemic, it may be difficult to quantify the full effect of COVID-19 on the insurer's operations. In that case, the exam team may consider providing a qualitative summary of known risk factors in the insurer's exposures. If the impact on the company's operations or financial standing is material, the exam team should determine the extent of which that information is suitable to be publicly disclosed and which details, if any, should be kept confidential. Figure 3 outlines the avenues available, both publicly and confidentially, to disclose COVID-19 impacts related to a company's subsequent events. To assist examiners with drafting a subsequent event disclosure in the public examination report, example language is available within the complete COVID-19 memo, linked below.

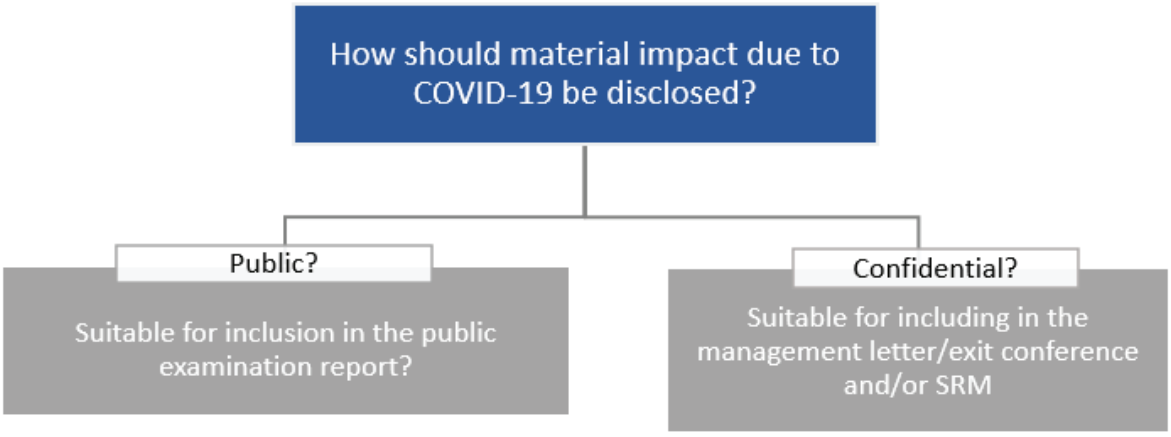

Figure 3

Conclusion

As we enter the second year of operating in this unique environment, state insurance regulators should remain understanding of possible disruptions that may arise and ensure proactive and timely communication with fellow regulators, peers in other departments, and company personnel. Due to the continued impact to examinations, the Examination Oversight (E) Task Force of the National Association of Insurance Commissioners (NAIC), which is charged with monitoring timeliness of examinations, has determined that COVID-19 related delays qualify as an exemption to the 18-month rule which stipulates that examination reports must be filed within 18 months of the examination's as-of date. However, in all circumstances, examinations must still be filed within 22 months of the examination's as-of date.

While conditions change and the future of the pandemic remains unclear, the topics discussed within this article can help to navigate the uncertainty of the current situation and completion of financial examinations in a remote work environment. For more detailed guidance, please refer to the NAIC's COVID-19 Memo. The memo, which can be accessed by regulators utilizing their StateNet credentials, can be found here: https://isiteplus.naic.org/statenet/documents/Examination-Considerations-COVID-19.pdf.

About the Authors

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Windfall for Insurers from Recovery of Unpaid Risk Corridor Payments May Lead to Payment of MLR Rebates to Enrollees

By Craig Moore, CFE
Examination Resources, LLC

Executive Summary

Some insurers who sold Patient Protection and Affordable Care Act (ACA) compliant policies in the health insurance exchange marketplace (the Exchange), have or will be receiving tens of millions of dollars in payments previously calculated and due from the Federal government under the Risk Corridors (RC) program. The RC program was designed as part of the ACA to provide protection against large losses and uncertainty in claims costs by insurers who participated in the Exchanges during 2014 through 2016. These payments from the Federal government are the result of a recent ruling by the Supreme Court of the United States, which concluded that the RC program created a government obligation to pay insurers the full amount of computed losses under the program.

As a result of these recoveries, which were written off in previous years as uncollectible receivables in accordance with statutory accounting rules, companies are required to recalculate MLRs for 2015 through 2018 to include the impact of the payments received from the Federal government. Recalculation of MLRs for these years will lead to additional MLR rebates being paid during 2021 by some insurers who participated in the RC program, some estimates being as high as three-hundred million dollars in additional rebates.

State insurance regulators may be interested in gaining more information on the recovery of the RC payments, and the potential additional rebates that may be due enrollees.

To understand the recent technical guidance issued by the U.S. Department of Health and Human Services (HHS) stipulating how the recoveries should be treated, and leading to the potential payment of additional MLR rebates, a little background is necessary on the RC program.

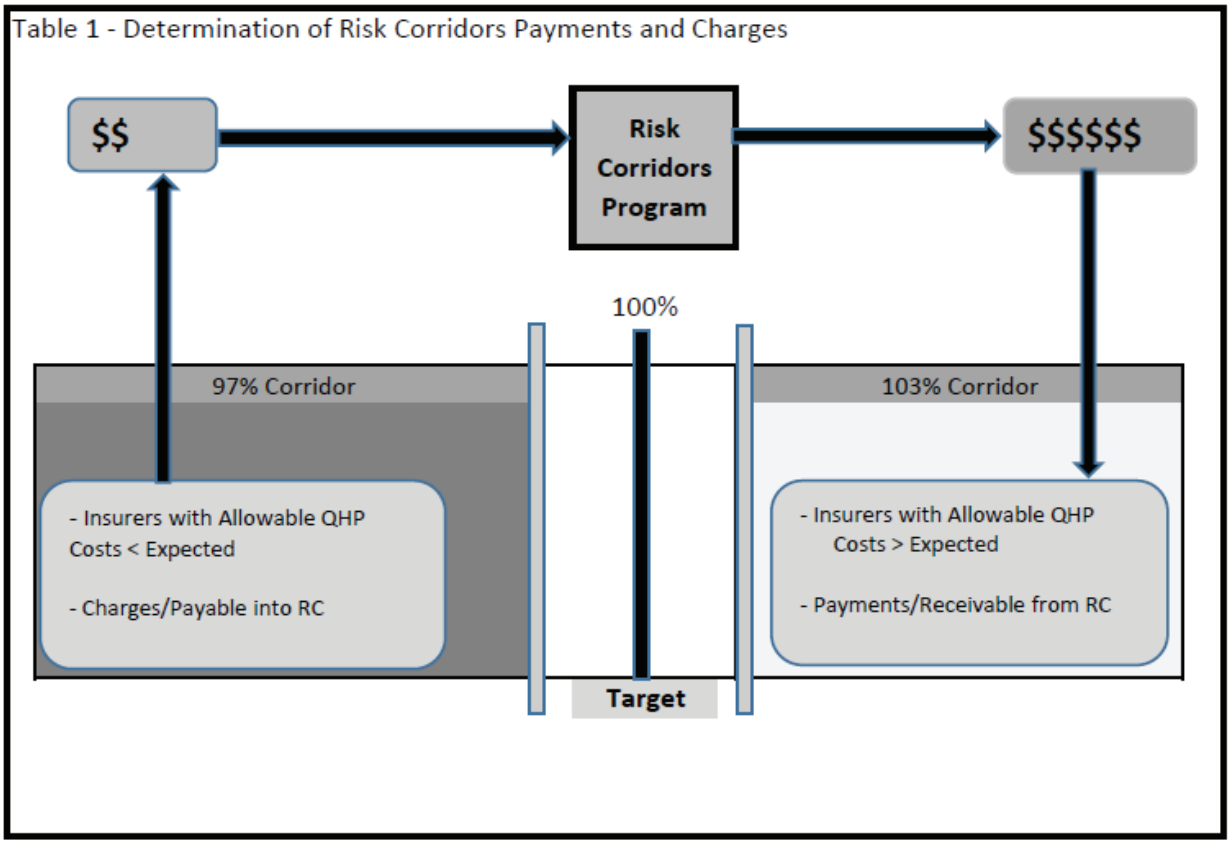
Risk Corridors Program – a premium stabilization program of the Affordable Care Act

The Federal Risk Corridors (RC) program was a temporary premium stabilization program developed as part of the ACA. Along with the other premium stabilization programs, Transitional Reinsurance and Risk Adjustment, the RC program was designed to provide consumers with affordable health insurance, to reduce incentives for insurers to avoid enrolling sicker people and to stabilize health insurance premiums in the individual and small group employer markets. Companies who offered qualified health plans (QHPs) on the Exchange, as well as through off-exchange distribution channels, during 2014, 2015 and 2016 were required to participate in the program, which offered a sort of safety net for insurers against inaccurate rate setting. A QHP is a health plan that is certified to be offered on the Federally-facilitated Marketplace, or the Exchanges, and that meets a number of requirements such as the inclu-

sion of all Essential Health Benefits required by the ACA, and established cost sharing limits, among other requirements. The RC program was designed to use charges/assessments collected from insurers who realized better than expected experience from the sale of QHPs to subsidize payments to insurers who realized significant losses from the sale of QHPs. While the majority of QHPs sold during the 2014 through 2016 period were on the Exchange, QHPs sold off-exchange were also included in the RC calculations.

The RC program provided payments to insurance companies based on how closely the premiums they charged covered the medical costs associated with their QHP enrollees. As shown in Table 1, an insurer whose allowable costs fell below 97% of the targeted amount included in its premium rate filings for QHPs, was required to make a payment into the program. For an insurer whose allowable costs exceeded 103% of the targeted amount, the program was designed to pay benefits to offset the high losses incurred by this insurer from the sale of QHPs. Allowable costs are essentially defined as actual claims costs incurred plus expenses for quality improvement activities. The targeted amount is defined as the projected premium for QHPs, less the projected administrative costs for the plans.

Table 1 - Determination of Risk Corridors Payments and Charges



According to the HHS Bulletin titled ***Risk Corridors and Budget Neutrality*** issued on April 11, 2014[1], the RC program was intended to be operated in a budget neutral manner, whereby the collective payments into the program by insurers who were profitable from selling QHP plans, on and off-exchange, would be enough to subsidize losses of other insurers who were unprofitable from the sale of similar QHP plans in the marketplace. While HHS anticipated that budget neutrality would be attained within the program, it stipulated that a pro-rata reduction in RC payments would be enacted to the extent of any shortfall from charges made into the program. In addition, HHS indicated that RC collections from the 2015 program year would be used first to offset the shortfall from the 2014 program year, before applying to any payments due to insurers for the 2015 program year. Any shortfall remaining after applying the collections from 2015 would be offset by 2016 collections before any payments would be made for the 2015 or 2016 program years.

Actual results from the program did not meet HHS' expectations of budget neutrality and therefore, only a small portion of the benefits were paid to insurers who had performed poorly from the sale of QHP health plans in the marketplace. After aggregating all collections from the program from the 2014, 2015 and 2016 program years, HHS paid approximately 16.8% of the total RC payments calculated for the 2014 program year. As a shortfall still existed from 2014, no payments were made to insurers due benefits from the program for the 2015 or 2016 years. After payments were distributed from available funds contributed by profitable insurers for the final year of the program (2016), it was estimated that more than $12 Billion in payments remained due under the RC program that were supposed to offset losses incurred by insurers.

As a result of the net shortfall in the program, many insurers incurred significant financial losses from participation in the QHP marketplace during the three years the program was in effect. Many of the large national insurers had a greater ability to absorb or limit these losses, through sheer size, strategic sale of QHPs only in select state markets, or often had significantly more resources available to ensure maximization of benefits from the other premium stabilization programs (Transitional Reinsurance and Risk Adjustment). However, one subset of insurers in particular were financially devastated by the unpaid benefits due from the program, CO-OPs.

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1 https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf

As part of the ACA, Consumer Operated and Oriented Plans (CO-OPS) were created as not-for-profit organizations to facilitate increased competition and choice in the marketplace, under the overall objective of providing affordable health insurance. Twenty-three qualified CO-OPS began operations in late 2014, funded through startup and solvency loans from the Federal government[2]. CO-OPS were required to operate under various requirements and restrictions including that at least 2/3 of business written had to be from QHPs in the individual and small group markets in each state. In addition, a majority of the voting board of director members had to be CO-OPs members, and representatives of a pre-existing insurance company or state government were prohibited from serving on the board of any CO-OP. At of the beginning of 2021, there were only three CO-OPS remaining[3], operating in five states. The rest either voluntarily or involuntarily ceased operations, with a number of CO-OPS being classified as insolvent. While many things contributed to their demise, including difficulty raising capital, shortage of expertise and highly competitive markets, one particular factor played a significant factor in the failure of these entities: the tens of millions of dollars in RC payments many were never able to collected from the Federal government. The very essence of the RC program, a safety net against significant losses for participating in the QHP marketplace, was not available to the CO-OPs, and many other insurers, when the funds were needed the most.

As part of annual appropriations legislation, in 2014, 2015 and 2016, Congress took specific actions to prevent the appropriation of funds from other programs to be used to offset any aggregate shortfall of RC payments. These actions were taken because of the significant shortfalls between the profitable insurers and those that incurred significant losses from participating in the QHP market, and to avoid tax payer money being used to make up the difference. As a result, the probability of collecting unpaid RC payments directly from the Federal government was thrown into serious doubt. As a result, dozens of lawsuits were filed against the Federal government seeking to recoup the unpaid amounts due under the program, including at least one large class action lawsuit.

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2 https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program
3 Common Ground HealthCare Cooperative (Wisconsin), Maine Community Health Options and Mountain Health CO-OP (Idaho/Montana).

Supreme Court of the United States - RC is an Enforceable Government Obligation

After numerous lower court trials and appeals, with mixed results, oral arguments were heard by the Supreme Court in December 2019 for the case of Maine Community Health Options vs. the United States[4]. The case had been consolidated with two other similar cases and claimed that the Federal government had an obligation to make payments calculated under the RC program. The plaintiff (insurers) had argued among other things that the failure to pay the amounts calculated under the program was essentially a government "bait-and-switch" and undermined the credibility of the Federal government. Counsel for the defendant (the United States) argued that insurers assumed the risk by participating in the RC program and that the benefits could not be paid absent an explicit appropriation from Congress.

On April 27, 2020, the Supreme Court concluded[5] that the payments to healthcare insurers, due to insurers who had suffered financial losses under the program, created a government obligation that required the payment to insurers for the full amount of their computed losses. As part of the ruling, the Supreme Court had also concluded that Maine Community Health Options had properly relied on the Tucker Act to sue for damages in the Court of Federal Claims. This created the precedent that allowed any insurer who participated in the RC program and was due amounts calculated under the program, to successfully sue and recover from the Federal government all unpaid benefits.

Statutory Accounting for the Risk Corridors Program

According to SSAP No. 103 – Risk Sharing Provisions of the Affordable Care Act, the determination of collectability of receivables from the RC program was required to be made each reporting period. Although the 90-day past due rule to treat such receivables as non-admitted assets did not apply because the amounts were due from a governmental agency, impairment testing was still required be applied each year. According to the SSAP, the RC receivables were allowed as admitted assets as long as the amounts were not considered impaired, or no payment denial was received from the Federal government administering the program. Upon notification that payments to be paid to the reporting entity would be less than the recorded receivables, any excess was required to be written off and charged to income. An exception to the requirement to write off any uncollected receivables existed for amounts that were under appeal, but such amounts were still required to be reported as a non-admitted asset.

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4 *Maine Community Health Options v. United States*, 140 S. Ct. 1308 (2020). 590 U.S. _ (2020).

5 https://www.scotusblog.com/case-files/cases/maine-community-health-options-v-united-states/

Many insurers interpreted the ongoing litigation against the government to be synonymous with an appeal, and as a result delayed the ultimate write-off of these receivables against income until later years, under the assumption that the amounts would eventually be collected. While a number of larger entities were able to delay the write-off of these significant receivables until 2017, the year after the RC program ended, many of the more financially distressed players were forced to acknowledge the probability of not collecting the unpaid amounts much sooner, given the relative materiality of the unpaid balances as a percentage of their total assets and capital. One strategy employed by a number of smaller entities that were highly dependent on the payments to keep their operations afloat involved selling the right to collect any future RC payments to third parties, including hedge funds and litigation finance firms. For a heavily discounted price, e.g. 30 cents on the dollar, some of the struggling CO-OPs and smaller regional insurers assigned their rights to all or most of any future recovery of the receivables from the program. No doubt that this allowed some temporary cash flow for these insurers to stay in business a little longer, or at least to soften the hard landing of an insolvency.

Medical Loss Ratio Requirement of the ACA

To facilitate an understanding of the impact of the recovery of RC amounts on the financial reporting of affected insurers, a basic understanding of the Medical Loss Ratio (MLR) is required. The MLR was designed as part of the ACA to facilitate transparency on how insurers were spending premium dollars and ensured that no more than 20% of premium could be used to cover administrative costs and profits (15% in the large group market). For companies that recognized an MLR below 80% in the individual and small group markets (generally between 1–50 employees), the insurer would be required to pay rebates to its enrollees equal to the amount necessary to bring its MLR back up to the minimum MLR standard. In the large group market (generally employer groups with greater than 50 employees), rebates would be due if the insurer's MLR fell below 85%.

The MLR can generally be understood by the following formula:

$$\frac{\text{Incurred Claims + Quality Improvement Activities}^{6}}{\text{Earned Premium – Taxes and Regulatory Fees}}$$

In addition, a credibility adjustment is added to reflect the challenges of the law of large numbers and other challenges in accurately projecting health care utilization and costs, such as is encountered in a population with a high prevalence of policies with large deductibles.

6 Quality Improvement Activities (QIA) - expenses that are classified as administrative/cost containment expenses, that do not meet the definition of a clinical claim, but that do improve health care quality.

So how is this related to the RC recovery payments from the Federal government many insurers have recently seen?

According to the MLR filing instructions issued by HHS, RC payments (receivables) and charges (payables) must be taken into account in the calculation of the MLR during the years of the RC program (2014 through 2016). Companies that were required to pay into the program (i.e. allowable costs lower than 97% of the target amounts) were required to add the charges to their reported incurred claims in calculating their MLR. This makes sense, as the insurer increased its costs by paying into the RC program – subsidizing losses/claims incurred by other participants in the QHP marketplace. For companies who were determined to be owed benefits from the program in any of the three years, HHS required the payments received to reduce their incurred claims included in the MLR calculation. Again, this makes sense, as the insurer received subsidized payments to offset higher losses on the sale of QHPs, therefore incurred claims should be reduced. As a result of recording the payments, the MLR would be reduced, and in theory, potentially lead to an increase in rebates being due to enrollees.

However, there is a caveat. If companies did not receive all the payments/benefits they were due under the program, it would not be equitable to require them to reduce incurred claims for amounts not collected. HHS dealt with this directly, issuing guidance effective beginning for the 2015 MLR filing, instructing insurers not to include unpaid RC payment amounts (receivables) from MLR calculations involving the 2014, 2015 and 2016 experience. As a result, a company with unpaid receivables would report a higher MLR based on this guidance, than if it had included the RC payments not yet paid as a deduction of its reported incurred claims.

The other important component of the MLR calculation is that the ratio is based on a three-year aggregate calculation. As a result, the MLR calculation is essentially an average of the MLRs from the current reporting year, and the two prior years. So for example, the 2018 MLR filing, which was required to be submitted by July 31, 2019, included the aggregate adjusted policy experience from the 2016, 2017 and 2018 reporting years. In terms of the RC program, any amount related to the 2016 program year could possibly impact the 2018 MLR calculation, no differently than the any other component of policy experience, including premium, claims, life-years, etc.

Treatment of Risk Corridors Program in the Medical Loss Ratio Calculation

On December 30, 2020, HHS issued final guidance[7] on how to account for the recovery of unpaid RC payments from the Federal government in the calculation of MLRs. The HHS guidance requires insurers to refile their MLR forms for years 2015 through 2018, but only if inclusion of the RC recovery amounts results in a higher rebate liability to its enrollees than the liability in each respective year it initially filed. As previously noted, because the MLR is a three-year aggregate calculation, accounting for RC benefits/payments and charges/assessments impacted the MLR calculation as well as payment of rebates to enrollees for the MLR filings for years 2015 through 2018. Because the accounting for unpaid RC amounts may have impacted the 2015, 2016, 2017 and 2018 MLR calculations, any RC amounts recovered must be used to recalculate the corresponding year MLRs and rebate amounts due to enrollees as if the amounts were actually collected when originally due. Remember, as filed, the 2015 through 2018 MLR filings only included the RC payments actually received (approximately 16.8% of 2014 benefits, and no payments from the 2015 and 2016 benefit years).

If additional rebates are due in any state or market, after inclusion of the recently recovered amounts for any MLR reporting year 2015 through 2018, companies must pay such rebates to enrollees for each respective year. Refiled MLRs for companies whose rebate obligations increased as a result of inclusion of RC recoveries must be submitted to HHS within 150 days from the receipt of recovery of the RC payment amounts, or publication of HHS' Guidance mentioned above (12/30/20), whichever is later.

HHS also provided specific guidance for situations in which an insurer may have sold its rights to receive all or a portion of recovered RC payments to a third party. Insurers under this scenario must include the full amount of recovered RC payments in the recalculation of its MLRs for the affected years, rather than limiting the amounts only to the cash settlement received from the third party. HHS goes on to provide guidance on reporting requirements for insurers acquired by another company, and provides sample language to be used in notifying enrollees of additional rebates due as a result of the RC recoveries.

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7 https://www.cms.gov/files/document/mlr-guidance-rc-recoveries-and-mlr-final.pdf

State Insurance Department Interest

Financial analysts at state insurance departments and other regulators have shown significant interest in the recovery of these RC amounts by their domestic insurers. In many cases, companies have recovered, or will be recovering, tens of millions of dollars in RC payments computed to be due from the Federal government. A handful of large companies with significant market share of QHP business were each due RC payments from the program equal to hundreds of millions of dollars. Many insurers recovered RC payments through legal action during the latter part of 2020. More are expected to recover amounts due in the early parts of 2021. For those that recovered amounts in 2020, disclosure of the recovery amounts, as well as the initial amounts previously written off, should be included in the notes to the 2020 Annual Statement, most likely in Note 24E – Risk Sharing Provisions of the ACA.

Understanding the net impact of these newly found windfalls on Risk Based Capital ratios, dividend calculations and generally understanding how insurers will use these funds seems to be the primary interest of the states. Some states have even factored the anticipated impact of the RC recoveries into their annual financial analysis functions, including projecting the amounts of additional rebates that may be due to the enrollees of its domestic insurers. Some estimates predict that additional MLR rebates could reach three-hundred million dollars being paid by insurers to enrollees as a result of the RC recoveries, collectively for all states and years.

About the Author

Craig Moore, **CFE,** has more than 28 years of experience in general auditing and insurance company examination services. He is the Director of Medical Loss Ratio (MLR) Examination Services for Examination Resources, and has supervised approximately 100 MLR examinations on behalf of the Department of Health and Human Services (HHS) and various state insurance departments. He also served as the Examiner-In-Charge (EIC), or in an overall supervisory role, on dozens of nationally significant risk-focused financial examinations throughout his career for various state insurance departments. Craig has taken a lead role in staff development and has presented various training topics to state insurance departments and SOFE, including many topics related to MLR, the Affordable Care Act and the risk focused examination approach.

Property Insurance: The Intersection of Reinsurance, Catastrophe Modeling and Exposure Management

By Alan Kaliski, FCAS, MAAA
Eide Bailly LLP

As regulators, financial examiners and analysts perform risk assessments of insurance organizations with significant property insurance business, it is important to understand the relationships between reinsurance, catastrophe modeling and exposure management. The objectives of the reinsurance program should be clear and well-defined, catastrophe modeling should support the terms and conditions of the program, with exposure management providing the mechanism for management monitoring.

The effectiveness of an insurer's overall risk management program often boils down to how well it structures its reinsurance program around its risk appetite, quantified with robust catastrophe modeling and monitored with rigorous exposure management.

The purpose of this paper is to assist regulatory examiners and analysts in their risk assessments of property insurance, by illustrating the intersection of reinsurance, catastrophe modeling and exposure management. The paper also discusses practical considerations when reviewing a company's reinsurance program as part of Risk-Focused Financial Examinations.

Reinsurance Program Objectives

An insurer's goal in its reinsurance program may be any one or a combination of the following:

- Increase capacity to write more business or meet the specific needs of larger accounts
- Mitigate earnings volatility
- Provide surplus relief to improve financial leverage

Different reinsurance structures are designed to satisfy these objectives (e.g., quota-share treaties, excess-of-loss treaties, property catastrophe treaties, and surplus share treaties, to name a few).

Financial examiners and analysts should be comfortable that management has a good understanding of their reinsurance program objectives and can articulate this clearly. Management should be able to prioritize its objectives so that the reinsurance program can be structured effectively and efficiently, without gaps or unnecessary overlaps.

For example, a company that has a functional operational model and acceptable performance metrics, but is surplus-challenged, may find that a simple quota share arrangement could "free up" capital by temporarily ceding off a portion of the written premium.

Another example could involve a company with surplus to write property risks up to a certain amount---say $5 million. However, the insurer has a business model, distribution sources and underwriting expertise that could support much larger accounts---say up to $50 million. In this case, an excess of loss treaty could support the company expanding its strategic objectives by writing larger accounts.

How Much Risk Should Be Retained?

The question of how much risk should be retained is fundamental to the risk management assessment. As an example, for a traditional excess-of-loss treaty, a primary insurer's risk management strategy is built on its retention and reinsurance coverage limit. Let's assume the insurer has capital and surplus of $100 million, written premium of $150 million, and a target annual profit of $10 million (i.e., 10 percent of capital and surplus). Management needs to then consider how much of a net loss it is willing to absorb from one large claim (or one large catastrophe event). The amount can be a percentage of surplus, a percentage of earnings, number of combined ratio points, or a combination of these metrics.

In this case, management may decide the insurer can reasonably absorb a large individual claim of up to 2 percent of surplus ($2 million per claim) or 2 points of combined ratio ($3 million per claim) or 15 percent of earnings ($1.5 million per claim).

From these metrics, management may settle on a retention of $2 million per claim. While this is an oversimplification, the point is that management needs to determine the metric (or combination of metrics) and actual dollar amounts of risk the insurer is willing to accept.

The reinsurance coverage limit might revolve around the insurance policy limits the company offers. For casualty coverages, suppose the company offers policy limits as high as $10 million per claim, with most policies equal to or less than $5 million per claim. Then, assuming the retention defines the company's risk tolerance for any individual claim, the reinsurance coverage limit could be the amount in excess of the retention.

Based on this example, it might mean an excess-of-loss reinsurance treaty of $8 million excess of $2 million per claim. This could also be accomplished using an excess-of-loss treaty of $3 million excess of $2 million per claim, with facultative reinsurance purchased on an as-needed basis for policies with limits above $5 million.

Here are some additional considerations for structuring reinsurance:

- **Adopt a formal process**. Although the level of analysis and sophistication may vary, risk tolerance ultimately is a management judgement; nonetheless, insurers should have a disciplined process to inform these decisions with reasonable frequency.

- **Conduct benchmarking**. Benchmarks can be obtained and examined through a variety of sources. Reinsurance intermediaries may be helpful. Also, publications, such as A.M. Best Reports, provide information on reinsurance structures of peer companies (such as personal lines, standard commercial lines, workers' compensation, excess and surplus lines carriers, etc.).

- **Evaluate quota-share arrangements**. The use of quota-share reinsurance enables primary carriers to partner with – and potentially benefit from – the underwriting expertise of a reinsurer, especially on new lines of business where the reinsurer may have a certain underwriting expertise.

- **Aim for diversification**. For a large reinsurance program, it is beneficial for there to be a panel of reinsurers diversified around those with high ratings or fully collateralized (by letters of credit, trust funds or other funds held arrangements). It is preferable not to have an inordinate portion of the reinsurance program with a single reinsurer, even a highly rated one.

- **Consider reinsurance market conditions**. When pricing is soft, as has generally been the case in recent years, primary insurers might opt to purchase reinsurance below the levels of their otherwise determined risk appetite. For example, if the reinsurance cost for the $1 million to $2 million layer is less than the company's estimated cost of retaining these losses, then it may be cost effective to transfer this risk to the reinsurance market.

- **Recognize the necessity versus cost of the reinsurance program evaluations**. Suppose an insurer needs to obtain a certain amount of reinsurance from a risk management standpoint, but the cost is prohibitive; this could suggest there may be issues with its business model. For instance, it may have too much risk concentration – in a specific coverage line, geography or a class of business or it may be too small from the standpoint of scale.

- **Review insurer's surplus position versus its reinsurance needs**. Insurers that have "excess surplus" (i.e., more surplus than is otherwise needed to support the business model) might notionally earmark the excess to replace some reinsurance coverage. "Excess surplus" may be defined as that in excess of a specified statutory risk-based capital (RBC) ratio or an A.M. Best BCAR or some other qualitative measure.

Using the previous example of an insurer's surplus position, let's assume the company is considering an excess-of-loss reinsurance treaty for $3 million excess of $2 million per claim. Let's say the company has "excess surplus" of as much as $5 million and this excess margin is more than sufficient to fund expected losses in the $2 million to $2.5 million layer. In this scenario, the insurer might choose an excess-of-loss reinsurance treaty of $2.5 million excess of $2.5 million (as opposed to $3 million excess of $2 million), thereby reducing its reinsurance costs by self-funding the $2 million to $2.5 million layer with "excess surplus."

Addressing Catastrophe Risk

A critical element of assessment for insurance companies writing property business involves addressing catastrophe risk. The process begins with understanding the insurer's risk appetite and process around exposure management.

The effective use of catastrophe modeling enables insurers to quantify their risk profile, determine their risk appetite and ultimately structure an appropriate property catastrophe reinsurance program.

Working with their reinsurance broker/intermediary or an independent modeling firm, the insurer provides detailed, policy-level exposure data on its property business (i.e., zip code, street address, construction type, exposed values, etc.).

The data are run through various catastrophe models to establish a risk profile. While not perfect, the output provides benchmarks and insight for developing a property catastrophe reinsurance program.

Consider this hypothetical example:

A probable maximum loss (PML) is shown for various time-frames (such as a 100-year, 250-year, 1,000- year event, etc.). PMLs are derived from the models by overlaying the company's specific risk profile against the model assumptions with respect to weather-related or other natural catastrophes. The 100- year PML represents the company's expected gross loss (before reinsurance) from an event that might occur once every 100 years (or with a 1 percent probability).

Assume the PML summary for our hypothetical company with surplus of $100 million is as follows:

Time Horizon	PML Amount
50 Year	$25 million
100 Year	$75 million
250 Year	$200 million

Next, management selects the PML it wants its catastrophe reinsurance program to protect against and the net loss it is comfortable retaining from a large catastrophe event. Suppose management is comfortable retaining a net loss of up to $5 million from any one large catastrophe event (i.e., 5% of its surplus). Further, assume that at the top end, management decides to protect against a 100-year PML event.

Thus, the company would seek to secure a catastrophe reinsurance treaty for $70 million excess of $5 million per event. The tower of this reinsurance program, $75 million, matches the 100-year PML amount.

Some points to consider:

- **Be aware of standard benchmarks**. Regarding PML levels to protect against, common industry benchmarks are generally in the 100-year to 250-year level.
- **Understand modeling capabilities and limitations**. Catastrophe modeling tends to be far more granular than discussed in this example. Notably, PMLs are typically shown by peril (i.e., wind/hail, winter storms, tornadoes, earthquake, etc.) and geographic region, as well as other nuances.
- **Articulation of risk appetite**. An insurer's risk appetite/tolerance statement might be expressed as: The company is willing to lose "X percent" of its surplus from a "Y-year" PML event.
- **Variations of coverages in the reinsurance layers**. Catastrophe reinsurance programs typically are far more complex than the examples provided in this article; there typically are multiple coverage layers in a reinsurance program, with the primary insurer participating in certain layers.

Keys to Effective Exposure Management

Once an insurer determines its risk appetite, the next step involves management monitoring the portfolio to ensure the company's actual business stays on track. Following are some keys to effective monitoring that the regulatory examiner or analyst might look for:

- **Obtain robust data**. Effective management starts with detailed policy data, which must be granular and readily accessible to produce management monitoring reports.

- **Generate regular reports** (monthly or more frequently). Show actual total insured values (TIVs) by granular geographic areas (such as zip code or specified distance from the shore, etc.). Management should monitor that actual TIVs in sensitive areas are in line with the assumptions underlying the catastrophe modeling and reinsurance program. Any areas growing beyond the risk appetite levels should then be identified, researched and acted upon.

- **Scrutinize TIV capacity allocation**. Some insurers allocate TIV capacity to individual agents, consistent with the general risk appetite determinations, and then monitor actual TIVs by agent against their respective allocated capacities. Others do not explicitly allocate TIV capacities to individual agents, but rather monitor the TIVs and deal with issues as they arise. The key is to be diligent in monitoring and acting, as needed.

- **Define responsibilities**. There should be established clear accountabilities for maintaining the data and producing the monitoring reports, as well as reviewing the reports and reporting to underwriting and/or senior management. It should be clear as to who is responsible for recommending or initiating actions on the red flags. Management must be committed to the process from a risk management standpoint and willing to make difficult business decisions when necessary.

SOFE Editor's Note: This article is an adaptation of an article written by Mr. Kaliski while he was a Senior Advisor with Hannover Stone Partners, and which was originally published by Carrier Management Magazine in the July/August 2018 edition. For the original version of the article, please visit https://www.carriermanagement.com/features/2018/07/12/181629.htm. Reprinted with permission.

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PwC NAIC Newsletter

January 2021

The National Association of Insurance Commissioners was active in the last quarter of 2020, continuing to address the many regulatory issues arising from the pandemic and other high priority projects. This newsletter contains information on activities that occurred in meetings since September 2020, with a focus on the virtual Fall National Meeting and subsequent conference calls through January 22. For questions or comments on this Newsletter, please feel free to contact us at the address given on the last page.

In this issue

Executive Summary

- The NAIC's Center for Insurance Policy and Research held a special session on pandemic business interruption insurance and the need for the Federal government to provide a backstop for industry for this type of coverage.
- The Group Capital Calculation Working Group completed its work on the GCC template, instructions and confidentiality provisions and adopted the final package with a proposed year-end 2022 implementation.
- The Insolvency and Technology Task Force adopted revisions to the Unfair Trade Practices Act to provide guidance on permitted rebates to customers.
- The Statutory Accounting Principles Working Group adopted new guidance on filing credit tenant loans with the SVO; the regulators also exposed for comment a proposal to extend the effective date of two Interpretations (INT 20-03 and INT 20-07) that provide COVID-related accounting relief. At the strong recommendation of industry, the working group set aside its first draft of an issue paper that would comprehensively revise SSAP 43R on loan-backed securities and formed a subgroup to draft a "principles-based definition of a Schedule D-1 bond."
- The Life RBC Working Group adopted a revision to the 2020 NOI calculation for commercial mortgage RBC and reaffirmed its commitment to adopt factors for the 20 bond designation categories for 2021 RBC filings. The Catastrophe Risk Subgroup approved a project to develop a risk charge for wildfire peril. The Health RBC Working Group adopted guidance for Exhibit 3A of the annual statement to improve the data quality of health care receivables.
- The VOS Task Force adopted guidance for year-end 2020 for financially modeled "zero loss" securities and continued their discussion of a long-term solution for nonconforming credit tenant loans.
- The Blanks Working Group exposed for comment a new Part 3 to Schedule Y to require additional disclosure of related parties and three proposals to gather additional health care data from Life, P/C and Health entities.
- The Financial Stability Task Force adopted revisions to the Holding Company Model Act to provide the legislative authority for the filing of the NAIC Liquidity Stress Test Framework by life and annuities companies meeting the defined scope criteria.
- The Life Actuarial Task Force adopted a revised minimum nonforfeiture rate of 0.15%, which amends the NAIC model Standard Nonforfeiture Law for Individual Deferred Annuities.

PwC NAIC Newsletter

January 2021

Executive Committee and Plenary

The NAIC elected the following officers for 2021: President, Commissioner David Altmaier (FL), Director Dean Cameron (ID), President-Elect, Director Chlora Lindley-Myers (MO), Vice-President and Andrew Mais (CT) as Secretary-Treasurer.

In addition to Executive Committee and Plenary adoptions discussed in various topics below, the Commissioners approved the following at the Fall National Meeting:

- Amendments to the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520), and
- Adoption of the Workers' Compensation Policy and the Changing Workforce whitepaper

Special Committee on Race and Insurance

The recently formed Special Committee on Race and Insurance, which has been organized into five workstreams, heard updates on these topics as discussed below. Currently, the workstreams are each in the process of researching identified issues and seeking feedback from interested parties to develop focused action items.

Workstreams 1 and 2, the diversity and inclusion initiatives within 1) the insurance industry and insurance products and 2) within the NAIC and state regulatory community, have held multiple sessions. The groups are currently working on focused engagement with stakeholders and developing best practices for D&I initiatives. These workstreams are aiming to provide recommendations in the coming months.

At the Fall National Meeting, the committee heard updates from workstreams 3/4/5 on their progress within their respective line of businesses (P/C products, life insurance and annuities and health insurance) to prioritize major categories of issues (including affordability, access and discrimination) and development of working plans for those sub-issues. These groups are aiming to provide more substantive recommendations in the coming months, with a targeted focus on what can be done as opposed to simply acknowledging issues.

Pandemic business interruption

As a special session during the Fall National Meeting, representatives from the Center for Insurance Policy and Research (CIPR) presented an overview of the current and potential future availability of business interruption pandemic insurance. Insurers generally agree that the pandemic exposed a protection gap in the industry regarding this coverage. The session covered key open items to move towards closing this gap: namely, the role of government programs to support industry and allow it to appropriately bear the risk without being overburdened.

The current prevailing industry view holds that without government intervention, pandemic business interruption risk is uninsurable due to the severity and systemic risk associated. However, in the CIPR's view, with participation of both the Federal government and industry, this risk can be insured and covered. The method by which this happens, including the specific federal programs, is up for debate. The special session covered several potential solutions, including the following:

Proposal from the American Property and Casualty Insurance Association and National Association of Mutual Insurance Companies for a Business Community Protection Program (BCPP) - This proposal would establish a voluntary federal program within the Treasury Department that allows for the purchase of revenue replacement assistance for business interruption caused by a viral pandemic or other epidemic infectious disease that have been federally declared as public health emergencies. The proposal also establishes a voluntary federal excess coverage program with a federal backstop for losses beyond what is covered by the BCPP's revenue replacement assistance and provides for the design of financial protection products to address event cancellations resulting from pandemic emergencies.

Proposal from the Business Continuity Coalition (BCC) Terrorism Risk Insurance Act Style Program
The BCC is a recently organized broad-spectrum group representing interests across numerous sectors including manufacturing, finance, real estate, and housing amongst others. Members include ViacomCBS, Disney, Marriott, Sony, and numerous industry groups from a wide range of backgrounds. The BCC proposed a TRIA-style availability and backstop Federal program for all impacted P&C

lines. The program would provide for a 95% quota share federal support program without an insurance deductible. In addition, the program would provide for federal financing, via a Federal Reserve liquidity facility.

The CIPR noted that industry groups and insurers are continuing to work on various proposals to address this on-going and future risk. The impact of the Biden administration and its willingness to provide federal assistance will be a key inflection point in the push to make pandemic risk insurable.

Group capital calculation

During its Executive Committee and Plenary session on December 8, the Commissioners adopted the final version of group capital calculation (GCC) template and instructions and proposed revisions to the Insurance Holding Company System Act (#440) and Regulation (#450) to implement the filing of the GCC with the lead state commissioner. This milestone completes a project begun in 2015.

Together these adoptions establish a filing requirement for insurance groups for the purposes of evaluating solvency at the group level, since current insurance capital requirements are focused exclusively at the insurance entity level. State legislatures and insurance departments can now begin to adopt the holding company system revisions; the goal of the NAIC is to have the GCC fully in place by year-end 2022.

The GCC calculation does not have specific regulatory actions but will instead be another "tool in the regulatory toolkit" to monitor overall solvency. An NAIC drafting group composed of regulators and industry will begin work in early 2021 to develop guidance for the Financial Analysis Handbook, which will assist insurance departments in the review of the GCC results submitted by insurers.

The GCC calculation will leverage NAIC RBC requirements at the legal entity level as well as existing requirements from banks and other jurisdictions. Incremental components are requirements for entities in the insurance group that previously have not had capital requirements and consolidation of the required and available capital requirements across the insurance group.

Although not included in the GCC ratio, the filed template will include a Sensitivity Analysis to provide the lead state regulator with the effect of certain "what if" scenarios, as follows:

1) an overall sensitivity analysis to show a ratio at a 300% ACL (versus the 200% ACL used in the "official" ratio),

2) adjustments to capital for state specific permitted or prescribed practices that differ from NAIC requirements,

3) adjustments for captives other than XXX/AXXX captives,

4) an additional capital allowance for certain debt (other than senior debt and hybrid capital instruments), and

5) scaling of foreign capital requirements

All insurance holding company groups in the U.S. will be expected to file an initial GCC with their lead state regulators on a confidential basis. After the initial filing, the lead state commissioner can exempt holding company groups meeting specific criteria, including having group premiums of less than $1 billion. A limited number of insurance holding company systems will be exempt from filing the group capital calculation, primarily those subject to a group capital calculation by either the Federal Reserve Board or a reciprocal jurisdiction.

The GCC working group has scheduled a January 28 public conference call to discuss a "high level analysis of 2019 GCC field test data run against the adopted GCC Template and Instructions and to have initial discussion of potential 2021 GCC data collection."

Note that the GCC Working Group has provided a short "post adoption Q&A" on its webpage addressing technical questions on the GCC template. A detailed narrative summary of the GCC project and related calculation has also been posted to the webpage.

To plan for 2022 adoption, insurance entities should familiarize themselves with the NAIC GCC template and instructions, determine results using current data, socialize with management, and begin preparations to discuss with their lead regulator before the effective date.

Innovation and technology initiatives

Anti-rebating
During the Fall National Meeting, the Innovation and Technology Task Force continued to discuss anti-rebating, which relates to rebates of premium or other consideration associated with the use of smart home devices and telematics to mitigate risk. The task force met and discussed updates to the previously exposed amendments to the NAIC's model Unfair Trade Practices Act (#880) to address anti-rebating and the inconsistent application of various states' unfair trade practices laws. Draft revisions to Section 4H of the model law to clarify permitted rebates were previously exposed for comment. Multiple comment letters were received and incorporated into a final revised model law, which was adopted by the task force at its virtual meeting.

The updated model law includes the following examples of permitted rebates:

- Certain products at reduced or no cost to the policyholder if they provide certain value- added activities including loss or risk mitigation, education related to financial or physical well-being, and reduction of claim costs.

- Meals or charitable donations on behalf of a customer, that do not exceed a reasonable amount. Similarly, non-cash gifts or services are permitted to institutional customers, provided they do not exceed a reasonable amount. While ultimate determination of what is reasonable is set by states, the regulation suggests the less of 5% of current premiums of $250.

- Conducting raffles or drawings, provided there is no financial cost to entrants and does not obligate the purchase or renewal of a policy in exchange for a gift.

Cybersecurity
The task force heard an update on states' progress on adoption of the NAIC Insurance Data Security Model Law (#668). Eleven states have done so, with additional adoptions expected in 2021. In addition, an on-going focus around international cybersecurity was discussed, with dialogue continuing with EU partners on potential cross-border insurance cybersecurity events and risk assessments. No formal plans or agreements have been agreed upon, but discussions continue.

Statutory Accounting Principles Working Group

Significant actions taken by the SAP Working Group since September are summarized below. (Appendix A to this Newsletter summarizes all actions taken by the working group in the fourth quarter of 2020.)

Newly adopted guidance

All statutory accounting Interpretations adopted in 2020 and 2021 are posted to the SAP Working Group's webpage (under the Related Documents tab).

INT 20-10 and SSAP 43R - Accounting for credit tenant loans (#2020-24) – The SAP Working Group continued work on its project to provide explicit guidance on credit tenant loans, which are currently not separately addressed in the APP Manual. In December the working group adopted INT 20-10, Reporting Nonconforming Credit Tenant Loans, which is discussed in detail in the VOS Task Force summary on page 6.

There appears to be regulatory consensus of continued reporting of conforming CTLs on Schedule D-1. During its Fall National Meeting, the working group discussed the 5% residual risk limit that has been in use by the SVO for 25 years for determining whether a CTL qualifies as conforming. The working group directed staff to draft a referral to the SVO and the Capital Markets Bureau requesting comments on whether it is appropriate to increase the existing 5% residual risk threshold.

Significant exposures

INT 20-03 & INT 20-07 extensions – In January 2021, the SAP Working Group exposed for comment a proposal to extend the effective date of COVID-related TDR relief for mortgage loans (INT 20-03) and certain mortgage loan-backed securities (INT 20-07) from December 31, 2020 to the earlier of January 1, 2022 or 60 days after the COVID national emergency is terminated. The regulators are expected to adopt this guidance by the end of January.

SSAP 43R revisions – The SAP Working Group continued slow progress on its project to revise SSAP 43R to address regulatory concerns, especially with securitizations done with equity-like investments that become "transformed" into debt securities. In March of 2020 the working group exposed for comment an issue paper on loan-backed and structured securities. The proposed guidance

provides new definitions of asset-backed securities, which industry has commented would "have the potential for wide-ranging consequences affecting fixed income securities more generally."

The working group held a conference call in October to review comment letters received from interested parties, including the Iowa Insurance Division and a 67-page comment letter from industry interested parties. As a result of significant concerns expressed, the working group agreed to set aside the issue paper for now and have the IID work with interested parties on its "principles-based definition of a bond to be reported on Schedule D, Part 1," which includes the following:

> "Asset backed securities represent debt issued through the securitization of financial assets. There are two defining characteristics that must be present in order for a security to meet the definition of an asset backed security:
>
> - The financial assets collateralizing the debt issuance are expected to be the primary source of cash flows for repayment of the debt;
> - The securitization of the financial assets collateralizing the debt issuance redistributes the credit risk of the underlying financial assets, such that the creditor is in a different position than if the underlying collateral were held directly.
>
> Asset backed securities are typically issued from a trust or special purpose vehicle; however, the presence or lack of a trust or special purpose vehicle is not a definitive criterion for determining that a security meets the definition of an asset backed security."

Interested parties provided preliminary observations in their comment letter submitted December 11, which noted that a small group of industry investment experts will be meeting weekly with the IID to continue work on the principles-based definition. The letter noted that "progress is being made with focus on the following key areas:"

- Defining the role of loans (other than mortgage loans and collateral loans) that may be interpreted by some insurers to not meet the technical definition of a security, but are in substance a bond,
- Principles defining and distinctions between an Issuer Credit Obligation and Asset Backed Security,
- Understanding the implications for securities that don't meet the principles-based definition,
- Residual or refinancing risk, and subordination or overcollateralization and their roles in the definition,
- Developing principles to exclude securities that have the same economics as owning equity investments directly, and
- Consideration of potential new categories of bonds within the existing Schedule D parameters or a new Schedule D reporting schedule.

Derivatives Hedging Fixed Indexed Products (#2020-36) — At the request of industry, the working group is soliciting comments from regulators and insurers on a project to provide guidance for derivatives hedging the growth in interest of fixed indexed products, such as fixed indexed annuities (FIA) and indexed universal life (IUL) reported in the general account. The project will likely result in a new SSAP.

Per the exposure document, the project is considered necessary because of a "mismatch of accounting provisions when derivatives are used to hedge the growth in interest credited to reserves (liability). Although the derivative may be an effective hedge to the interest credited for the performance of a referenced index, under SSAP 86, the derivative does not qualify for hedge accounting."

The two proposed options exposed for comment are as follows:

1. Report the derivative at amortized cost, with fair value changes in the hedging derivative (at settlement) recognized in net investment income (or realized gains and losses) to offset the recognized change in the FIA/IUL reserve.
2. Report the derivative at fair value, with the change in fair value bifurcated for reporting based on whether the change is an effective hedge to the interest crediting rate change in the hedged FIA/IUL reserve.

Comments on the exposed document are due February 26.

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 September 2020.)

Investment RBC
Bond factors - With input from the Life RBC Working Group, the ACLI has engaged a consultant, Moody's Analytics, to review the AAA's bond factor model, which the ACLI and other interested parties believe produces RBC bond factors that are too conservative. A final report is expected in early February.

Real estate factors - The Life RBC Working Group resumed its review of the proposed real estate factors for the Life RBC formula, which had been inactive since 2017 while the Investment RBC Working Group worked to complete the bond factor project. The ACLI's proposal recommends a 10% factor for both Schedule A and Schedule BA real estate; the current charges are 15% for Schedule A and 23% for Schedule BA indirect equity investments in real estate.

During its January 21 meeting, the Life RBC Working Group voted to expose for comment the ACLI-proposed structural changes to the Real Estate Worksheet pages until March 8. The working group will schedule future calls to discuss the proposal from the ACLI to reduce the real estate factor charge to 10%.

The chair of LRBC Working Group noted that the Financial Condition Committee has included a charge for the working group to complete its work to implement the new bond and real estate factors for 2021 RBC. (All insurance entities will be filing RBC reports for 2020 detailing their total investment in bonds using the new 20 NAIC bond designation categories.)

Life RBC
2020 NOI calculation – Industry had requested temporary changes to the commercial mortgage RBC net operating income calculation as a result of the effects of COVID on mortgage loan income. During its October meeting, the working group adopted the revision below, which will be first effective for the 2021 calculation:

> Where RBC reporting instructions specify 2020 NOI as an input into the calculation of Rolling Average NOI for 2021, 2022, and 2023 RBC reporting, use the greater of 1) 2020 NOI or 2) 85% of 2019 NOI.

The working group also adopted a proposal that the actual 2020 NOI should be disclosed in the RBC filings; NAIC staff is drafting these instructional changes for discussion at a subsequent meeting.

Guaranty Association Assessment Risk
The Life RBC Working Group reviewed the 2017 adopted amendments to the Life and Health Insurance Guaranty Association Model Act (#520) and concluded that no changes to Life RBC (C-4a) are necessary as a result of the revisions. The risk charge is based on the maximum amount of assessments in any one year for a life company, which is not affected by the changes to Model #520.

P/C RBC
Catastrophe risk – After numerous discussions and presentations to the subgroup over several years, the Catastrophe Risk Subgroup approved a project to consider adding wildfire peril to the catastrophe risk (Rcat) charge.

The NAIC's Center for Insurance Policy and Research has volunteered to assist the subgroup in the following projects: "1) educating and validating the wildfire models and methodology; 2) engaging with catastrophe modeling vendors and insurers that have internally developed wildfire models to understand individual models; 3) advising on the design of the Rcat charge; and 4) drafting review questions and the process to permit the use of wildfire models for Rcat purposes."

Health RBC
Health Annual Statement Test – The Health RBC Working Group exposed for comment in 2019 a proposal to revise the annual statement "health test," which would require entities who write predominantly health business and file on the life or P/C blank to begin filing on the Health blank. This summer the working group decided to put this proposal on "pause" to pursue other options, such as new schedules for the Life and P/C blanks, due to the significant work involved in converting to the Health annual statements.

At the December Blanks Working Group meeting, the regulators exposed for comment three proposals which would gather additional health data, which will be reviewed by the Health Test Ad Hoc Group. See the Blanks Working Group summary for discussion of the three proposals.

Health care receivable factors – The Health RBC Working Group has been studying the need to revise the RBC charges for all heath care receivables. The regulators have concluded that data quality needs to be improved before revised factors can be considered. In October, the working group adopted "Guidance on reporting Exhibit 3A collection and offset amounts," and the Blanks Working Group has posted the guidance on its webpage as unofficial guidance for 2020 reporting. Minor changes to this guidance are being proposed for 2021, which is expected to be exposed for comment by the Blanks Working Group in 2021. The information gathered 2020 through 2022 will be used to develop the health care receivable RBC factors.

Health RBC bond factors – The Health RBC Working Group continued its discussion of the proposal to include an investment income adjustment factor in the underwriting risk H2 factors for XR012. The working group asked the American Academy of Actuaries to model factors for the most significant lines of business: comprehensive medical, Medicare supplement, dental and vision, and stand-alone Medicare Part D coverage. The working group is asking for a quick turnaround on this analysis, as they hope to include the factors in the 2021 RBC formula.

In parallel, the working group is also evaluating variables that will ultimately drive the choice of investment income return (e.g. duration/time horizon and current interest rate vs average long-term rate), which are the most significant variables in the investment income adjustment factor.

Valuation of Securities Task Force

The task force had significant activity on the following projects.

P&P Manual amendment adoptions

Financially modeled "zero loss" securities - The task force had previously adopted guidance that RMBS and CMBS tranches that have zero expected loss under all modelling scenarios should be mapped to the highest NAIC designation category of 1.A. However, a AAA rating would also be required. Based on comments from the industry, the task force in December removed the AAA rating requirement and updated the instructions to reflect that zero loss securities be mapped to 1D category regardless of the insurer's book/adjusted carrying value. This mapping is temporary, and the task force is moving forward with a project to provide 20 new modeled prices for RMBS/CMBS in the future.

Nonconforming credit tenant loans – In connection with an issue exhaustively discussed by both the VOS Task Force and SAPWG, the regulators concluded that specific guidance is necessary for year-end 2020. To that end, the SAP Working Group adopted an interpretation (INT 20-10) that provides a limited-time exception to the instructions in the SVO P&P Manual for nonconforming CTL transactions (leased-backed securities that do not meet the definition of a CTL or ground finance lease, and although rated, are not to be eligible for filing exempt). The interpretation also clarifies that there should be no presumption of approval of the use of the CRP ratings for NAIC designations and that all nonconforming CTLs acquired prior to January 1, 2020 are to be filed with the SVO for assessment.

The limited-time exception is as follows:

- If a nonconforming CTLs is filed by February 15, 2021 for future receipt of an SVO-assigned NAIC designation, the CTL may continue to be reported on Schedule D; however, it must be disclosed as a permitted practice in the financial statement footnotes until a designation is finally received from the SVO.
- If not filed by February 15, the nonconforming CTL is required to be reported on Schedule BA without a CRP designation.
- Nonconforming CTLs that have previously been reported on another schedule (e.g. Schedule B or Schedule BA) can remain on that schedule with no requirement to pursue an SVO designation. This exception to report on Schedule D expires October 2021 and is intended to avoid reporting schedule changes while SAPWG continues its broader SSAP 43 project.

Initial and subsequent annual filings - Due to several instances where insurers have not provided all the information requested by the SVO to complete its review of security filings, the task force adopted revised guidance in the P&P manual to reinforce the expectation that insurers will provide all the necessary information requested on a timely basis for initial as well as subsequent filings to maintain a previous designation. The amendment also included the types of information that the SVO may require including interim financial statements and internal credit analysis memos.

Use and regulation of derivatives in ETFs - The task force adopted an SVO report that discusses the use

and regulation of derivatives in exchange traded funds and the SEC's proposed Rule 18f-4 which includes a derivative risk management program requirement and a value-at-risk (VaR) based limit on leverage. The SVO does not believe the rule will change how it analyzes derivatives in ETFs as the focus of that analysis is whether the cash flows are fixed income-like, but the rule may provide more information on ETFs' use of derivatives.

P&P Manual amendment exposures

Private rating letter rationale reports - In May, the task force received and exposed an SVO issue paper on concerns about bespoke securities and reliance on CRP ratings. These securities are not broadly syndicated and are usually privately rated by only one credit rating provider. There were several recommendations in the issue paper including monitoring and evaluating rating agency activities, and one of the first steps the SVO is taking is increasing their "scrutiny" over private letter securities.

During its November meeting, the task force proposed an amendment to the P&P manual, effective January 1, 2022, to require that "private letter rationale reports" be filed with the SVO in addition to the private letter received either directly or through a CRP rating feed. The reports will be reviewed but "without the SVO's discretion over evaluating the appropriateness of the rating or methodology utilized, at least at this time." The amendment was exposed for comment until February 5, 2021.

Blanks Working Group

The working group adopted during the fourth quarter of 2020 the following significant changes to the 2021 annual statements and instructions (unless otherwise noted). All adopted changes are summarized by the Blanks Working Group on their webpage.

- Remove from the Life annual statement questions 29, 30, 31 and 32 from the Supplemental Exhibits and Schedules Interrogatories since this information will now be provided in the PBR Actuarial Report required by VM-31. (2020-24BWG)

- Add a new column 5 to Schedule T to specifically capture Children's Health Insurance Program (CHIP) premium as it relates to guaranty fund assessments, effective January 1, 2021. (2020-25BWG)

- Revise Schedule DB to implement the new accounting guidance in SSAP 86 for financing premiums, effective January 1, 2021. (2020-26BWG)

- Add a new category line to Schedule E, Part 2 for Qualified Cash Pools to implement the new guidance in SSAP 2R related to such cash pools, effective January 1, 2021. (2020-42BWG)

- Remove the disclosure of the ACA Section 9010 Assessment (as a result of the repeal of the ACA fee) and provide guidance for year-end 2020 reporting. (2020-02BWG)

- Replace the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation and Related Adjustments Exhibit in all blanks with "modernized exhibits." (2020-31BWG)

The Blanks Working Group exposed for comment the following significant proposals, which have a suggested effective date of year-end 2021.

- Add a new Schedule Y, Part 3 to include all entities with ownership greater than 10% of an insurance entity, the ultimate controlling parties of those owners and other entities that the ultimate controlling party controls (2020-37BWG). This proposed new schedule is part of the SAP Working Group's project on disclosures of related parties, including those for which an insurance entity has received a disclaimer of control or affiliation.

- Add a new Health Care Receivables Supplement to the Life annual statement. (2020-32BWG)

- Modify the annual statement line descriptions used in the Underwriting and Investment Exhibits, State Page and Insurance Expense Exhibit in the P/C blank. (2020-33BWG)

- Revise the Accident and Health Policy Experience Exhibit filed by Life, P/C and Health entities and change the due date from April 1 to March 1. (2020-38BWG)

The final three proposals are part of the NAIC's project to make reporting of health care receivables

and other health data more consistent across all entities, to allow more analysis at the nationwide level.

Reinsurance Task Force

At the Fall National Meeting, the task force heard an update on the progress of states' adoption of the 2019 revisions to the Credit for Reinsurance Model Law (#785) and Regulation (#786) to comply with the EU and UK Covered Agreements by September 1, 2022. Sixteen U.S. states have adopted the revisions to the model law, and thirteen jurisdictions have action under consideration. Progress has been slowed by COVID-19 because some states had to stop all legislative activity this spring or curtail sessions.

Principles-based reserving

Valuation Manual amendments
The Life Actuarial Task Force continued to provide new guidance for the implementation of principles-based reserving through issuance of Amendment Proposal Forms. The most notable adoptions and exposures are summarized below.

Adopted guidance

APF 2020-02 clarifies VM-20 Section 2.H and introduces Section 2.I to ensure that in the determination of the minimum reserve under VM-20 companies do not skip mandated steps on grounds of materiality or reliance on approximations. A guidance note provides examples of steps that cannot be omitted (e.g. computation of at least a simplified NPR and inclusion of prescribed margins).

APF 2020-03 clarifies that direct calculation of the net premium reserve is acceptable in lieu of using mean or mid-terminal methods, consistent with language in SSAP 51R.

APF 2020-08 provides an alternative method for mortality aggregation that starts at an intermediate level, rather than a fully top-down or bottom-up approach.

APF 2020-09 modifies the life PBR exemption to 1) remove the requirement for an annual filing of subsequent statements of exemption if the company continues to qualify for the exemption, 2) allow exemptions for companies not meeting required premium thresholds for exemption, but for which new business was generated only from policyholder elections of policy benefits or features from existing policies that are being valued under VM-A and VM-C, and 3) clarify that premiums considered in meeting the threshold for exemption are in force premiums.

Exposed guidance

APF 2019-33 proposes revisions to clarify that group life contracts with individual life certificates meeting certain requirements are included in the requirements of VM-20. LATF discussion and subsequent updates to the APF exposed in summer 2020 remove references to VM-51 which will be considered in a different amendment proposal. Proposed changes would be applicable to policies issued on or after January 1, 2024.

APF 2020-11 proposes changes that would allow the exemption criteria under APF 2020-09 to apply to policies from prior issue years (i.e. 2020 or 2021) if the current VM requirements had been in effect during those issue years. The amendment effectively allows the 2022 exemption criteria to apply to prior issue years without requiring state regulators to grant permitted practices for such use.

Other VM project updates

YRT Reserve Credit Field Test
LATF members continued discussion of the YRT field test results, building on the lengthy discussion at the Summer National Meeting. To facilitate the discussion a group of regulators drafted "Criteria to Assess VM-20 Solutions for Modeling Non-Guaranteed YRT Reinsurance," which lists potential criteria for regulators to consider as they determine a long-term solution for the appropriate YRT reinsurance reserve credit for agreements subject to a principle-based reserve. The three APFs for which results were studied incorporate revisions which address alternative mortality improvement scenarios (2019-40), prudent estimates (2019-41) and prescribed reinsurance premium margins (2019-42). Areas of consideration in selecting the appropriate APF include:

- Level of prescription
- Modeling complexity
- Variation in interpretations leading to variation in results
- Potential for asymmetry between assumed and ceded interpretations
- Defined level of risk sharing
- Mortality improvement beyond the valuation date

- Requirements outside the VM (e.g. alignment with APP Manual)
- Other general business considerations

VM-22 Fixed Annuity PBR
LATF heard updates from the VM-22 Subgroup and the Academy Annuity Reserves Work Group on activities related to fixed annuity PBR. This fall the subgroup held calls to discuss the Academy's proposed framework, culminating in the exposure of the Academy presentation "Preliminary Framework Elements for Fixed Annuity PBR" for a public comment period which ended in December. The exposure addresses the following framework elements:

- Methodology (e.g. scope, aggregation, exclusion tests)
- Assets (e.g. discount rates, reinvestments, economic scenarios)
- Liabilities (e.g. mortality, policyholder behavior, non-guaranteed elements)
- Other considerations (e.g. VM-31 disclosures, experience reporting)

The proposed framework elements are largely consistent with VM-20, VM-21 and VM-22 where applicable.

The subgroup also discussed considerations relative to a standard projection amount (SPA), similar to the SPA in VM-21, and the subgroup voted unanimously to recommend to LATF exploration of a SPA for the fixed annuity PBR framework.

The timeline in the framework continues to indicate implementation as of January 1, 2023; however, a January 1, 2024 effective date may be more realistic considering current progress.

Life Actuarial Task Force

Standard Nonforfeiture Law for Annuities
Following the NAIC's adoption at the Summer National Meeting of a to-be-determined reduction in the minimum nonforfeiture rate in the Standard Nonforfeiture Law for Individual Deferred Annuities (#805), LATF members continued discussions about what the reduced rate should be. The 0% floor previously adopted by LATF in June was flagged by the NAIC for further consideration to promote quicker adoption by legislatures of the revised model regulation. Industry representatives favored a 0% floor, and while most regulators supported a significant reduction from the current 1% level, some regulators preferred to retain the 1% rate. Ultimately LATF adopted a proposed minimum nonforfeiture rate of 0.15%, which was subsequently adopted by the full NAIC at the Fall National Meeting.

IUL Illustration Regulation
At the Fall National Meeting the NAIC's Executive Committee adopted technical amendments to Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49-A) to revise the effective date for policies sold from "on or after November 25, 2020" to "on or after December 14, 2020." The change in effective date was necessitated by the delayed timing of the Fall National Meeting. The NAIC also adopted revisions to AG 49 to allow companies the option to apply the AG-49A guidance to policies issued before the new effective date.

ESG implementation project
In 2020, the NAIC initiated a process to identify economic scenario generator (ESG) vendors to replace the AAA and selected Conning & Company as the ESG vendor. At the Fall National Meeting LATF members heard an update from NAIC staff on the ESG implementation project. Project deliverables include the following:

- Selection of an existing ESG (prior to regulator modifications) capable of producing real-world economic scenarios for use in calculations of life and annuity statutory reserves and capital under NAIC requirements; Conning's GEMS® ESG was selected as the existing ESG,

- A customized ESG to reflect any modifications adopted by state regulators. The final scenarios, referred to as the "Basic Data Set," will be prescribed for statutory reporting,

- Tools for selecting representative scenarios, generating specific VM-20 and VM-21 scenarios and calibration criteria, and

- Robust training materials for end users

A link to the Basic Data Set, documentation and training materials will be provided on the NAIC website and accessible by any end user.

There will be a single ESG field test, expected to include comparisons of reserves and capital produced by the Conning model against those produced by the Academy model. The target implementation date is January 1, 2022. Recent presentations on this project, including the timeline and a recording of the Fall National Meeting session

are available on the LATF website under "Related Documents."

Long-term care issues

Long-Term Care Insurance (EX) Task Force
During the Fall National Meeting the task force heard an update from two of its three subgroups: the LTCI Multistate Rate Review Subgroup and the LTCI Reduced Benefit Options Subgroup. The Financial Solvency Subgroup, which will continue its work on LTC restructuring options and techniques, did not provide an update this fall. The meetings of the subgroups are not currently open to the public but are expected to be opened at some time in 2021.

Multi-state rate review practices – The goal of this workstream is to develop a recommendation for a consistent national approach to multi-state LTCI rate reviews. The workstream members are currently reviewing several rate filings as part of a pilot project and determining what the final work product will be. The subgroup drafted and provided an outline of a framework for the multi-state rate review process to its members for comment and expects to have a draft framework document by the 2021 Spring National Meeting.

Reduced benefits options (RBO) – This subgroup is focused on information gathering on practices for the state regulatory review of reduced benefit options in lieu of premium increases, and consumer notices sent by companies. The subgroup will also evaluate whether reduced benefit options offered to consumers are fair and equitable.

During its November meeting, the LTC Task Force adopted a RBO Principles document intended to provide guidance to state regulators as they evaluate RBO offerings and cover issues including fairness and equity for policyholders, clarity of communications, whether states should encourage or require companies to offer certain RBOs, and product innovation. The task force also adopted an RBO consumer notices principles document that provides guidance on timing of delivery of rate action letters, frequency of notices for rate increases that are phased in, and readability and accessibility.

Financial Stability Task Force

Revisions to Holding Company Model Law
The task force adopted revisions to the Insurance Holding Company System Regulatory Act (#440) to provide state legislative authority to require the filing of the NAIC Liquidity Stress Test Framework with the lead state regulator by companies meeting the defined scope criteria. The changes have been included with holding company revisions adopted by the NAIC related to the group capital calculation, with the plan for states to adopt the revisions as a package.

Liquidity stress testing data collection
The Liquidity Assessment Subgroup was charged in early 2020 with assessing how the insurance sector is navigating market conditions due to the economic impact of the pandemic. Based on data collected for the first and second quarters of 2020 from 23 companies, the subgroup concluded that "most insurers continued to report that their existing liquidity stress testing is more punitive than the current stresses caused by COVID-19, and current stresses were well within risk appetite ranges."

International Insurance Relations Committee

The committee heard an update on projects in process.

FSAP review
The IMF previously published its final results of the 2020 Financial Sector Assessment Program's review of the U.S. financial regulatory system. Strengths of the U.S. state-based system include implementation of PBR and risk-focused surveillance and monitoring invested asset risks. Recommendations include "further development of risk-based supervision, consistency of life insurer liability valuation methods, further regulatory requirements in corporate governance, and enhancing regulatory responses to the increasing risk and severity of natural catastrophes."

During its October meeting, the committee adopted a referral plan of the FSAP's recommendations that the committee believes merit further consideration. Adoption of the referral plan does not mean charging the other respective NAIC groups with a specific project, but that the designated committee or group should consider the recommendation further.

IAIS update

The International Association of Insurance Supervisors completed its annual global monitoring exercises as part of the implementation of the Holistic Framework and issued the 2020 Global Insurance Market Report. The exercise had been refocused on COVID-related information to assist with forming a view of the impact of the coronavirus on the insurance industry and included specific COVID data collection. The report concluded that "the global insurance sector has demonstrated both operational and financial resilience" and "insurers available capital resources generally remained well above requirements." The IAIS will continue to monitor how the insurance sector is affected.

The IAIS is also performing an implementation assessment of the holistic framework which is being done in phases and will inform the Financial Stability Board's review of the effectiveness of the holistic framework in 2022.

The IAIS completed and exposed a draft application paper on the Supervision of Climate-related Risks in the Insurance Sector that the International Insurance Relations Committee is discussing and will provide comments on.

The IAIS also released a draft high-level principles document for assessing comparability of the Aggregation Method (AM) developed by the United States to the Insurance Capital Standard (ICS): Aggregation Method: Draft Level 1 Document.

Restructuring Mechanisms

The Restructuring Mechanisms Working Group has not held a public meeting in 2020 due to the regulatory focus on COVID. In 2021, the working group plans to resume drafting its white paper to 1) address the perceived need for restructuring statutes and alternatives that insurers are currently employing, 2) summarize existing state restructuring statutes, 3) address legal issues resulting from an order of a court or insurance department in one state affecting the policyholders of other states, and 4) consider the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring. The working group hopes to complete this white paper by the 2021 Summer National Meeting.

Climate risk

The Climate Risk and Resilience Task Force (elevated this summer from a working group of the Property/Casualty C Committee to a task force of the Executive Committee) has identified five workstreams integral to its work in 2021, as follows:

- A focus on matters of solvency, including enhancements to regulator solvency tools and exploration of methods to quantify insurer's risk exposure;
- Consideration of enhancements to the climate risk disclosure and alignment with other climate-related financial disclosures (as discussed in detail below);
- A focus on pre-disaster mitigation including collaboration with various stakeholders;
- A focus on innovation including products brought to market to respond to climate risk; and
- Discussion of technology used to understand and identify climate-related risk.

During its Fall National Meeting, the task force discussed the current state of the NAIC Climate Risk Disclosure Survey, including the results for the survey concluded in August 2020, as well as the potential for updates and expansion of the disclosure itself. Six states (CA, CT, MN, NM, NY, and WA) currently administer the survey; however, the survey, which has not been recently updated, is not required for all companies and does not collect quantitative data to make industry wide assessments.

The task force heard a presentation from the AAA of Actuaries noting 70-80% of respondents provide little of their climate risk plans or management of the risk in their responses. The task force also discussed comparisons to other climate disclosures, including the Financial Stability Board's Task Force on Climate Related Financial Disclosures (TCFD) which is required for many companies by the European Commission and was allowed to be submitted by companies in lieu of the NAIC Survey for the first time in 2020.

The task force also heard a presentation from the Center for Insurance Policy and Research, noting the move globally for more countries to accept and require the TCFD level of disclosure. While concerns have been voiced by the industry, namely on the time and resource investment to thoroughly respond to the questions in both the NAIC Survey and the TCFD, a move away from certain narrative heavy portions (to multiple choice answers) could present an opportunity to create comparable data with less burden on respondents. The presentations also noted the Biden administration has already signalled it may push for a mandatory filing of the TCFD for all financial institutions.

The task force plans to research and make a recommendation on potential changes to the NAIC Survey, including use of the TCFD, in 2021.

Mortgage guaranty insurance capital model

The Mortgage Guaranty Insurance Working Group has not held a public meeting in 2020 but has a goal of finalizing revisions to the Mortgage Guaranty Insurance Model Act (#630) by the 2021 Spring National Meeting.

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The 2021 Spring National Meeting of the NAIC is scheduled for April 10-13; more information on the meeting will be available in February. 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 September 2020 on open agenda items. Items exposed for comment are due January 22, except as otherwise noted. For full proposals exposed and other documents, see the SAP Working Group webpage.

Issue/ Reference #	Status	Action Taken/Discussion	Proposed Effective Date
ASU 2016-13 – Credit Losses (#2016-20)	Discussion deferred	In 2019, the SAP Working Group asked NAIC staff to continue monitoring implementation of ASU 2016-13 after the FASB extended the effective date until 2023 for all entities except large SEC filers. The regulators may resume consideration of the statutory other-than-temporary impairment methodology for available-for-sale bonds in late 2021 or 2022.	TBD
SSAP 86 – ASU 2017-12, Derivatives and Hedging (#2017-33)	Discussion deferred	This project will review the overall accounting and reporting changes required by this ASU as potential substantive revisions to SSAP 86. NAIC staff expects discussion to resume in later 2021 or 2022.	TBD
SSAPs 68 & 97 – ASU 2014-17, Pushdown Accounting (#2019-12) and SSAPs 68 & 97 – Goodwill (#2019-14)	Discussion deferred	Discussion of goodwill issues has been deferred due to all the time spent on COVID-related accounting issues in 2020. During its Fall National Meeting, NAIC staff proposed a project to "holistically review the business combinations and goodwill guidance" in SSAP 68. Once that is approved by SAPWG, these agenda items are expected to be addressed in that project.	TBD
SSAP 43R – Revised Issue Paper (#2019-21)	Re-exposed	In November, the working group exposed for comment the Iowa Insurance Division's proposal to establish principle-based concepts for investments to be reported on Schedule D, Part 1. See further discussion above in the SAP Working Group summary.	TBD
SSAP 71 – Commission Financing (#2019-24)	Re-exposed	The intent of these proposed revisions is to prevent insurers from deferring the recognition of commission expense using "financing transactions." After two very lengthy discussions this fall, the working group exposed non-substantive revisions with minor clarifications to SSAP 71. Other revisions distinguish traditional persistency commissions from funding agreements. The regulators directed NAIC staff to draft an issue paper documenting these discussions, noting the guidance is intended to be effective upon adoption for all contracts in force at that date.	First quarter of 2021
SSAP 25 – Related Parties, Disclaimers of Affiliation and Variable Interest Entities (#2019-34)	Re-exposed	The regulators updated their proposal to clarify the identification of and disclosures required for related parties with a disclaimer of control or affiliation. The revisions also include a new disclosure to capture related party information, which will be accomplished through a new schedule, Schedule Y, Part 3. See the summary of the Blanks Working Group's activities above (2020-37BWG).	TBD

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SSAP 62R – Retroactive Reinsurance Exception (#2019-49)	Discussion deferred	The regulators have been asked to address inconsistencies in application of the retroactive reinsurance accounting and reporting guidance, especially with respect to the Schedule P reporting. NAIC staff have begun holding preliminary discussions with members of the Casualty Actuarial and Statistical Task Force. This project could result in revisions to SSAP 62R to "clarify Schedule P expectations."	TBD
SSAP 97 – Investment in SCAs (#2020-17)	Adopted	The adopted edits to Exhibit A, SCA Reporting Process, modify the communication process of completed SCA reviews for both domestic regulators and filers, as well as update minor language within the standard.	January 1, 2021
SSAP 97 – Investments in SCAs (#2020-18)	Adopted	The nonsubstantive revisions remove superseded language around guarantees/commitments between reporting entities and SCAs that could result in negative equity SCA valuations.	November 12, 2020
SSAP 37, Participating in Mortgage Loans (#2020-19)	Adopted	The working group adopted a proposal for non-substantive revisions to clarify that a participant's financial rights in a mortgage participation agreement may include the right to take legal action against the borrower or participate in the determination of legal action, but they do not require that the participant has the right to solely initiate legal action, foreclosure or require the ability to communicate directly with the borrower.	November 12, 2020
SSAP 2R - Cash Equivalent Disclosures (#2020-20)	Adopted	The adopted revisions require the identification of cash equivalents, or substantially similar investments, that are disclosed on the same reporting schedule for more than one consecutive reporting period. The disclosure is satisfied by using reporting code (%) on the investment schedules.	November 12, 2020
SSAP 43R - NAIC Designation Categories for RMBS/CMBS (#2020-21)	Adopted	The adopted revisions reflect the updated NAIC designation category guidance for RMBS and CMBS recently adopted by the VOS Task Force for the SVO P&P Manual. See further discussion in the VOS Task Force summary for guidance related to "zero-loss" securities.	November 12, 2020
SSAP 26R – Perpetual Bonds (#2020-22)	Re-exposed	The originally exposed revisions would have required that all perpetual bonds be reported at fair value as opposed to amortized cost. The re-exposure clarifies language that perpetual bonds with call features should apply the yield-to-worst amortization concept and be reported at amortized cost. Perpetual bonds without call features are to be reported at fair value.	January 1, 2021
SSAP 19 – Amortization of Leasehold Improvements (#2020-23)	Adopted	The adopted revisions update the amortization guidance for leasehold improvements to allow such improvements to have lives that match the associated lease term, which is consistent with U.S. GAAP.	November 12, 2020

Appendix A

SSAP 43R – Accounting for Credit Tenant Loans (#2020-24) and INT 20-10, Non-Conforming Credit-Tenant Loans	Adopted	The SAP Working Group had extensive discussion of the December 31, 2020 reporting of non-conforming credit tenant loans, resulting in the issuance of INT 20-10 and adoption on December 28. See further discussion of this issue in the SAPWG and VOSTF summaries above.	December 31, 2020
SSAPs 5R & 62R - Editorial Updates (#2020-25EP)	Adopted	The adopted editorial revisions delete redundant language in SSAP 5R and add a table of contents for Exhibit A (Implementation Q&A) within SSAP 62R.	November 12, 2020
Issue Paper 99 – Proposals to reject recent GAAP guidance	Adopted	The working group adopted guidance to reject the following GAAP guidance as not applicable to statutory accounting: ASU 2015-10 (Technical Corrections and Improvements), ASU 2019-09 (Financial Services–Insurance: Effective Date), ASU 2020-01 (Financial Instruments, Recognition and Measurement of Financial Assets and Financial Liabilities), and ASU 2020-05 (Effective Dates for Certain Entities).	October 13, 2020
SSAPs 53, 54R & 66 – Policyholder refunds (#2020-30)	Exposed	The regulators requested input from industry on whether additional guidance is necessary related to discretionary policyholder refunds and other premium adjustments for heath and P/C lines of business. Based on feedback, the working group directed NAIC staff to draft a future agenda item to propose additional guidance, including for group health premiums and premium adjustments as the result of newer policy form types, such as those involving data telematics.	TBD
SSAP 32R – Preferred stock (#2020-31)	Adopted	In response to industry feedback, the working group adopted nonsubstantive edits to the already substantively revised SSAP 32R to allow early adoption for year-end 2020.	January 1, 2021, with early adoption permitted
SSAP 26R – Disclosure update (#2020-32)	Exposed	SAPWG exposed for comment non-substantive revisions to expand the called-bond disclosures in SSAP 26R to include bonds terminated through a tender offer.	TBD
SSAP 32R – Preferred stock warrants (#2020-33)	Exposed	The regulators exposed non-substantive revisions to capture publicly traded preferred stock warrants in SSAP 32R (and not in SSAP 86, Derivatives) and specified that warrants shall be reported at fair value.	TBD
SSAP 43R – GSE CRT Program (#2020-34)	Exposed	Proposed revisions to SSAP 43R would incorporate modifications reflecting recent changes to the Freddie Mac Structured Agency Credit Risk (STACR) and Fannie Mae CT. Avenue Securities (CAS) programs, which allow credit risk transfer securities from these programs to remain in scope of SSAP 43R when issued through a REMIC structure.	TBD
SSAP 97 – Audit Opinions (#2020-35)	Exposed	The SAP Working Group is requesting comments on the prevalence of situations in which SSAP 97, par. 8.b.iii. entities (U.S. and foreign non-insurance U.S. GAAP basis SCAs) are not admitted by the parent insurer due to the inability to quantify the departure(s) from U.S. GAAP.	TBD

Appendix A

SSAPs 86 & 108 – Derivatives Hedging Fixed Indexed Products (#2020-36)	Exposed	The working group announced its intent to work with fixed annuity writers to develop accounting and reporting guidance for derivatives hedging the growth in interest for fixed indexed products. See additional discussion in the SAPWG summary.	TBD
SSAP 56 – Separate Accounts (#2020-37)	Exposed	In response to the recent growth of pension risk transfer transactions and registered indexed linked annuity products, the working group is soliciting comments from state insurance regulators and industry regarding the "degree of product identifying details needed to adequately assess the product features and reserve liabilities."	TBD
SSAP 56 – Pension Risk Transfer (#2020-38)	Exposed	Possible modifications to SSAP 56 to address pension risk transfers transactions were exposed for comment, including separate identification of individual PRT transactions, guarantees, and reserve assumptions. A future proposal could include new general interrogatories or new schedules or exhibits.	TBD
Appendix F – Interpretation Policy Statement (#2020-39)	Exposed	The working group exposed revisions to clarify the issuance and adoption process of accounting interpretations (INTs). The revisions would require a two-thirds majority of the full Accounting Practices and Procedures Task Force to "overturn, amend or defer" a decision made by the SAP Working Group, or a simple majority of the Financial Condition Committee. These changes are proposed in response to issues related to the adoption of INT 02-08 on COVID premium refunds.	TBD
Preamble – Prescribed Practices (#2020-40)	Exposed	The SAP Working Group proposed revisions to clarify that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state shall be reflected in the financial statements filed with the NAIC, and these are the financial statements subject to the independent auditor requirements.	TBD
SSAPs 5, 72, & 86 Convertible Instruments (#2020-41)	Exposed	Proposed revisions to reject ASU 2020-06, Convertible Instruments, were exposed for comment. This ASU primarily addresses various convertible debt valuation models along with bifurcating embedded derivative components, which are not concepts supported by statutory accounting.	TBD
Appendix D – Not-for-Profit Entities (#2020-42)	Exposed	The working group has proposed rejection of ASU 2020-07, Presentation and Disclosures by Not-for-Profit Entities as not applicable to statutory accounting.	TBD
COVID-19 Impacts (#INT 20-02, INT 20-04, INT 20-05)	Nullified	The working group considered several accounting interpretations adopted during the on-going pandemic, noting three of the interpretations had expired as of 9/30/2020. The regulators did not extend the deadlines and the interpretations are considered nullified.	October 1, 2020
INT 20-03 and INT 20-07 Guidance Extensions	Exposed	The SAP Working Group exposed for comment proposed revisions to extend the effective date of TDR relief guidance until January 1, 2022. See discussion in the SAPWG summary above.	January 1, 2021

Appendix B

This chart summarizes recent action on other proposals of the RBC Working Groups, i.e. those not discussed on pages 4-5 of this Newsletter. The detail of all proposals adopted for 2020 and 2021 RBC are posted to the Capital Adequacy Task Force's webpage.

RBC Formula	Action taken/discussion	Effective Date/ Proposed Effective Date
All/multiple formulas		
ACA fee sensitivity test deletion (2020-02-CA)	The Capital Adequacy Task Force **adopted** deletion the federal Affordable Care Act (ACA) fee sensitivity test from all three formulas as a result of the repeal of the ACA fee.	2021 RBC Filings
Hybrid securities (2020-10-CA)	The Capital Adequacy Task Force **exposed** for comment a proposal to incorporate hybrid securities into the new bond designation categories. This proposal affects the P/C and Health RBC formulas.	2021 RBC Filings
Health RBC	Action taken/discussion	Effective Date/ Proposed Effective Date
Bond and Miscellaneous Asset Pages (2020-07-H)	The Health RBC Working Group **adopted** revisions the Health formula to separate the bonds and miscellaneous page into two separate pages: XR007 and XR008. This was necessary due to the expansion of the bond designation categories from 6 to 20 under the bond granularity project.	2021 RBC Filings
P/C RBC	Action taken/discussion	Effective Date/ Proposed Effective Date
2020 U.S. and non-U.S. Catastrophe Event Lists	The Catastrophe Risk Subgroup **exposed** for comment until January 25 a proposed revised list that had been previously adopted in 2020; new events had been identified based on the sources from Swiss Re and Aon Benfield.	2020 RBC Filings
Catastrophe Risk Interrogatories (2020-08-CR)	The Catastrophe Risk Subgroup **exposed** for comment new instructions to clarify how insurers with no gross exposure to earthquake or hurricane should complete the Interrogatories.	2021 RBC Filings

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