

EXECUTIVE (EX) COMMITTEE AND PLENARY

Executive (EX) Committee and Plenary, Dec. 9, 2020, Minutes

Adopted the NAIC 2021 Proposed Budget (Attachment One)

Adopted the NAIC 2021 Proposed Committee Charges (Attachment Two)

Adopted the 2021 Generally Recognized Expense Table (GRET) (Attachment Three)

Adopted Amendments to *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49) (Attachment Four)

Adopted the Amendments to *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805) (Attachment Five)

Adopted Amendments to *Health Maintenance Organization Model Act* (#430) (Attachment Six)

Adopted the *Workers' Compensation Policy and the Changing Workforce* Whitepaper (Attachment Seven)

Adopted the State Disaster Response Plan (Attachment Eight)

Adopted Amendments to the Market Conduct Annual Auto and Home Data Call & Definitions (Attachment Nine)

Adopted Amendments to the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) (Attachment Ten)

Report on States' Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Eleven)

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Draft: 12/28/20

Executive (EX) Committee and Plenary
Virtual 2020 Fall National Meeting
December 9, 2020

The Executive (EX) Committee and Plenary met Dec. 9, 2020. The following members participated: Raymond G. Farmer, Chair (SC); David Altmaier, Vice Chair (FL); Dean L. Cameron, Vice President (ID); Chlora Lindley-Myers, Secretary-Treasurer (MO); Eric A. Cioppa, Most Recent Past President (ME); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Elizabeth Perri (AS); Evan G. Daniels (AZ); Ricardo Lara (CA); Michael Conway (CO); Andrew N. Mais (CT); Karima M. Woods (DC); Trinidad Navarro (DE); John F. King represented by Martin Sullivan (GA); Dafne M. Shimizu (GU); Colin M. Hayashida (HI); Doug Ommen (IA); Robert H. Muriel (IL); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Grace Arnold (MN); Mark O. Rabauliman (MP); Mike Chaney (MS); Matthew Rosendale represented by Bob Biskupiak (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread (ND); Bruce R. Ramge (NE); Chris Nicolopoulos (NH); Marlene Caride (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Linda A. Lacewell represented by My Chi To (NY); Tynesia Dorsey (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Rafael Cestero Lopategui represented by Alexander Adams (PR); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Carter Lawrence (TN); Texas represented by Doug Slape (TX); Tanji J. Northrup (UT); Scott A. White (VA); Tregenza A. Roach (VI); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

1. Adopted the Report of the Executive (EX) Committee

Director Farmer reported that the Executive (EX) Committee met Dec. 9. and adopted the Dec. 2 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Executive (EX) Committee adopted its interim meeting report from Oct. 27 and Sept. 30, which included the following action: 1) approved release of the proposed NAIC 2021 budget for public review and comment; 2) reappointed Commissioner Altmaier, Commissioner Anderson, Director Farmer, and Michael F. Consedine (NAIC) to the International Association of Insurance Commissioners (IAIS) Executive Council; 3) adopted the July 14 minutes of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee; 4) adopted the Sept. 9 minutes of the Internal Administration (EX1) Subcommittee; 5) adopted the report of the Audit Committee; 6) adopted the report of the Information Systems (EX1) Task Force; 7) approved the Economic Scenario Generator (ESG) fiscal; 8) appointed Commissioner Anderson as the alternate representative on the Financial Stability Oversight Council (FSOC); 9) received an update on the System for Electronic Rate and Form Filing (SERFF) Assessment; and 10) received a joint chief executive officer (CEO)/chief operating officer (COO) report.

The Executive (EX) Committee adopted the reports of its task forces: 1) the Climate and Resiliency (EX) Task Force; 2) the Financial Stability (EX) Task Force; 3) the Government Relations (EX) Leadership Council; 4) the Innovation and Technology (EX) Task Force; 5) the Long-Term Care Insurance (EX) Task Force; and 6) the Special (EX) Committee on Race and Insurance.

The Executive (EX) Committee also: 1) adopted its 2021 proposed charges; 2) adopted amendments to the *Unfair Trade Practices Act* (#880); and 3) received a status report on the NAIC *State Ahead* strategic plan implementation.

The Executive (EX) Committee received a status report on model law development efforts for amendments to: 1) the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) the *Annuity Disclosure Model Regulation* (#245); 3) the *Health Maintenance Organization Model Act* (#430); 4) the *Insurance Holding Company System Regulatory Act* (#440); 5) the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450); 6) the *Life Insurance Disclosure Model Regulation* (#580); 7) the *Mortgage Guaranty Insurance Model Act* (#630); 8) the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805); 9) Model #880; and 10) the following new models: a) the Real Property Lender-Placed Insurance Model Act; b) the Pet Insurance Model Law; and c) the Pharmacy Benefit Manager (PBM) Model Law.

The Executive (EX) Committee also heard reports from the National Insurance Producer Registry (NIPR) and the Interstate Insurance Product Regulation Commission (Compact).

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Superintendent Toal made a motion, seconded by Commissioner Ommen, to adopt the Dec. 9 report of the Executive (EX) Committee (see *NAIC Proceedings – Fall 2020, Executive (EX) Committee*). The motion passed unanimously.

2. Adopted by Consent the Committee, Subcommittee and Task Force Minutes of the Summer National Meeting

Commissioner Mais made a motion, seconded by Acting Commissioner Shimizu, to adopt by consent the committee, subcommittee and task force minutes of the Summer National Meeting. The motion passed unanimously.

3. Adopted the NAIC Proposed 2021 Budget

Commissioner Altmaier reported that on Oct. 27, the Executive (EX) Committee approved the release of the proposed 2021 budget for public review and comment. The proposed budget was posted on the NAIC website on Oct. 28. The NAIC leadership team held a public briefing for interested parties on Nov. 4. No comment letters were received on the proposed budget. A Public Hearing was held on Dec. 2 to allow interested parties to make public comments. The Executive (EX) Committee approved the proposed 2021 budget during its joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

Commissioner Altmaier provided a brief overview of the budget as approved at the joint Executive (EX) Committee and Internal Administration (EX1) Subcommittee meeting on Dec. 2. The proposed budget is based on \$117.2 million in operating revenues and operating expenses of \$127.2 million. It includes four fiscals that are included in the budget numbers. The proposed fiscals are in alignment with the members' priorities, as outlined in the NAIC's *State Ahead* strategic plan, and they will enhance the important regulatory support provided to the members.

After including nearly \$1.8 million of investment income, the NAIC's proposed budget reflects a reduction in net assets of \$8.2 million. This budgeted reduction is higher than usual, but it reflects the NAIC's commitment to fund many of the *State Ahead* initiatives by leveraging its current financial position with minimal changes in the revenue structure.

Based on projected 2020 financial results and assuming the proposed 2021 budget is approved, the liquid operating reserve ratio will be approximately 104.9% at the end of 2020 and 100.6% at the end of 2021. NAIC management and the Executive (EX) Committee will continue to monitor this ratio to ensure that the NAIC remains financially secure and stays within the approved liquid operating reserve ratio range of 83.4% to 108.2%.

Commissioner Altmaier made a motion, seconded by Director Wing-Heir, to adopt the NAIC proposed 2021 budget (Attachment One). The motion passed unanimously.

4. Adopted the NAIC 2021 Proposed Committee Charges

Commissioner Altmaier reported that the 2021 proposed committee charges are the work planned for the working groups, task forces and committees that operate through the NAIC. These charges have been exposed, discussed and adopted by each of the letter committees. The charges document is a dynamic document, and as the work of the Special (EX) Committee on Race and Insurance is still underway, it is anticipated that there will be additional charges for the letter committees as the work proceeds in 2021.

Commissioner Altmaier made a motion, seconded by Commissioner Roach, to adopt the NAIC 2021 proposed committee charges (Attachment Two). The motion passed unanimously.

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

Commissioner Caride reported that the Life Insurance and Annuities (A) Committee met Dec. 7 and adopted its Nov. 10 and Summer National Meeting minutes, which included the following action: 1) adopted its July 10 minutes; 2) adopted its 2021 proposed charges; 3) adopted the Life Actuarial (A) Task Force's 2021 proposed charges; 4) adopted revisions to Model #805; 5) adopted the Generally Recognized Expense Table (GRET); 6) adopted revisions to *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49); and 7) adopted technical revisions to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest Sold On or After November 25, 2020* (AG 49-A).

The Committee adopted the following working group and task force reports: 1) the Annuity Disclosure (A) Working Group, including an extension of the Request for NAIC Model Law Development to revise Section 6—Standards for Illustrations in

Draft Pending Adoption

Model #245 to address issues identified by the Working Group related to innovations of annuity products currently in the marketplace that are not addressed or not adequately addressed in the current standards; 2) the Accelerated Underwriting (A) Working Group, including its Nov. 17 minutes; 3) the Annuity Suitability (A) Working Group, including its Summer National Meeting minutes; 4) the Life Actuarial (A) Task Force; 5) the Life Insurance Illustration Issues (A) Working Group, including an extension of the Request for NAIC Model Law Development to revise Model #580 to reference a short policy-overview document; and 6) the Life Insurance Online Guide (A) Working Group, including its Oct. 20 and Feb. 24 minutes. During these meetings, the Life Insurance Online Guide (A) Working Group reviewed its work plan for the online guide and discussed next steps related to its charge to “develop an online resource on life insurance, including the evaluation of existing content on the NAIC website, to be published digitally for the benefit of the public.”

6. Adopted the 2021 GRET

Director Farmer reported, on behalf of Commissioner Caride, that the Society of Actuaries (SOA) Committee on Life Insurance Company Expenses submitted its GRET analysis to the Life Actuarial (A) Task Force for the upcoming year. The SOA followed the same methodology in developing the 2021 GRET as last year for the 2020 GRET. The 2021 GRET was adopted by the Life Insurance and Annuities (A) Committee at its Nov. 10 meeting.

Commissioner Caride made a motion, seconded by Commissioner Mais, to adopt the 2021 GRET (Attachment Three). The motion passed unanimously.

7. Adopted Amendments to AG 49

Commissioner Caride reported that the amendments proposed for adoption will sunset AG 49 for new issues in order to coordinate the effective date of AG 49 with the effective date of the updated AG 49-A, which was adopted by the NAIC at the Summer National Meeting. AG 49 as revised, and it applies to policies issued before Dec. 14. AG 49-A will apply to policies issued after Dec. 14. Companies may choose to follow AG 49-A for policies issued before Dec. 14.

Commissioner Caride made a motion, seconded by Commissioner Ommen, to adopt amendments to AG 49 (Attachment Four). Deputy Commissioner To stated, “New York will vote against these amendments because these illustrations are supposed to show consumers how a given product works and how it is expected to perform going forward. As a practical matter, they are being used by insurers to compete with one another in selling these products by showing what we believe are unrealistic growth of cash values. This harms and misleads consumers that we as regulators have a duty to protect. We, as the NAIC and all of us, should be strong advocates for the use of more realistic credit rates to make sure consumers understand what they are buying and what their expectations should be. New York strongly opposes these amendments because they continue to allow unrealistic and unreasonable credit rates.” Commissioner Toal expressed the same concerns and said he supports New York’s comment. The motion passed, with New Mexico and New York dissenting.

8. Adopted Amendments to Model #805

Commissioner Caride reported that revisions to Model #805 arise out of concern with the 1% minimum nonforfeiture rate, which is difficult for insurers to achieve in the current very low interest rate environment. Insurers are unable to offer some annuity products due to the financial strain caused by the 1% minimum. These revisions reduce the minimum nonforfeiture rate to 0.15%. This minimum does not prohibit a company from guaranteeing more than that. This change would also have an impact on the Compact’s Uniform Standards for deferred annuities. The Uniform Standards reference Model #805 for the actuarial nonforfeiture requirements, and upon the NAIC’s adoption of the amendment, it would take automatic effect for the purposes of reviewing and approving Compact product submissions.

At its Dec. 4 annual meeting, the Compact put in place an emergency rule to stay the effectiveness of this amendment once it is approved by the NAIC for the purposes of the Uniform Standards. The Compact took this action while it navigates the implications under the recent Colorado Supreme Court opinion in the *Amica v. Wertz* case, which indicated, in the absence of Congressional consent, the Uniform Standards may not conflict with state statute. If the Compact were to immediately apply this lower rate, it would conflict with existing state statute. The emergency rule is in effect for 120 days while the Compact and its Product Standards Committee study and recommend when and how this amendment could become effective for the purposes of the Uniform Standards.

Commissioner Caride made a motion, seconded by Director Ramge, to adopt amendments to Model #805 (Attachment Five). Deputy Commissioner To said New York will vote against the amendments on consumer protection grounds and because of the high potential for a surrender penalty. Deputy Commissioner To said, “Consumers should have a meaningful guarantee of

Draft Pending Adoption

interest rates.” The motion passed with a two-thirds majority and Nevada, New Mexico, New York, Northern Mariana Islands, Virgin Islands and Washington dissenting.

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

Commissioner Altman reported that the Health Insurance and Managed Care (B) Committee met Dec. 7. During this meeting, the Committee adopted its Nov. 2 and Summer National Meeting minutes. During its Nov. 2 meeting, the Committee took the following action: 1) adopted the 2021 proposed charges of the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force; 2) adopted its 2021 proposed charges; 3) adopted revisions to Model #430. The revisions address conflicts and redundancies in Model #430 with provisions in the revised *Life and Health Insurance Guaranty Association Model Act* (#520), which added health maintenance organizations (HMOs) as members of the guaranty association; and 4) received an update on the Consumer Information (B) Subgroup’s work related to its charge to develop information or resources that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance. The Subgroup recently adopted updates to its “Frequently Asked Questions (FAQ) About Health Reform” document in preparation for the 2021 open enrollment period. The Subgroup also developed a new document for consumers when they are considering purchasing a short-term policy that is not subject to the requirements of the federal Affordable Care Act (ACA).

The Committee adopted the report of the Consumer Information (B) Subgroup, including its Oct. 29 and Oct. 20 minutes. During these meetings, the Subgroup took the following action: 1) discussed revisions to the FAQ document and the development of a document to assist consumers considering the purchase of a short-term policy that is not subject to the requirements of the ACA; and 2) adopted the revised FAQ document and the new consumer document for consumers on short-term policies.

The Committee adopted the report of the Health Innovations (B) Working Group, including its Nov. 9 minutes, which included the following action: 1) adopted its Summer National Meeting minutes; and 2) heard presentations on hospital prices, a new hospital cost tool, and prices of COVID-19 tests.

The Committee adopted the reports of the Health Actuarial (B) Task Force and the Regulatory Framework (B) Task Force.

The Committee adopted the report of the Senior Issues (B) Task Force, including its Oct. 20 minutes, which included the following action: 1) adopted its Oct. 8 minutes, which included adopting its 2021 proposed charges and a discussion of Medicare and payment of the costs of administering a coronavirus vaccine if approved by the U.S. Food and Drug Administration (FDA) under an emergency-use authorization; 2) adopted its Sept. 2 minutes, which included hearing a presentation from AlliedVirtualCare on its initiative to reduce long-term care insurance (LTCI) costs and a discussion on deceptive COVID-19 marketing and sales practices targeting seniors; and 3) adopted its Summer National Meeting minutes.

The Committee heard an update on legal actions related to the ACA, including a discussion of the Nov. 10 oral arguments before the U.S. Supreme Court (Supreme Court) in the case of *California v. Texas*, which challenges the constitutionality of the individual mandate and the potential impact of the decision on other key ACA provisions. It is anticipated that a decision in the case will be issued in 2021. The update also included a discussion of the *Rutledge v. Pharmaceutical Care Management Association* case, which was argued before the Supreme Court on Oct. 6. This case challenges the authority of the states to regulate pharmacy benefit managers (PBMs).

The Committee received an update on the work of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup in completing its charge to develop a new NAIC model regulating PBMs. The Subgroup exposed the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model Act) for a public comment period ending Sept. 1. The Subgroup then met to consider revisions to the draft based on the comments received. The Subgroup adopted the PBM Model Act on Oct. 29 and forwarded it to the Regulatory Framework (B) Task Force for its consideration. During its Nov. 19 meeting, the Regulatory Framework (B) Task Force exposed the PBM Model Act for an additional 30-day public comment period ending Sept. 22.

10. Adopted Amendments to Model #430

Commissioner Altman reported that the revisions to Model #430 represent the work of the Health Maintenance Organization (HMO) Issues (B) Subgroup to complete its charge to revise provisions in Model #430 to address conflicts and redundancies with provisions in the revised Model #520, which added HMOs as members of the guaranty association.

Draft Pending Adoption

Those provisions include Section 14—Continuation of Benefits; Section 20—Uncovered Expenditures Deposit; and Section 3HH, the definition of “uncovered expenditures.” For states that do not intend to adopt the revised Model #520, for reference, a new appendix to the model includes these deleted provisions. The Subgroup also deleted Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency because the section’s provisions are obsolete due to the ACA.

The Subgroup adopted the revisions July 13, and the Regulatory Framework (B) Task Force adopted the revisions Sept. 24. The Health Insurance and Managed Care (B) Committee adopted the revisions Nov. 2.

Commissioner Altman made a motion, seconded by Commissioner Kreidler, to adopt amendments to Model #430 (Attachment Six). The motion passed unanimously.

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

Commissioner Schmidt reported that the Property and Casualty Insurance (C) Committee met Dec. 8. During this meeting, the Committee took the following action: 1) adopted an extension of time for revisions to the proposed Pet Insurance Model Act; 2) adopted the Real Property Lender-Placed Insurance Model Act; and 3) adopted its 2021 proposed charges.

The Committee adopted the *Regulatory Review of Predictive Models* white paper. The white paper identifies best practices for the review of predictive models and analytics filed by insurers with state insurance regulators to justify rates.

The Committee adopted a Request for NAIC Model Law Development related to the *Nonadmitted Insurance Model Act* (#870) to work on amendments to the model to modernize it and bring it into compliance with the Non-admitted and Reinsurance Reform Act (NRRRA).

The Committee adopted the reports of its task forces and working groups: 1) the Casualty Actuarial and Statistical (C) Task Force; 2) the Surplus Lines (C) Task Force; 3) the Title Insurance (C) Task Force; 4) the Workers’ Compensation (C) Task Force; 5) the Cannabis Insurance (C) Working Group; 6) the Catastrophe Insurance (C) Working Group; 7) the Climate Risk and Resilience (C) Working Group; 8) the Lender-Placed Insurance Model Act (C) Working Group; 9) the Pet Insurance (C) Working Group; 10) the Terrorism Insurance Implementation (C) Working Group; and 11) the Transparency and Readability of Consumer Information (C) Working Group.

12. Adopted the Workers’ Compensation Policy and the Changing Workforce White Paper

Commissioner Schmidt reported that in 2018, the NAIC/International Association of Industrial Accident Boards and Commissions (IAIABC) Joint (C) Working Group of the Workers’ Compensation (C) Task Force was charged with updating the 2009 white paper, *An Overview of Workers’ Compensation Independent Contractor Regulatory Approaches*.

The white paper explores how changes in work and the evolving landscape surrounding the legality of employment options are shifting responsibility for coverage and benefits related to occupational injuries, illnesses and fatalities. The white paper is divided into the following sections: 1) changing relationships with work; 2) determining employment status; and 3) alternative coverage models. The white paper also includes an appendix that provides state standards used to determine independent contractor status.

The white paper was adopted by the Workers’ Compensation (C) Task Force on July 22, and it was adopted by the Property and Casualty Insurance (C) Committee on Aug. 12.

Commissioner Schmidt made a motion, seconded by Superintendent Toal, to adopt the *Workers’ Compensation Policy and the Changing Workforce* white paper (Attachment Seven). The motion passed with Washington abstaining.

13. Adopted the State Disaster Response Plan

Commissioner Schmidt reported that the Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee was originally charged with updating the NAIC *State Disaster Response Handbook* (Handbook).

The Handbook is a document that the state insurance departments can use as a template to create a disaster response plan. The Handbook provides state insurance regulators with information regarding: 1) the purpose of the disaster response plan; 2) NAIC disaster assistance; 3) preparation steps and planning; 4) the data collection process; 5) the disaster response and incident

Draft Pending Adoption

management team and its roles and responsibilities; 6) business continuity organizational charts; 7) response levels and definitions; and 8) sample contact lists that state insurance departments can use.

State departments of insurance (DOIs) are able to edit and format the Handbook to meet their needs. The Catastrophe Insurance (C) Working Group adopted the Handbook May 26, and the Committee adopted it Aug. 12.

In addition to the creation of the Handbook, the NAIC is creating a disaster program, which will provide a one-stop shop for state insurance regulators with sample bulletins, publications to help state DOIs educate consumers about catastrophic events (these can be modified by the DOI), information regarding NAIC data calls, and various other tools for state insurance regulators. The NAIC Communications Department will also help to create interactive tools and podcasts regarding catastrophe topics.

The NAIC envisions creating a website where state insurance regulators can access information and tools prior to a disaster to be better able to help protect citizens. As part of this project, the NAIC would like to identify a point person in every state DOI to be a disaster representative.

Commissioner Schmidt made a motion, seconded by Commissioner Chaney, to adopt the State Disaster Response Plan (Attachment Eight). The motion passed unanimously.

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

Commissioner Richardson reported that the Market Regulation and Consumer Affairs (D) Committee met Dec. 8 and took the following action: 1) adopted its Summer National Meeting minutes; and 2) adopted its 2021 proposed charges, which included the proposed charges of the Antifraud (D) Task Force, the Market Information Systems (D) Task Force, and the Producer Licensing (D) Task Force.

The Committee adopted revisions to the *Antifraud Plan Guideline* (#1690), which serves as a guide for insurance companies preparing antifraud plans to document efforts to prevent and report fraud. The revisions focus on reorganizing the guidelines to eliminate repetitive requirements and adding language to align more closely with existing state mandates.

The Committee adopted clarifications to proposed revisions to the Market Conduct Annual Statement (MCAS) to continue using the definition of “lawsuit” currently being used for the auto and home MCAS blanks and change to the definition of “lawsuits closed with consideration to the consumer” to adapt it for use with the auto and home MCAS blanks. With these clarifications, the collection of lawsuit information will be limited to lawsuits arising from claims only. This is the methodology used in all prior auto and home MCAS filings.

The Committee adopted a standardized data request (SDR) for long-term care (LTC) in-force policies and an SDR for LTC claims to be included in the reference documents of the *Market Regulation Handbook*.

The Committee adopted revisions to Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook*. The revised guidance is based on the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170), and it addresses supplementary short-term, limited-duration (STLD) health plans.

The Committee voted to defer discussion on the Market Conduct Annual Statement Blanks (D) Working Group’s request for feedback on the collection of transactional data.

The Committee adopted the reports of its task forces and working groups: 1) the Antifraud (D) Task Force; 2) the Market Information Systems (D) Task Force; 3) the Producer Licensing (D) Task Force; 4) the Market Conduct Annual Statement Blanks (D) Working Group; 5) the Market Conduct Examination Standards (D) Working Group; 6) the Market Analysis Procedures (D) Working Group; 7) the Market Regulation Certification (D) Working Group; and 8) the Privacy Protections (D) Working Group.

15. Adopted Revisions to the MCAS

Director Farmer noted that after the adoption of the MCAS revisions on July 27, the Market Regulation and Consumer Affairs (D) Committee adopted clarifications to the July 27 revisions during its Dec. 8 meeting. Because these changes affect the 2021 data year filings, the joint Executive (EX) Committee and Plenary are being asked to consider the changes at this time.

Draft Pending Adoption

Commissioner Richardson reported that prior to the Summer National Meeting, the Market Conduct Annual Statement Blanks (D) Working Group decided to make the MCAS questions regarding lawsuits consistent across all lines of business. As a result, the Working Group voted to add the data element “lawsuits closed in consideration of the consumer” to the home and auto MCAS blanks and copied the 2021 “lawsuit” definition from the life and annuity MCAS blank to both the auto and home MCAS blanks.

After adopting these revisions, the Working Group discovered that the new definition of “lawsuit” was crafted specifically for the life and annuity lines of business, and the definition did not match some important provisions for the auto and home MCAS blank. On Nov. 16, the Working Group voted to revert back to the definition of “lawsuit” currently being used for the auto and home MCAS blank; however, the Working Group did not address the definition of the new data element “lawsuits closed during the period with consideration to the consumer.” This was raised during the Committee meeting on Dec. 8, and the Committee voted to continue using the definition of “lawsuit” currently being used for the auto and home MCAS blank and change to the definition of “lawsuits closed with consideration to the consumer” to adapt it for use with the auto and home MCAS by clarifying that it applies to lawsuits brought by claimants. The impact of these changes is to limit the collection of lawsuit information for the auto and home MCAS blanks to lawsuits arising from claims only. This is the methodology used in all prior auto and home MCAS filings.

Commissioner Richardson made a motion, seconded by Commissioner Clark, to adopt the revisions to the MCAS (Attachment Nine). The motion passed unanimously.

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

Commissioner White reported that the Financial Condition (E) Committee met Dec. 8 and adopted its Nov. 19, Oct. 27 and Summer National Meeting minutes, which included the following action: 1) adopted proposed changes to Model #440 and Model #450; and 2) adopted its 2021 proposed charges.

The Committee adopted the reports of the following task forces and working groups: 1) the Accounting Practices and Procedures (E) Task Force; 2) the Capital Adequacy (E) Task Force; 3) the Examination Oversight (E) Task Force; 4) the Receivership and Insolvency (E) Task Force; 5) the Reinsurance (E) Task Force; 6) the Risk Retention Group (E) Task Force; 7) the Valuation of Securities (E) Task Force; 8) the Group Capital Calculation (E) Working Group; 9) the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group; 10) the National Treatment and Coordination (E) Working Group; and 11) the Risk-Focused Surveillance (E) Working Group.

The Committee adopted the *Guideline for Administration of Large Deductible Policies in Receivership* and the *Group Capital Calculation (GCC) Template and Instructions*.

Note: Items adopted within the Financial Condition (E) Committee’s task force and working group reports that are considered technical, non-controversial and not significant by NAIC standards—i.e., they do not include model laws, model regulations, model guidelines, or items considered to be controversial—will be considered for adoption by the Executive (EX) Committee and Plenary through the Financial Condition (E) Committee’s technical changes report process. Pursuant to this process, which was adopted by the NAIC in 2009, a listing of the various technical changes will be sent to the NAIC members shortly after completion of the Fall National Meeting, and the members will have 10 days to comment with respect to those items. If no objections are received with respect to a particular item, the technical changes will be considered adopted by the NAIC membership and effective immediately.

17. Adopted Amendments to Model #440 and Model #450

Commissioner White reported that the proposed amendments to Model #440 and Model #450 enable the NAIC’s Group Capital Calculation (GCC) and the Liquidity Stress Test, two projects that have been priorities for the NAIC. This also includes the actual GCC instructions, which reference the GCC template itself. Both were adopted by the Financial Condition (E) Committee during its Dec. 8 meeting.

Commissioner White reported that the proposed changes to the models provide the legislative language needed to enable the GCC and the Liquidity Stress Test. The GCC does that through its proposed changes to Section 4L (2) of Model #440, which require the ultimate controlling person of every insurer subject to registration to file the GCC with the lead state. This is immediately followed by exemptions of four different types in Sections 4L(2)(a)-(d). This is followed by Section 4L(2)(e), the most controversial aspects of the model, which provides that the lead state may require, under certain circumstances, a subgroup capital calculation.

Commissioner White noted that this section of the model was controversial, and during the Committee meeting on Nov. 19,

Draft Pending Adoption

Texas asked whether Federal Insurance Office (FIO) had been consulted on the final version of the model. NAIC staff had a number of calls to consult with the FIO as the model was being developed, and while the FIO has not “signed off” on the model and the adopted approach, it did approve of the move away from a more explicit retaliatory approach than was in an earlier version of the model.

The model regulation provides the commissioner with the authority to exempt other groups as defined in the regulation, and it also provides details of the NAIC process for maintaining a list of other jurisdictions whose groups “recognize and accept the GCC” and are therefore exempt from filing the GCC.

With regard to the Liquidity Stress Test that will only be required for a small number of companies, similar to the GCC, it requires the ultimate controlling person to complete the GCC, but the Scope Criteria that is directly below Section 4L(3) of Model #440 results in the very small group of companies actually subject to this (less than 25 currently). Both the GCC and the Liquidity Stress Test are required to be held confidential under the provisions of Section 8 of Model #440.

Commissioner White made a motion, seconded by Commissioner Altmaier, to adopt amendments to Model #440 and Model #450, along with the GCC Instructions and Template (Attachment Ten). The motion passed unanimously.

Deputy Commissioner Slape commented that he appreciates all the work that went into the development of these amendments during this limited window of time to get it done given the pending deadline of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement). “Texas will vote to adopt the amendments given the urgency to adopt the amendments at this meeting, however, there are elements of the amendments we have had, and continue to have, concerns with, specifically: 1) the broad application of these amendments to all U.S. groups and the somewhat bureaucratic, and in many cases unnecessary, process for groups to obtain exemptions from the filing of GCCs; and 2) we have concerns with the language in the amendments about what may trigger the sub-group reporting by international groups operating in the U.S. In both instances, we believe the language is unnecessary and goes beyond the terms and/or requirements in the Covered Agreement, and it may result in conflicts with the Covered Agreement that could result in future preemption action by the FIO. We have concerns with the development of any accreditation standards that go beyond the elements of the amendments required to meet the terms of the Covered Agreement.”

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

Superintendent Dwyer reported that the Financial Regulation Standards and Accreditation (F) Committee met Dec. 3 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Idaho, Kentucky, Oklahoma and Vermont.

The Committee met Dec. 7 and adopted its Summer National Meeting minutes and its 2021 proposed charges, which remain unchanged from its 2020 charges.

The Committee adopted revisions to the Review Team Guidelines and the Self-Evaluation Guide for Part C: Organizational and Personnel Practices, effective Jan. 1, 2021. The revisions incorporate consideration of where each department’s average salaries fall in relation to the range as defined in the *Financial Analysis Handbook* and the *Financial Condition Examiners Handbook*.

The Committee adopted revisions to the Review Team Guidelines for Part B1: Financial Analysis, effective Jan. 1, 2021. The proposed revisions consist of a technical clarification related to risk retention groups (RRGs) and the use of the “Captives and/or Insurers Filing on a U.S. GAAP Basis Worksheet.”

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

Commissioner Anderson reported that the International Insurance Relations (G) Committee met Dec. 9 and adopted its Oct. 28 and Summer National Meeting minutes, which includes the following action: 1) heard an update on key 2020 projects of the IAIS; 2) heard an update on the International Monetary Fund (IMF) Financial Sector Assessment Program (FSAP); 3) heard an update on the Organisation for Economic Co-operation and Development (OECD) and other supervisory cooperation activities; 4) heard an update on international-related NAIC events; and 5) heard an update on international activities.

Draft Pending Adoption

The Committee adopted its 2021 proposed charges. The Committee also heard an update on activities of the IAIS, including: 1) the holistic framework for systemic risk in the insurance sector; and 2) and the insurance capital standard (ICS) and aggregation method (AM) data collection and comparability. The Committee also heard initial comments from interested parties on the IAIS public consultation on the draft definition and high-level principles for developing criteria to assess comparability, as well as highlights for upcoming activities and workstreams for 2021.

The Committee heard an update on recent and upcoming international activities, including bilateral meetings with the Japan Financial Services Agency (FSA), the European Insurance and Occupational Pensions Authority (EIOPA), and European Union (EU) member states; meetings of the OECD Insurance and Private Pensions Committee; and meetings of the Sustainable Insurance Forum (SIF).

20. Received a Report on the States' Implementation of NAIC Adopted Model Laws and Regulations

Director Farmer referred attendees to the written report for updates on the states' implementation of NAIC-adopted model laws and regulations (Attachment Eleven).

21. Heard the Results of the 2021 NAIC Zone Officer Election

The Executive (EX) Committee and Plenary received the results of the 2021 zone officer elections. Midwest Zone: Director Deiter, Chair (SD); Commissioner Mulready, Vice Chair (OK); and Commissioner Ommen, Secretary (IA). Northeast Zone: Commissioner Altman, Chair (PA); Commissioner Anderson, Vice Chair (MA); and Commissioner Birrane, Secretary (MD). Southeast Zone: Commissioner Ridling, Chair (AL); Commissioner Chaney, Vice Chair (MS); and Commissioner Donelon, Secretary (LA). Western Zone: Director Wing-Heier, Chair (AK); Commissioner Conway, Vice Chair (CO); and Commissioner Stolfi, Secretary (OR).

22. Elected the 2021 NAIC Officers

The NAIC membership elected the 2021 NAIC officers: Commissioner Altmaier, President (FL); Director Cameron, President-Elect (ID); Director Lindley-Myers, Vice President (MO); and Commissioner Mais, Secretary-Treasurer (CT).

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

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Date: November 30, 2020

To: All NAIC Members and Interested Parties

From: Commissioner David Altmaier, NAIC President-Elect
Michael Consedine, NAIC Chief Executive Officer
Andy Beal, NAIC Chief Operating Officer and Chief Legal Officer
Jim Woody, NAIC Chief Financial Officer

Re: Summary of Comments on the Proposed NAIC 2021 Budget

The NAIC's annual budget and related process is transparent and subject to several layers of review and approval including NAIC Senior Staff, NAIC Officers, and the NAIC Executive (EX) Committee and Internal Administration (EX1) Subcommittee. In addition, the proposed budget is exposed publicly for review and comment by interested parties before the proposed budget is presented to NAIC membership for final approval.

The proposed NAIC 2021 budget was released for public review on Wednesday, October 28 and a briefing with interested parties was held on Wednesday, November 4. Written comments to the NAIC CFO were due on Friday, November 20, and no comments were received on the proposed 2021 budget.

The NAIC's proposed 2021 budget includes total revenues (including investment income) of \$119.0 million and total expenses of \$127.2 million, which represents a 1.1 percent increase and 1.5 percent increase, respectively, from the 2020 budget. Included in the proposed budget are four Fiscal Impact Statements (Fiscals) with associated expenses of \$2.1 million. Overall, the proposed 2021 budget results in a reduction in Net Assets of \$8.2 million – an overview of key elements of the budget is attached (Attachment One).


The next step in the budget process is a Public Hearing which will be held on Wednesday, December 2nd – participation instructions for the Public Hearing can be accessed at on the NAIC About Budget page (https://content.naic.org/about_budget.htm).

If you have any questions about the proposed 2021 budget or process, please contact Jim Woody, NAIC CFO, at jwoody@naic.org.

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Executive Summary NAIC 2021 Budget



National Association of Insurance Commissioners

About the NAIC

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

Through the NAIC, state insurance regulators establish standards and best practices, conduct peer reviews, and coordinate their regulatory oversight activities. NAIC staff supports these efforts and represents the collective domestic and international views of state insurance regulators.

NAIC members, together with the central resources of the association, form the national system of state-based insurance regulation in the U.S. NAIC members are elected or appointed state government officials who, along with their departments and staff, regulate the conduct of insurance companies and agents/brokers in their respective jurisdictions.

The NAIC's annual budget supports the many valuable services and benefits provided to state insurance regulators, insurance consumers, and the insurance industry. Each year, the budget is developed with the goal of enabling the membership to accomplish its key strategic priorities.

The year 2020 has seen a number of surprises, not least of which was a global pandemic. Natural disasters ranged from devastating hurricanes to historic wildfires. Civil unrest highlighted unresolved issues of importance to society. These issues and more have had an impact to the insurance industry, and through it all, the NAIC has sought to provide leadership, resources, and a path forward.

Naturally, the year 2021 will also bring surprises. Yet as the world moves toward an unknown future, having a plan in place to address key issues and provide guidance and direction is crucial. Over the past three years, the NAIC has utilized its strategic plan, *State Ahead*, as a compass. The plan articulated a comprehensive vision for the future of state insurance regulation and outlined how the NAIC could help the membership stay ahead of the curve in a rapidly evolving marketplace. Although the original intent was to expand the plan in 2021 as *State Ahead 2.0*, the vast number of surprises this year required NAIC leadership to carry several initiatives from the plan into 2021, so that attention could be focused on the response to the pandemic, natural disasters, and social issues that came to the forefront in 2020.

As a result, the 2021 budget continues to incorporate funding for several key initiatives from *State Ahead*, particularly completing the migration of applications to the Cloud, the build out of the centralized data warehouse and its governance, and the development of business intelligence dashboards for market regulatory oversight. The budget demonstrates a firm commitment to support technology advancements and the continuing modernization of insurance regulation in areas such as innovation, cybersecurity, and international standard-setting.

The budget also continues the NAIC's commitment to support the variety of programs, products, and services in the financial solvency and market regulatory arenas. The NAIC offers a wide range of publications, data, and information systems; accreditation reviews; and many other

services to assist state insurance regulators in achieving their fundamental insurance regulatory goals in a timely and cost-effective manner.

Support of the Membership

The mission of the NAIC is to assist the state insurance regulators in serving the public interest and achieving its goals of protecting the public interest; promoting a competitive marketplace; facilitating the fair and equitable treatment of insurance customers; ensuring the reliability, solvency, and financial stability of insurers; and supporting and improving state insurance regulation. Leveraging NAIC technology solutions, regulatory tools, and staff resources allow member states to achieve these goals at a significant cost savings. Without these options, many systems would be cost-prohibitive for the states to implement on their own. Without membership in the NAIC, the amount of state funding required to provide or access similar types of services and data the NAIC provides — often at no extra charge — would far exceed what a state pays in member dues to the NAIC.

A Focus on Consumers

The NAIC provides a multi-channel approach to reach and assist consumers in making informed decisions on insurance matters. These multi-pronged marketing communications campaigns include items like consumer insights, a consumer section on naic.org, mobile apps, and targeted social campaigns. In 2021, naic.org will be updated to enable consumers and regulators to better navigate NAIC resources.

Valuable Products and Services

The NAIC seeks to support its mission through a wide variety of products and services offered to both the insurance industry and state regulators. NAIC web-based systems automate, standardize, and streamline regulatory processes by transmitting data and facilitating regulatory transactions between insurers, consumers, and state insurance regulators.

By the Numbers

NAIC products and services make life easier.

- ▶ **Life Policy Locator** – 175,006 requests received from inception in Nov. 2016 through year-end 2019, with 60,247 located life insurance policies for a total claims amount of more than \$821 million
- ▶ **System for Electronic Rates & Forms Filing (SERFF)** – 577,165 transactions processed in 2019
- ▶ **Online Premium Tax for Insurance (OPTins)** – 139,313 transactions processed in 2019
- ▶ **State Based Systems (SBS)** – back-office services licensed to 32 jurisdictions in 2020
- ▶ **Professional Designation Program** – 1,310 designations awarded since the program's inception in October 2006 through year-end 2019
- ▶ **Center for Insurance Policy and Research (CIPR) Key Research Issues** – 180 briefs currently available online including NAIC key initiatives and topics ranging from cybersecurity and innovation to natural catastrophe risk and resiliency

The NAIC is committed to maintaining and enhancing these systems to provide high-quality service to all stakeholders. The 2021 budget includes four technology-based fiscals, which represent initiatives to incorporate cutting-edge technology to improve decision-making and analysis, build out the data infrastructure, eliminate redundant processes, and improve data quality.

Building the Budget

The NAIC strives for transparency in its budget process as well as in its operations. The budget process gets underway in the spring each year, when department managers evaluate current-year revenues and expenses in order to assess the year-end picture, then propose a budget for the following year based on their operational objectives and member initiatives. Managers carefully focus on variances between the current year's budget and projected results and anticipated business needs for the coming year. This process includes a review of all projects, products, programs, services, committee charges, and technology initiatives in light of the NAIC's mission and the membership's strategic priorities, particularly those outlined in *State Ahead*. NAIC senior management reviews each department budget in detail with its division director to adjust according to the strategic and financial needs of the association and ultimately consolidates all requests into a single, comprehensive budget.

Following the extensive development and internal review process, the budget is presented to the NAIC Officers, the Executive (EX) Committee and Internal Administration (EX1) Subcommittee, and the full NAIC membership before being released for public review and comment. To ensure transparency, a public hearing is held to receive public comments before final consideration and adoption by the NAIC Executive (EX) Committee and Plenary.

Expected Results for 2020

Based on actual operating results (before adding investment income) through June 30, 2020, the NAIC projects a net negative operating margin of \$3.6 million compared to a budgeted net negative operating margin of \$10.8 million, an improvement of nearly \$7.2 million. Investment income is projected to be \$3.0 million, resulting in a net asset decrease of nearly \$591,000. As a result of the COVID-19 pandemic, 2020 was an unusual year resulting in the cancellation of most in-person meetings causing travel, meetings, and Grant/Zone to be significantly lower than budget.

2020: Year Three of *State Ahead*

State Ahead includes 91 key initiatives. By year end, 60 projects will be completed, or 66%.

2020: Transforming

By the end of 2020, the NAIC will be positioned to provide its members with new analytics, technology, and tools to more effectively regulate their markets.

Several initiatives outlined in the *State Ahead* blueprint resulted in fiscal impact statements for 2020. These fiscals were made available for public comment in advance of membership consideration, approval, and incorporation into the 2020 budget.

Additional information regarding 2020 projected variances is included throughout the detailed footnotes of the budget.

2021: *State Ahead* remains a focus

Several key projects will carry into 2021 as the transforming phase continues.

Cloud Migrations, Data Asset Management, Macroprudential Surveillance Tools, Enhanced Financial Reporting & Risk Assessment, among others.

2021 Budget

The 2021 budget demonstrates NAIC's continued strong focus on prudent financial management, which is critically important in these unprecedented times. The 2021 budget also assumes in-person meetings will be held again starting in the first quarter.

The 2021 NAIC operating budget (before adding investment income) reflects revenues of \$117.2 million

and expenses of \$127.2 million, which represent a 2.4% and a 1.5% increase, respectively, from the 2020 budget, resulting in \$10.0 million in projected expenses over revenues. Viewed in relation to the 2020 projected totals which were significantly impacted by the pandemic, the 2021 budget represents operating revenue increase of 4.1% and operating expense increase of 9.4%. Additional information about the 2021 budget is included throughout the detailed footnotes of the budget.

A fiscal impact statement (fiscal) is prepared for new or existing NAIC initiatives with revenue, expense, or capital impacts of \$100,000 or more either in the current budget or within the following few years' budgets or requires more than 1,150 hours of internal technical resources to accomplish. Each fiscal includes a detailed description of the initiative; impact on key stakeholders; financial and operational impact of the initiative; and an assessment of the risks. The total financial impact of the four fiscals included in the 2021 budget is \$2.1 million in expenses with no associated revenues. Additional information about each initiative is included in the various fiscal sections of the budget.

The 2021 budget includes \$1.8 million in investment income from the NAIC's Long-Term Investment Portfolio. Investment income is composed of interest and dividends earned reduced by investment management fees – investment gains and losses are not projected nor included in the budget.

Combining budgeted results from operations with budgeted investment income, the 2021 budget has a reduction in net assets of \$8.2 million.

Preparing for the Unknown

The budget includes all known activities anticipated to occur in 2021. However, as 2020 has proven to be a year that deviated from the expected, situations will likely arise during 2021 that require additional funding. In such an event, a funding request is prepared and presented to the Executive (EX) Committee and Internal Administration (EX1) Subcommittee for consideration. Funding for any approved project comes from the Regulatory Modernization and Initiatives Fund, established in 2005 to manage requests that

2021 Fiscal Impact Statements

- ▶ **Artificial Intelligence and Machine Learning for Financial Analysis** – proposes to utilize an external consultant with expertise in AI and predictive analysis to assist NAIC staff in improving the accuracy of the NAIC Scoring System for life and accident & health insurers, which is a key financial analysis solvency tool used by regulators to identify and assess potential financial risks and to prioritize financial surveillance efforts.
 - 2021 expense of \$150K
- ▶ **Enterprise Data Asset Management** – continues to build-out the new Enterprise Data Platform in AWS and adds new tools and technologies to modernize the NAIC's data capabilities in areas such as data movement, data quality, data preparation, and data science. Advanced data users at state insurance departments will gain efficiencies in their data work and gain more powerful insights from their analyses, while less technical users will be empowered to perform some of their own data discovery and analysis.
 - 2021 expense of \$1.4M
- ▶ **MCAS/FDR Separation** – due to the growth of MCAS filings from the initial four lines of business in 2014 to nine lines of business in 2021, this project will address the growing complexity of the MCAS system relying on the FDR system. This project will allow the MCAS system to operate independently of the FDR system and reduce work across multiple NAIC departments when setting up annual data validations and MCAS scorecard ratios. Eliminating system dependencies and simplifying internal work processes will provide for more efficient use of NAIC resources to meet the needs of the NAIC Members.
 - 2021 expense of \$266K; 2022 expense of \$134K
- ▶ **SERFF Plan Management Enhancements** – these updates will streamline processes supporting data collection related to the Patient Protection and Affordable Care Act. The resulting process will require less NAIC staff support and improve data quality as well as simplify the process for insurance companies.
 - 2021 Expense of \$292K

arise following the adoption and implementation of an annual budget. The Fund is based on 1.5% of the NAIC's projected consolidated net assets as of December 31, 2021, or \$2.1 million with the inclusion of fiscals.

Ensuring Financial Stability

The NAIC's operating reserve is designed to ensure the financial stability of the NAIC in the event of emerging business risks and uncertainties and to absorb new priority initiatives pursued by NAIC membership. The association's reserve status is of paramount consideration in the budgeting process, as is strong and prudent financial management of the NAIC's assets.

Operating Reserve	
2019 Audited	104.9%
2020 Projected	104.9%
2021 Proposed	100.6%

In July 2015, the Executive (EX) Committee and Internal Administration (EX1) Subcommittee approved a report from an independent financial advisory firm which established the NAIC's liquid operating reserve target range of 83.4% to 108.2%. This range was the result of a comprehensive review of current and future identified risks and an evaluation of comparable organizations. This report recognized the increased level of uncertainty facing the NAIC and anticipated future investments which would be required to enhance the association's information

technology and technical infrastructure, which is represented by many elements of the 2021 budget.

Contact Information

The NAIC appreciates the opportunity to present this 2021 budget and believes it provides a comprehensive review of the NAIC's business and financial operations for the current and upcoming fiscal year. A summary of the 2021 budget's key components is included in the budget overview.

Please feel free to contact Jim Woody, Chief Financial Officer, at (816) 783-8015, or Carol Thompson, Senior Controller, at (816) 783-8038, should you have any questions or need additional information.

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Draft: 11/18/20

NAIC 2021 Proposed Committee Charges
(Adopted by the Executive (EX) Committee and Plenary, Dec. 9, 2020)

EXECUTIVE (EX) COMMITTEE

The mission of the Executive (EX) Committee is to manage the affairs of the NAIC in a manner consistent with its Articles of Incorporation and its Bylaws.

Ongoing Support of NAIC Programs, Products or Services

1. The **Executive (EX) Committee** will:
 - A. Identify the goals and priorities of the organization and make recommendations to achieve such goals and priorities based on input of the membership. Make recommendations by the 2021 Commissioners Conference.
 - B. Create/terminate task force(s) and/or Executive (EX) Committee-level working groups to address special issues and monitor the work of these groups. Create necessary task force(s) and/or Executive (EX) Committee-level working groups throughout 2021 as necessary.
 - C. Submit reports and recommendations to NAIC members concerning the activities of its subcommittee and the standing committees. Submit a report at each national meeting.
 - D. Consider requests from NAIC members for friend-of-the-court briefs.
 - E. Establish and allocate functions and responsibilities to be performed by each NAIC zone.
 - F. Pursuant to the Bylaws, oversee the NAIC offices to assist the organization and the individual members in achieving the goals of the organization.
 - G. Conduct strategic planning on an ongoing basis.
 - H. Plan, implement and coordinate communications and activities with the Federal Insurance Office (FIO).
 - I. Plan, implement and coordinate communications and activities with other state, federal, local and international government organizations to advance the goals of the NAIC and promote understanding of state insurance regulation.
 - J. Review and approve requests for the development of model laws and/or regulations. Coordinate the review of existing model laws and/or regulations.
 - K. Select NAIC national meeting sites five and six years in advance of the meeting date to ensure efficient and economical locations and facilities.
 - L. Review and revise, as necessary and appropriate, the criteria and categories for registrants at NAIC national meetings.

NAIC Support Staff: Andrew J. Beal/Kay Noonan

CLIMATE AND RESILIENCY (EX) TASK FORCE

The mission of the Climate and Resiliency (EX) Task Force is to serve as the coordinating NAIC body for discussion and engagement on climate-related risk and resiliency issues, including dialogue among state insurance regulators, industry, and other stakeholders.

Ongoing Support of NAIC Programs, Products or Services

The **Climate and Resiliency (EX) Task Force** will:

1. Consider appropriate climate risk disclosures within the insurance sector, including:
 - A. Evaluation of the Climate Risk Disclosure Survey.
 - B. Evaluation of alignment with other sectors and international standards.
2. Evaluate financial regulatory approaches to climate risk and resiliency in coordination with other relevant committees, task forces and working groups, such as the Financial Condition (E) Committee and the Financial Stability (EX) Task Force, including:
 - A. Evaluation of the use of modeling by carriers and their reinsurers concerning climate risk.
 - B. Evaluation of how rating agencies incorporate climate risk into their analysis and governance.
 - C. Evaluation of the potential solvency impact of insurers' exposures, including both underwriting and investments, to climate-related risks.
 - D. Evaluation and development of climate risk-related disclosure, stress-testing, and scenario modeling.
3. Consider innovative insurer solutions to climate risk and resiliency, including:
 - A. Evaluation of how to apply technology and innovation to the mitigation of storm, wildfire, other climate risks and earthquake.
 - B. Evaluation of insurance product innovation directed at reducing, managing and mitigating climate risk, and closing protection gaps.
4. Identify sustainability, resilience and mitigation issues and solutions related to the insurance industry.
5. Consider pre-disaster mitigation and resiliency and the role of state insurance regulators in resiliency.

NAIC Support Staff: Jennifer Gardner

FINANCIAL STABILITY (EX) TASK FORCE

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

Ongoing Support of NAIC Program, Products or Services

1. The **Financial Stability (EX) Task Force** will:
 - A. Consider issues concerning domestic and global financial stability as they pertain to the role of state insurance regulators and make recommendations to the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council and/or the Executive (EX) Committee, as appropriate.
 1. Analyze existing post-financial crisis regulatory reforms for their application in identifying macroeconomic trends, including identifying possible areas of improvement or gaps, and propose to the Financial Condition (E) Committee or other relevant committee enhancements and/or additions to further improve the ability of state insurance regulators and the industry to address macroprudential impacts; consult with such committees on implementation, as needed.
 - B. Consider state insurance regulators' input to national and international discussions on macroeconomic vulnerabilities affecting the insurance sector.
 1. Monitor international macroprudential activities at forums like the International Association of Insurance Supervisors (IAIS).
 2. Implement the Macroprudential Initiative (MPI) domestically, which includes enhancements to the U.S. regulatory toolkit as part of the *State Ahead* initiative.
 - C. Serve as a forum to coordinate state insurance regulators' perspectives on a wide variety of issues arising from the designation of a U.S. insurance group as "systemically important" and "internationally active" both pre- and post-designation, including:
 1. Where appropriate, develop policy recommendations and/or guidance regarding the role, responsibilities and activities of state insurance regulators in the context of consolidated supervision resulting from designation.
 2. Analyze proposed rules by the federal agencies that relate to financial stability.
 3. Analyze proposed policy measures regarding supervisory standards for global systemically important insurers (G-SIIs) and internationally active insurance groups (IAIGs).
 4. Develop comment letters on such analysis for further consideration by the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council, and/or the Executive (EX) Committee, as appropriate.
2. The **Liquidity Assessment (EX) Subgroup** will:
 - A. Continue to consider regulatory needs for data related to liquidity risk, and develop recommendations as needed.
 - B. Refine and implement a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee.
 - C. Continue to develop and administer data collection tools, leveraging existing data where feasible, to provide the Financial Stability (EX) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating market conditions affected by the COVID-19 pandemic.

NAIC Support Staff: Todd Sells/Tim Nauheimer

GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

The Government Relations (EX) Leadership Council coordinates the NAIC's ongoing work with the federal government and state government officials on legislative and regulatory policy. The Leadership Council, in conjunction with the NAIC's other standing committees, is responsible for quickly responding to federal legislative and regulatory developments that affect insurance regulation.

The mission of the Government Relations (EX) Leadership Council is to develop, coordinate and implement the NAIC's legislative, regulatory and outreach initiatives. The Leadership Council will devise strategies for NAIC action and promote the participation of all NAIC members in the NAIC's government relations initiatives.

Ongoing Support of NAIC Programs, Products or Services

1. The **Government Relations (EX) Leadership Council** will:
 - A. Monitor, analyze and respond to federal legislative and regulatory actions and other issues of importance to the NAIC membership.
 - B. Work with other standing committees, task forces and working groups to help develop and communicate the NAIC's policy views to federal and state officials on pending legislation and regulatory issues by involvement of NAIC members through testimony, correspondence and other approaches.
 - C. Develop a strategy and program for directly engaging NAIC members with the U.S. Congress and federal agencies to advocate for NAIC objectives and the benefits and efficiencies of state-based insurance regulation.
 - D. Secure broader participation from NAIC membership on all government affairs advocacy initiatives.
 - E. Report to the Executive (EX) Committee on all activities and matters relating to the annual charges of the Leadership Council.

NAIC Support Staff: Ethan Sonnichsen/Mark Sagat/Brian R. Webb

INNOVATION AND TECHNOLOGY (EX) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Innovation and Technology (EX) Task Force** will:
 - A. Provide forums, resources and materials for the discussion of innovation and technology developments in the insurance sector, including the collection and use of data by insurers and state insurance regulators—as well as new products, services and distribution platforms—in order to educate state insurance regulators on how these developments affect consumer protection, privacy, insurer and producer oversight, marketplace dynamics, and the state-based insurance regulatory framework.
 - B. Develop and coordinate the development of regulatory guidance, model laws or model law revisions, and white papers or make other recommendations related to innovation and technology, to the Executive (EX) Committee, as appropriate.
 - C. Discuss emerging issues related to companies or licensees leveraging new technologies to develop products for on-demand insurance purposes—in addition to potential implications on the state-based insurance regulatory structure—including, but not limited to, reviewing new products and technologies affecting the insurance space and the associated regulatory implications.
 - D. Coordinate with other NAIC committees and task forces, as appropriate, on technology, innovation, cybersecurity issues and data privacy.

2. The **Big Data and Artificial Intelligence (EX) Working Group** will:
 - A. Research the use of big data and artificial intelligence (AI) in the business of insurance and evaluate existing regulatory frameworks for overseeing and monitoring their use. Present findings and recommend next steps, if any, to the Innovation and Technology (EX) Task Force and which may include model governance for the use of big data and AI for the insurance industry.
 - B. Review current audit and certification programs and/or frameworks that could be used to oversee insurers' use of consumer and non-insurance data and models using intelligent algorithms, including AI. If appropriate, recommend to and coordinate with the appropriate subject matter expert (SME) committees on development of modifications to model laws and/or regulations and regulatory guidance and/or handbooks regarding marketing, rating, underwriting and claims, regulation of data vendors and brokers, regulatory reporting requirements, and consumer disclosure requirements.
 - C. Assess data needs and required tools for state insurance regulators to appropriately monitor the marketplace, and evaluate the use of big data and intelligent algorithms, including AI in underwriting, rating, claims and marketing practices. This assessment shall include gaining a better understanding of currently available data and tools, as well as recommendations for additional data and tools, as appropriate. Based on this assessment, propose a means to include these tools into existing and/or new regulatory oversight and monitoring processes.

3. The **Speed to Market (EX) Working Group** will:
 - A. Consider proposed System for Electronic Rate and Form Filing (SERFF) features or functionality presented to the Working Group by the SERFF Advisory Board, likely originating from the SERFF Product Steering Committee (PSC). Upon approval and acquisition of any needed funding, direct the SERFF Advisory Board to implement the project. Receive periodic reports from the SERFF Advisory Board, as needed.
 - B. Provide feedback and recommendations concerning the SERFF modernization when requested by the Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive (EX) Committee.
 - C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies related to product filing needs, efficiencies and effective consumer protection. This includes the following activities:
 1. Provide a forum to gather information from the states and the industry regarding tools, policies and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly with regard to uniformity. Evaluate the state survey results compiled in 2020 regarding the usefulness of existing tools and potential new tools, and propose a plan to make improvements.

INNOVATION AND TECHNOLOGY (EX) TASK FORCE *(Continued)*

2. Use SERFF data to develop, refine, implement, collect and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts as measured by nationwide and individual state speed to market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
 3. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval and notification of changes. Monitor, assist with and report on state implementation of any PCM changes.
 4. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all of the operational efficiency tools and describes best practices for industry filers and state reviewers with regard to the rate and form filing and review process. Develop and implement a communication plan to inform states about the *Product Filing Review Handbook*.
- D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development and enhancements. Direct NAIC staff to provide individual state speed to market reports to each commissioner at each national meeting. Receive periodic reports from NAIC staff, as needed.
- E. Conduct the following activities as desired by the Interstate Insurance Product Regulation Commission (Compact):
1. Provide support to the Compact as the speed to market vehicle for asset-based insurance products, encouraging the states' participation in, and the industry's usage of, the Compact.
 2. Receive periodic reports from the Compact, as needed.

NAIC Support Staff: Scott Morris/Denise Matthews

LONG-TERM CARE INSURANCE (EX) TASK FORCE

Ongoing Support of NAIC Programs, Products or Services

1. The **Long-Term Care Insurance (EX) Task Force** will:
 - A. Recognizing the gravity of the threat posed by the current long-term care insurance (LTCI) environment both to consumers and our state-based system of insurance regulation, this Task Force is charged to:
 1. Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.
 2. Further evaluate and recommend options to provide consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases.
 3. Deliver such a proposal to the Executive (EX) Committee by the 2021 Summer National Meeting.
2. The **Long-Term Care Insurance Multistate Rate Review (EX) Subgroup** will:
 - A. Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The Subgroup should complete its charges by the 2021 Summer National Meeting.
3. The **Long-Term Care Insurance Financial Solvency (EX) Subgroup** will:
 - A. Explore restructuring options and techniques to address potential inequities between policyholders in different states and techniques to mitigate policyholders' risk to state guaranty fund benefit limits, including states' pre-rehabilitation planning options. Evaluate the work of the consultant and report on the work to the Task Force.
 - B. Monitor work performed by other NAIC solvency working groups and assist in the timely multi-state coordination/communication of the review of the financial condition of long-term care (LTC) insurers.
 - C. Complete its charges by the 2021 Summer National Meeting.

NAIC Support Staff: Jeffrey C. Johnston

SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

Ongoing Support of NAIC Programs, Products or Services

1. The **Special (EX) Committee on Race and Insurance** will:
 - A. Conduct research and analyze the level of diversity and inclusion within the insurance sector.
 - B. Engage with a broad group of stakeholders on issues related to race, diversity and inclusion in, and access to, the insurance sector and insurance products.
 - C. Examine and determine which current practices or barriers exist in the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups.
 - D. Make recommendations to the Executive (EX) Committee and membership by year-end regarding steps: 1) both state insurance regulators and the insurance industry can take to increase diversity and inclusion within the sector; 2) that should be taken to address practices that potentially disadvantage people of color and/or historically underrepresented groups; and 3) to ensure ongoing engagement of the NAIC on these issues through charges to its committees, task forces and working groups.

NAIC Support Staff: Andrew J. Beal/Michael F. Consedine

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

The mission of the Internal Administration (EX1) Subcommittee is to monitor the operations of the NAIC, including: 1) preparing a budget for Executive (EX) Committee review; 2) providing direction on personnel issues; 3) approving emergency expenditures; 4) evaluating the chief executive officer (CEO); and 5) assisting the CEO in resolving competing demands for NAIC staff resources.

Ongoing Support of NAIC Programs, Products or Services

1. The **Internal Administration (EX1) Subcommittee** will:
 - A. Review and approve all expenditures of funds not included in the annual budget by considering any fiscal impact statements of unbudgeted resource requests and reporting its actions to the Executive (EX) Committee.
 - B. Annually work with the CEO, chief operating officer/chief legal officer (COO/CLO), and chief financial officer (CFO) to review the business operations plan, which will incorporate the Executive (EX) Committee's strategic management initiatives, and report its actions to the Executive (EX) Committee.
 - C. Oversee a review of any management areas of the NAIC that should be designated for formal operational reviews by working with the CEO and COO/CLO.
 - D. Oversee the development, revision and delivery of all NAIC education programs, or the addition of new programs, by coordinating with other committees, as appropriate, and providing direction to the CEO and COO/CLO.
 - E. Receive a report at each national meeting from the NAIC Audit Committee, which will be chaired by the secretary-treasurer. The NAIC Audit Committee will meet with NAIC management at or before each national meeting, or more frequently as necessary, to review the NAIC financial statements and hear reports from NAIC management on emerging financial issues for the NAIC, and it will report such information to the Internal Administration (EX1) Subcommittee. The NAIC Audit Committee shall also carry out the following activities pursuant to its charter:
 1. Engage the NAIC's independent accountants with respect to the annual audit. This will include the appointment of an independent audit firm, a review of the results of the annual audit, and discussions with the independent auditors and NAIC management to ensure that all audit comments or suggestions are addressed in a timely manner.
 2. Engage the NAIC's service advisory firm. This will include the selection of an independent firm to provide Statement on Standards for Attestation Engagements (SSAE) services to the NAIC.
 - F. Serve as the primary liaison between the NAIC membership and the NAIC investment advisor, or appoint a subcommittee to act in that capacity, including receiving reports on the performance of the NAIC's investment portfolio and, from time to time, meeting directly with investment firm representatives to hear periodic reports and recommendations.
 - G. Review and revise, as necessary and appropriate, the criteria and categories for registrants at NAIC national meetings.
 - H. Appoint the Information Systems (EX1) Task Force to provide regulator-based technology expertise.
 - I. Conduct evaluations of the CEO and COO/CLO, and make appropriate recommendations to the Executive (EX) Committee. Consult with the CEO and COO/CLO on compensation of senior management.

NAIC Support Staff: Andrew J. Beal/Jim Woody

INFORMATION SYSTEMS (EX1) TASK FORCE

The mission of the Information Systems (EX1) Task Force is to: 1) provide regulator-based technology expertise to the Internal Administration (EX1) Subcommittee; and 2) support committee activities and objectives by monitoring projects that provide technical services or systems for state-based insurance regulation, as prioritized by the Executive (EX) Committee.

Ongoing Support of NAIC Programs, Products or Services

1. The **Information Systems (EX1) Task Force** will:
 - A. Serve as the Internal Administration (EX1) Subcommittee's project-independent technology monitor and consultant. This involves monitoring the development, deployment and operations of NAIC information technology (IT) systems and services for state insurance regulators and, based on this effort, providing reports and recommendations to the Subcommittee as appropriate. To achieve this, the Task Force will receive regular portfolio and technical operational reports.
 - B. Provide consultation to the NAIC technology staff, as well as the interpretation of intent and specific technology direction where needed. For example, from time to time, NAIC technology staff may request approval of a specific technology approach, such as a proposal to drop support for a particular version of software. The Task Force will provide direction in such matters, either directly or through a working group. Task Force members will also communicate current and future state technology changes planned for their state to alert NAIC technology staff of potential impacts and requirements for NAIC systems and services used by state insurance regulators.
 - C. Review, with technical recommendations for the Subcommittee: 1) Fiscal Impact Statements Appendix A for all *State Ahead* projects, as well as others involving a technology component exceeding \$100,000 or 1,150 hours of technology staff development and which is not limited to the support of the internal operations; and 2) project requests that involve technology being submitted to the Subcommittee or directly to the Executive (EX) Committee.

NAIC Support Staff: Cheryl McGee/Sherry Stevens

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

The mission of the Life Insurance and Annuities (A) Committee is to: 1) consider issues relating to life insurance and annuities; and 2) review new life insurance products.

Ongoing Support of NAIC Programs, Products or Services

1. The **Life Insurance and Annuities (A) Committee** will:
 - A. Monitor the activities of the Life Actuarial (A) Task Force.
2. The **Accelerated Underwriting (A) Working Group** will:
 - A. Consider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue; and, if appropriate, draft guidance for the states.
3. The **Annuity Disclosure (A) Working Group** will:
 - A. Review and revise, as necessary, Section 6—Standards for Annuity Illustrations in the *Annuity Disclosure Model Regulation* (#245) to take into account the disclosures necessary to inform consumers in light of the product innovations currently in the marketplace.
4. The **Annuity Suitability (A) Working Group** will:
 - A. Review and revise, as necessary, the *Suitability in Annuity Transactions Model Regulation* (#275).
 - B. Consider how to promote greater uniformity across NAIC member jurisdictions.
5. The **Life Insurance Illustration Issues (A) Working Group** will:
 - A. Explore how the narrative summary required by Section 7B of the *Life Insurance Illustrations Model Regulation* (#582) and the policy summary required by Section 5A(2) of the *Life Insurance Disclosure Model Regulation* (#580) can be enhanced to promote consumer readability and understandability of these life insurance policy summaries, including how they are designed, formatted and accessed by consumers.
6. The **Life Insurance Online Guide (A) Working Group** will:
 - A. Develop an online resource on life insurance, including the evaluation of existing content on the NAIC website, to be published digitally for the benefit of the public.
7. The **Retirement Security (A) Working Group** will:
 - A. Explore ways to promote retirement security consistent with the NAIC’s continuing “Retirement Security Initiative.”

NAIC Support Staff: Jennifer R. Cook/Jolie H. Matthews

LIFE ACTUARIAL (A) TASK FORCE

The mission of the Life Actuarial (A) Task Force is to identify, investigate and develop solutions to actuarial problems in the life insurance industry.

Ongoing Support of NAIC Programs, Products or Services

1. The **Life Actuarial (A) Task Force** will:
 - A. Work to keep reserve, reporting and other actuarial-related requirements current. This includes principle-based reserving (PBR) and other requirements in the *Valuation Manual*, actuarial guidelines, and recommendations for appropriate actuarial reporting in blanks. Respond to charges from the Life Insurance and Annuities (A) Committee and referrals from other groups or committees, as appropriate.
 - B. Report progress on all work to the Life Insurance and Annuities (A) Committee and provide updates to the Financial Condition (E) Committee on matters related to life insurance company solvency. This work includes the following:
 1. Work with the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) to develop new mortality tables for valuation and minimum nonforfeiture requirements, as appropriate, for life insurance and annuities.
 2. Provide recommendations for guidance and requirements for accelerated underwriting, as needed.
 3. Evaluate and provide recommendations regarding the VM-21, Requirements for Principle-Based Reserves for Variable Annuities/*Actuarial Guideline XLIII—CARVM Variable Annuities* (AG 43) Standard Projection Amount, which may include continuing as a required floor or providing a disclosure. This evaluation is to be completed prior to year-end 2023.
 4. Work with the SOA on the annual development of the Generally Recognized Expense Table (GRET) factors.
 5. Provide recommendations and changes, as appropriate, to other reserve and nonforfeiture requirements to address issues and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.
 6. Work with the selected vendor to develop and implement a new economic scenario generator (ESG) for use in regulatory reserve and capital calculations.
 7. Monitor international developments regarding life and health insurance reserving, capital, and related topics. Compare and benchmark with PBR requirements.
2. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
 - A. Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made.
 - B. Develop and recommend appropriate changes, including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.
3. The **Experience Reporting (A) Subgroup** will:
 - A. Continue development of the experience reporting requirements within the *Valuation Manual*. Provide input, as appropriate, for the process regarding the experience reporting agent, data collection, subsequent analysis, and use of experience submitted.
4. The **Indexed Universal Life (IUL) Illustration (A) Subgroup** will:
 - A. Monitor the results and practices of IUL illustrations following implementation of *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold On or After Dec. 14, 2020* (AG 49-A). Provide recommendations for consideration of changes to *Life Insurance Illustrations Model Regulation* (#582) to the Life Actuarial (A) Task Force, as needed.
5. The **Longevity Risk (E/A) Subgroup** of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:
 - A. Provide recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate. Complete by the 2021 Summer National Meeting.
6. The **Valuation Manual (VM)-22 (A) Subgroup** will:
 - A. Recommend requirements, as appropriate, for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Life Actuarial (A) Task Force. Continue working with the Academy on a PBR methodology for non-variable annuities.

LIFE ACTUARIAL (A) TASK FORCE *(Continued)*

7. The **Guaranteed Issue (GI) Life Valuation (A) Subgroup** will:
 - A. Provide recommendations regarding valuation requirements for GI life business, including any appropriate mortality table(s) for valuation, as well as nonforfeiture. Initial recommendations are to be provided to the Life Actuarial (A) Task Force by the 2021 Summer National Meeting.

NAIC Support Staff: Reggie Mazyck/Jennifer Frasier

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

The mission of the Health Insurance and Managed Care (B) Committee is to consider issues relating to all aspects of health insurance.

Ongoing Support of NAIC Programs, Products or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
 - A. Respond to inquiries from the U.S. Congress (Congress), the White House and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony, when requested.
 - B. Monitor the activities of the Health Actuarial (B) Task Force.
 - C. Monitor the activities of the Regulatory Framework (B) Task Force.
 - D. Monitor the activities of the Senior Issues (B) Task Force.
 - E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA) and URAC.
 - F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
 - G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
 - H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs) and packaged indemnity health products.
2. The **Consumer Information (B) Subgroup** will:
 - A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
 - B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.
3. The **Health Innovations (B) Working Group** will:
 - A. Gather and share information, best practices, experience and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
 - B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision-making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
 - C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
 - D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to utilize the information gathered by the Working Group.
 - E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

HEALTH ACTUARIAL (B) TASK FORCE

The mission of the Health Actuarial (B) Task Force is to identify, investigate and develop solutions to actuarial problems in the health insurance industry.

Ongoing Support of NAIC Programs, Products or Services

1. The **Health Actuarial (B) Task Force** will:
 - A. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices and rate changes.
 - B. Provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).
 - C. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
 - D. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
 - E. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary to other NAIC groups relative to their work on health actuarial matters.
2. The **Health Care Reform Actuarial (B) Working Group** will:
 - A. Assist the Health Actuarial (B) Task Force in completing its charge to provide support for issues related to implementation of, and/or changes to, the ACA.
3. The **Long-Term Care Actuarial (B) Working Group** will:
 - A. Assist the Health Actuarial (B) Task Force in completing the following charges:
 1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices and rate changes.
 2. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
 3. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

NAIC Support Staff: Eric King

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products and Services

1. The **Regulatory Framework (B) Task Force** will:
 - A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
 - B. Review managed health care reforms, their delivery systems occurring in the marketplace and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority and structures.
 - C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
 - D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2021.
 - E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze and report developments related to association health plans (AHPs).
 - F. Monitor, analyze and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.
2. The **Accident and Sickness Insurance Minimum Standards (B) Subgroup** will:
 - A. Review and consider revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).
3. The **ERISA (B) Working Group** will:
 - A. Monitor, report and analyze developments related to the federal ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
 - B. Monitor, facilitate and coordinate with the states and the U.S. Department of Labor (DOL) related to sham health plans.
 - C. Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.
 - D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) and modify it, as necessary, to reflect developments related to ERISA. Report annually.
4. The **Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group** will:
 - A. Monitor, report and analyze developments related to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and make recommendations regarding NAIC strategy and policy with respect to those developments.
 - B. Monitor, facilitate and coordinate best practices with the states, the DOL and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
 - C. Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to the MHPAEA.
 - D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC *Market Regulation Handbook*.
 - E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.
5. The **Pharmacy Benefit Manager Regulatory Issues (B) Subgroup** will:
 - A. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook

SENIOR ISSUES (B) TASK FORCE

The mission of the Senior Issues (B) Task Force is to: 1) consider policy issues; 2) develop appropriate regulatory standards; and 3) revise, as necessary, the NAIC models, consumer guides and training material on Medicare supplement insurance, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

Ongoing Support of NAIC Programs, Products or Services

1. The **Senior Issues (B) Task Force** will:
 - A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans. Review the *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
 - B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist the states, as necessary, with regulatory issues. Maintain a dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Assist the states and serve as a clearinghouse for information on Medicare Advantage plan activity.
 - C. Provide the perspective of state insurance regulators to the U.S. Congress (Congress), as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations with respect to senior health care initiatives and other impacts on the states.
 - D. Monitor developments concerning the State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Provide assistance to the states with issues relating to SHIPs and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials, as appropriate, on issues concerning SHIPs.
 - E. Monitor, maintain and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.
 - F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Review the existing *Long-Term Care Insurance Model Act* (#640), the *Long-Term Care Insurance Model Regulation* (#641), the *Limited Long-Term Care Insurance Model Act* (#642), and the *Limited Long-Term Care Insurance Model Regulation* (#643) to determine their flexibility to remain compatible with the evolving delivery of long-term care (LTC) services and the evolving LTCI marketplace. Work with federal agencies, as appropriate.
 - G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces and working groups on possible solutions.
2. The **Long-Term Care Insurance (LTCI) Model Update (B) Subgroup** will:
 - A. Review and update Model #640 and Model #641 to determine their flexibility to remain compatible with the evolving delivery of LTC services and the evolving LTCI marketplace.
 - B. Update Model #642 and Model #643 to correlate with Model #640 and Model #641.
 - C. Consider recommendations referred from the Long-Term Care Insurance (EX) Task Force and/or its subgroups.

NAIC Support Staff: David Torian

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Property and Casualty Insurance (C) Committee** will:
 - A. Discuss issues arising and make recommendations with respect to advisory organization and insurer filings for personal and commercial lines, as needed. Report yearly.
 - B. Monitor the activities of the Casualty Actuarial and Statistical (C) Task Force.
 - C. Monitor the activities of the Surplus Lines (C) Task Force.
 - D. Monitor the activities of the Title Insurance (C) Task Force.
 - E. Monitor the activities of the Workers' Compensation (C) Task Force.
 - F. Provide an impartial forum for considering appeals of adverse decisions involving alien insurers delisted or rejected for listing to the *Quarterly Listing of Alien Insurers*. Appeal procedures are described in the International Insurers Department (IID) Plan of Operation.
 - G. Monitor and review developments in case law and rehabilitation proceedings related to risk-retention groups (RRGs). If warranted, make appropriate changes to the *Risk Retention and Purchasing Group Handbook*.
 - H. Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators:
 1. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation.
 2. Review law changes and court decisions and, if warranted, make appropriate changes to the *Federal Crop Insurance Program Handbook: A Guide for Insurance Regulators*.
 3. Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvement or revisions, as needed.
 - I. Report on the cyber insurance market including data reported within the Cybersecurity Insurance and Identity Theft Coverage Supplement.
 - J. Monitor and discuss regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.
2. The **Cannabis Insurance (C) Working Group** will:
 - A. Assess and periodically report on the status of federal legislation that would protect financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.
 - B. Encourage admitted insurers to ensure coverage adequacy in states where cannabis, including hemp, is legal.
 - C. Provide insurance resources to stakeholders and keep up with new products and innovative ideas that may shape insurance in this space.
 - D. Collect aggregated insurance availability and coverage gap information, as well as other cannabis and hemp insurance-related data, to then share in a publicly released report by the end of 2021.
3. The **Catastrophe Insurance (C) Working Group** will:
 - A. Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
 - B. Evaluate potential state, regional and national programs to increase capacity for insurance and reinsurance related to catastrophe perils.
 - C. Monitor and assess proposals that address disaster insurance issues at the federal and state levels. Assess concentration-of-risk issues and whether a regulatory solution is needed.
 - D. Provide a forum for discussing issues and recommending solutions related to insuring for catastrophe risk, including terrorism, war and natural disasters.
 - E. Provide a forum for discussing various issues related to catastrophe modeling, and monitor issues that will result in changes to the *Catastrophe Computer Modeling Handbook*.
 - F. Investigate and recommend ways the NAIC can assist states in responding to disasters, while building a central repository of timely resources for state insurance regulators to better prepare for disasters.
 - G. Continue to monitor the growth of the private flood insurance market and assess the actions taken by individual states to facilitate growth. Update the Considerations for Private Flood Insurance appendix to include new ways states are growing the private flood insurance market.

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE (Continued)

- H. Study, in coordination with other NAIC task forces and working groups, earthquake matters of concern to state insurance regulators. Consider various innovative earthquake insurance coverage options aimed at improving take-up rates.

- 4. The **Pet Insurance (C) Working Group** will:
 - A. Complete the development of a model law to establish appropriate regulatory standards for the pet insurance industry.

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

- 6. The **Transparency and Readability of Consumer Information (C) Working Group** will:
 - A. Study and evaluate actions that will improve the capacity of consumers to comparison shop based on differences in coverage provided by different insurance carriers offering personal lines products.
 - B. Facilitate consumers' capacity to understand the content of insurance policies and assess differences in insurers' policy forms.
 - C. Assist other groups with drafting language included within consumer-facing documents.
 - D. Consider drafting regulatory best practices that serve to inform consumers of the reasons for significant premium increases related to property/casualty (P/C) insurance products.
 - E. Update and develop webpage and mobile content for *A Shopping Tool for Homeowners Insurance* and *A Shopping Tool for Automobile Insurance*.
 - F. Consider the possibility of disclosures or consumer education information regarding the fact that homeowners policies do not cover losses from flood, earthquake or other specified disasters

NAIC Support Staff: Aaron Brandenburg/Jennifer Gardner

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

The mission of the Casualty Actuarial and Statistical (C) Task Force is to identify, investigate, and develop solutions to actuarial problems and statistical issues in the property/casualty (P/C) insurance industry. The Task Force's goals are to assist state insurance regulators with maintaining the financial health of P/C insurers; ensuring that P/C insurance rates are not excessive, inadequate or unfairly discriminatory; and ensuring that appropriate data regarding P/C insurance markets are available.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Casualty Actuarial and Statistical (C) Task Force** will:
 - A. Provide reserving, pricing, ratemaking, statistical, and other actuarial support to NAIC committees, task forces and/or working groups. Propose changes to the appropriate work products (with the most common work products noted below) and present comments on proposals submitted by others relating to casualty actuarial and statistical matters. Monitor the activities, including the development of financial services regulations and statistical (including disaster) reporting, regarding casualty actuarial issues.
 1. Property and Casualty Insurance (C) Committee – ratemaking, reserving or data issues.
 2. Blanks (E) Working Group – P/C annual financial statement, including Schedule P; P/C quarterly financial statement; P/C quarterly and annual financial statement instructions, including Statement of Actuarial Opinion (SAO) and Actuarial Opinion Summary Supplement.
 3. Capital Adequacy (E) Task Force – P/C risk-based capital (RBC) report.
 4. Group Solvency Issues (E) Working Group and ORSA Implementation (E) Subgroup – Own Risk and Solvency Assessment (ORSA).
 5. Statutory Accounting Principles (E) Working Group – *Accounting Practices and Procedures Manual* (AP&P Manual), and review and provide comments on statutory accounting issues being considered under *SSAP No. 65—Property and Casualty Contracts*.
 6. Speed to Market (EX) Working Group – P/C actuarial sections of the *Product Filing Review Handbook*.
 - B. Monitor national casualty actuarial developments and consider regulatory implications.
 1. Casualty Actuarial Society (CAS) – Statements of Principles and *Syllabus of Basic Education*.
 2. American Academy of Actuaries (Academy) – Standards of Practices, Council on Professionalism, and Casualty Practice Council.
 3. Society of Actuaries (SOA) – general insurance track's basic education.
 4. Federal legislation.
 - C. Facilitate discussion among state insurance regulators regarding rate filing issues of common interest across the states through the scheduling of regulator-only conference calls.
 - D. Work with the CAS and SOA to identify: 1) what types of learning P/C Appointed Actuaries are using to meet CE requirements for "Specific Qualification Standards" today and 2) whether more specificity should be added to the P/C Appointed Actuaries' CE requirements to ensure that CE is aligned with the educational needs for a P/C Appointed Actuary.
 - E. Facilitate training and the sharing of expertise through predictive analytics webinars (Book Club).
2. The **Actuarial Opinion (C) Working Group** will:
 - A. Propose revisions to the following, as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:
 1. *Financial Analysis Handbook*.
 2. *Financial Condition Examiners Handbook*.
 3. *Annual Statement Instructions—Property/Casualty*.
 4. Regulatory guidance to appointed actuaries and companies.
 5. Other financial blanks and instructions, as needed.
3. The **Statistical Data (C) Working Group** will:
 - A. Consider updates and changes to the *Statistical Handbook of Data Available to Insurance Regulators*.
 - B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically evaluate the demand and utility versus the costs of production of each product.
 1. *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance*.
 2. *Auto Insurance Database*.
 3. *Competition Database Report*.
 4. *Report on Profitability by Line by State*.

NAIC Support Staff: Kris DeFrain/Jennifer Gardner/Libby Crews

SURPLUS LINES (C) TASK FORCE

The mission of the Surplus Lines (C) Task Force is to monitor the surplus lines market and regulation, including the activity and financial condition of U.S. and alien surplus lines insurers by providing a forum for discussion of issues and to develop or amend relevant NAIC model laws, regulations and/or guidelines.

Ongoing Support of NAIC Programs, Products or Services

1. The **Surplus Lines (C) Task Force** will:
 - A. Provide a forum for discussion of current and emerging surplus lines-related issues and topics of public policy and determine appropriate regulatory response and action.
 - B. Review and analyze quantitative and qualitative data on U.S. domestic and alien surplus lines industry results and trends.
 - C. Monitor federal legislation related to the surplus lines market and ensure all interested parties remain apprised.
 - D. Develop or amend relevant NAIC model laws, regulations and/or guidelines.
 - E. Oversee the activities of the Surplus Lines (C) Working Group.

2. The **Surplus Lines (C) Working Group** will:
 - A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing surplus lines topics and policy issues, such as amendments to the International Insurers Department (IID) Plan of Operation.
 - B. Maintain and draft new guidance within the IID Plan of Operation regarding standards for admittance and continued inclusion on the NAIC *Quarterly Listing of Alien Insurers*.
 - C. Review and consider appropriate decisions regarding applications for admittance to the NAIC *Quarterly Listing of Alien Insurers*.
 - D. Analyze renewal applications of alien surplus lines insurers on the NAIC *Quarterly Listing of Alien Insurers* and ensure solvency and compliance per the IID Plan of Operation guidelines for continued listing.
 - E. Provide a forum for surplus lines-related discussion among jurisdictions.

NAIC Support Staff: Andy Daleo/Robert Schump

TITLE INSURANCE (C) TASK FORCE

The mission of the Title Insurance (C) Task Force is to study issues related to title insurers and title insurance producers.

Ongoing Support of NAIC Programs, Products or Services

1. The **Title Insurance (C) Task Force** will:
 - A. Monitor issues and developments occurring in the title insurance industry, and provide support and expertise to other NAIC committees, task forces and/or working groups, or outside entities, as appropriate.
 - B. Review and assist various regulatory bodies in combating fraudulent and/or unfair real estate settlement activities. Such efforts could include working with the Antifraud (D) Task Force and other NAIC committees, task forces and/or working groups to combat mortgage fraud and mitigating title agent defalcations through the promotion of closing protection letters (CPLs) and other remedies. Report results at each national meeting.
 - C. Consult with the Consumer Financial Protection Bureau (CFPB) and other agencies responsible for information; education; and disclosure for mortgage lending, closing and settlement services about the role of title insurance in the real estate transaction process.
 - D. Consider the effectiveness of changes in financial reporting by title insurance companies, and identify further improvements and clarifications to blanks, instructions, Statement of Statutory Accounting Principles (SSAPs), solvency tools, and other matters, as necessary. Coordinate efforts with the Statutory Accounting Principles (E) Working Group.
 - E. Revise the Title Insurance Consumer Shopping Tool Template to include questions and answers about title insurance-related fraud topics, including but not limited to, CPLs and wire fraud.
 - F. Evaluate the effectiveness of CPLs, including but not limited to, intent, state regulation and requirements, consumer protections offered and excluded, and potential alternatives for coverage.
 - G. Explore short-term and long-term issues and solutions from the pandemic.

NAIC Support Staff: Anne Obersteadt

WORKERS' COMPENSATION (C) TASK FORCE

The mission of the Workers' Compensation (C) Task Force is to study the nature and effectiveness of state approaches to workers' compensation and related issues, including, but not limited to: assigned risk plans; safety in the workplace; treatment of investment income in rating; occupational disease; cost containment; and the relevance of adopted NAIC model laws, regulations and/or guidelines pertaining to workers' compensation.

Ongoing Support of NAIC Programs, Products or Services

1. The **Workers' Compensation (C) Task Force** will:
 - A. Oversee the activities of the NAIC/International Association of Industrial Accident Boards and Commissions (IAIABC) Joint (C) Working Group.
 - B. Discuss issues with respect to advisory organizations, rating organizations, statistical agents and insurance companies in the workers' compensation arena.
 - C. Monitor the movement of business from the standard markets to the assigned risk pools. Alert state insurance department representatives if the growth of assigned risk pools changes dramatically.
 - D. Follow workers' compensation issues regarding cannabis in coordination with the Cannabis Insurance (C) Working Group.
 - E. Discuss workers' compensation issues related to COVID-19.
2. The **NAIC/IAIABC Joint (C) Working Group** will:
 - A. Study issues of mutual concern to state insurance regulators and the IAIABC. Review relevant IAIABC model laws and white papers and consider possible changes in light of the Working Group's recommendations.

NAIC Support Staff: Sara Robben/Aaron Brandenburg

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

The mission of the Market Regulation and Consumer Affairs (D) Committee is to monitor all aspects of the market regulatory process for continuous improvement. This includes market analysis, regulatory interventions with companies, and multi-jurisdictional collaboration. The Committee will also review and make recommendations regarding the underwriting and market practices of insurers and producers, as those practices affect insurance consumers, including the availability and affordability of insurance.

Ongoing Support of NAIC Programs, Products or Services

1. The **Market Regulation and Consumer Affairs (D) Committee** will:
 - A. Monitor the centralized collection and storage of market conduct data, national analysis, and reporting at the NAIC, including issues regarding the public availability of data.
 - B. Monitor and assess the current process for multi-jurisdictional market conduct activities and provide appropriate recommendations for enhancement, as necessary.
 - C. Evaluate all data currently collected in the NAIC Market Information Systems (MIS) and considered confidential to determine what, if any, can be made more widely available.
 - D. Oversee the activities of the Antifraud (D) Task Force.
 - E. Oversee the activities of the Market Information Systems (D) Task Force.
 - F. Oversee the activities of the Producer Licensing (D) Task Force.
 - G. Monitor the underwriting and market practices of insurers and producers, as well as the conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
 - H. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
 - I. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
 - J. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
 - K. Review the “Best Practices and Guidelines for Consumer Information Disclosures” (adopted October 2012) and update, as needed.
2. The **Advisory Organization Examination Oversight (D) Working Group** will:
 - A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive, efficient, and possibly less frequent than the current system of single-state exams. Solicit input and collaboration from other interested and affected committees and task forces.
 - B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
 - C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).
3. The **Market Actions (D) Working Group** will:
 - A. Facilitate interstate communication and coordinate collaborative state regulatory actions.
4. The **Market Analysis Procedures (D) Working Group** will:
 - A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.
 - B. Discuss other market data collection issues and make recommendations, as necessary.
 - C. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS).
5. The **Market Conduct Annual Statement Blanks (D) Working Group** will:
 - A. Review the MCAS data elements and the “Data Call and Definitions” for those lines of business that have been in effect for longer than three years and update them, as necessary.
 - B. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE (Continued)

6. The **Market Conduct Examination Guidelines (D) Working Group** will:
 - A. Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook*.
 - B. Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models.
 - C. Develop updated standardized data requests, as necessary, for inclusion in the *Market Regulation Handbook*.
 - D. Develop uniform market conduct procedural guidance (e.g., a library, depository or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook*.
 - E. Coordinate with the Innovation and Technology (EX) Task Force to develop market conduct examiner guidance for the oversight of regulated entities' use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
 - F. Discuss the effectiveness of a group's supervision of market conduct risks and develop examination procedural guidance, as necessary.
 - G. Discuss the role of market conduct examiners in reviewing insurers' corporate governance as outlined in the NAIC's *Corporate Governance Annual Disclosure Model Act* (#305) and *Corporate Governance Annual Disclosure Model Regulation* (#306).

7. The **Market Regulation Certification (D) Working Group** will:
 - A. Develop a formal market regulation certification proposal for consideration by the NAIC membership that provides recommendations for the following: 1) certification standards; 2) a process for the state implementation of the standards; 3) a process to measure the states' compliance with the standards; 4) a process for future revisions to the standards; and 5) assistance for jurisdictions to achieve certification.

8. The **Privacy Protections (D) Working Group** will:
 - A. Review state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions and make recommended changes, as needed, to certain NAIC models, such as the *NAIC Insurance Information and Privacy Protection Model Act* (#670) and the *Privacy of Consumer Financial and Health Information Regulation* (#672).

NAIC Support Staff: Tim Mullen/Randy Helder

ANTIFRAUD (D) TASK FORCE

The mission of the Antifraud (D) Task Force is to serve the public interest by assisting the state insurance supervisory officials, individually and collectively, through the detection, monitoring and appropriate referral for the investigation of insurance crime, both by and against consumers. The Task Force will assist the insurance regulatory community by conducting the following activities: 1) maintain and improve electronic databases regarding fraudulent insurance activities; 2) disseminate the results of research and analysis of insurance fraud trends, as well as case-specific analysis, to the insurance regulatory community; and 3) provide a liaison function between state insurance regulators, law enforcement (federal, state, local and international), and other specific antifraud organizations. The Task Force will also serve as a liaison with the NAIC Information Technology Group (ITG) and other NAIC committees, task forces and/or working groups to develop technological solutions for data collection and information sharing. The Task Force will monitor all aspects of antifraud activities by its working groups on the following charges.

Ongoing Support of NAIC Programs, Products or Services

1. The **Antifraud (D) Task Force** will:
 - A. Work with NAIC committees, task forces and working groups (e.g., Title Insurance (C) Task Force, etc.) to review issues and concerns related to fraud activities and schemes related to insurance fraud.
 - B. Coordinate efforts to address national concerns related to agent fraud and activities of unauthorized agents related to insurance sales.
 - C. Coordinate the enforcement and investigation efforts of state and federal securities regulators with state insurance fraud bureaus.
 - D. Coordinate with state, federal and international law enforcement agencies in addressing antifraud issues relating to the insurance industry.
 - E. Review and provide comments to the International Association of Insurance Supervisors (IAIS) on its Insurance Core Principles (ICPs) related to insurance fraud.
 - F. Coordinate activities and information from national antifraud organizations and provide information to state insurance fraud bureaus.
 - G. Coordinate activities and information with state and federal fraud divisions to determine guidelines that will assist with reciprocal involvement concerning antifraud issues resulting from natural disasters and catastrophes.
 - H. Coordinate efforts with the insurance industry to address antifraud issues and concerns.
 - I. Evaluate and recommend methods to track national fraud trends.
2. The **Antifraud Education Enhancement (D) Working Group** will:
 - A. Develop seminars, trainings and webinars regarding insurance fraud. Provide three webinars by the 2021 Fall National Meeting.
3. The **Antifraud Technology (D) Working Group** will:
 - A. Review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.
 - B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2021 Fall National Meeting.

NAIC Support Staff: Greg Welker/Lois E. Alexander

MARKET INFORMATION SYSTEMS (D) TASK FORCE

The mission of the Market Information Systems (D) Task Force is to provide business expertise regarding the desired functionality of the NAIC Market Information Systems (MIS) and the prioritization of regulatory requests for the development and enhancements of the MIS.

Ongoing Support of NAIC Programs, Products or Services

1. The **Market Information Systems (D) Task Force** will:
 - A. Ensure that the MIS support the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee.
 - B. Develop recommendations for the incorporation of artificial intelligence (AI) abilities in MIS for use in market analysis. Complete by the 2021 Fall National Meeting.
 - C. Analyze the data in the MIS. If needed, recommend methods to ensure better data quality. Complete by the 2021 Fall National Meeting.
 - D. Provide guidance on the appropriate use of the MIS and the data entered in them.
 1. Complaints Database System (CDS).
 2. Electronic Forums.
 3. Market Actions Tracking System (MATS).
 4. Market Analysis Profile.
 5. Market Analysis Prioritization Tool (MAPT).
 6. Market Analysis Review System (MARS).
 7. Market Conduct Annual Statement (MCAS).
 8. Regulatory Information Retrieval System (RIRS).
 9. 1033 State Decision Repository (in conjunction with the Antifraud (D) Task Force).
2. The **Market Information Systems Research and Development (D) Working Group** will:
 - A. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.
 - B. Assist the Task Force with tasks as assigned, such as:
 1. Analyze MIS data.
 2. Provide state users with query access to MIS data.
 3. Provide guidance on the appropriate use of the MIS.

NAIC Support Staff: Randy Helder

PRODUCER LICENSING (D) TASK FORCE

The mission of the Producer Licensing (D) Task Force is to: 1) develop and implement uniform standards, interpretations and treatment of producer and adjuster licensees and licensing terminology; 2) monitor and respond to developments related to licensing reciprocity; 3) coordinate with industry and consumer groups regarding priorities for licensing reforms; and 4) provide direction based on NAIC membership initiatives to the National Insurance Producer Registry (NIPR) Board of Directors regarding the development and implementation of uniform producer licensing initiatives, with a primary emphasis on encouraging the use of electronic technology.

Ongoing Support of NAIC Programs, Products or Services

1. The **Producer Licensing (D) Task Force** will:
 - A. Work closely with NIPR to encourage the full utilization of NIPR products and services by all of the states and producers, and encourage accurate and timely reporting of state administrative actions to the NAIC's Regulatory Information Retrieval System (RIRS) to ensure that this data is properly reflected in the State Producer Licensing Database (SPLD) and the Producer Database (PDB).
 - B. Facilitate roundtable discussions, as needed, with the state producer licensing directors for the exchange of views, opinions and ideas on producer licensing activities in the states and at the NAIC.
 - C. Discuss, as necessary, state perspectives regarding the regulation and benefit of the activities of the federal Affordable Care Act (ACA), established enrollment assisters (including navigators and non-navigator assisters and certified application counselors), and the activities of producers in assisting individuals and businesses purchasing in the health insurance marketplaces. Coordinate with the Health Insurance and Managed Care (B) Committee and the Antifraud (D) Task Force, as necessary.
 - D. Monitor the activities of the National Association of Registered Agents and Brokers (NARAB) in the development and enforcement of the NARAB membership rules, including the criteria for successfully passing a background check.
 - E. Coordinate through NAIC staff to provide guidance to NIPR on producer licensing-related electronic initiatives. Hear a report from NIPR at each national meeting.
 - F. Coordinate with the Market Information Systems (D) Task Force and the Antifraud (D) Task Force to evaluate and make recommendations regarding the entry, retention and use of data in the NAIC's Market Information Systems (MIS).
 - G. Monitor the state implementation of adjuster licensing reciprocity and uniformity; update, as necessary, NAIC adjuster licensing standards.
 - H. Finalize the white paper on the role of chatbots and artificial intelligence (AI) in the distribution of insurance and the regulatory supervision of these technologies by the 2021 Spring National Meeting.
 - I. Draft procedures for amending the NAIC's uniform producer licensing applications and uniform appointment form to ensure consistency with the NAIC membership's goal of maintaining uniform and stable applications that encourage the efficient use of electronic technology.
2. The **Producer Licensing Uniformity (D) Working Group** will:
 - A. Work closely with state producer licensing directors and exam vendors to ensure that: 1) the states achieve full compliance with the standards in order to achieve greater uniformity; and 2) the exams test the qualifications for an entry-level position as a producer.
 - B. Provide oversight and ongoing updates, as needed, to the *State Licensing Handbook*.
 - C. Monitor and assess the state implementation of the Uniform Licensing Standards (ULS) and update the standards, as needed.
 - D. Review and update, as needed, the NAIC's uniform producer licensing applications and uniform appointment form. Provide any recommended updates to the Producer Licensing (D) Task Force by June 1.
3. The **Uniform Education (D) Working Group** will:
 - A. Update, as needed, the reciprocity guidelines, the uniform application forms for continuing education (CE) providers, and the process for state review and approval of courses. Provide any recommended updates to the Producer Licensing (D) Task Force by the 2021 Fall National Meeting.
 - B. Coordinate with NAIC parent committees, task forces and/or working groups to review and provide recommendations, as necessary, on precensing education and CE requirements that are included in NAIC model acts, regulations and/or standards.

NAIC Support Staff: Tim Mullen/Greg Welker

FINANCIAL CONDITION (E) COMMITTEE

The mission of the Financial Condition (E) Committee is to be the central forum and coordinator of solvency-related considerations of the NAIC relating to accounting practices and procedures; blanks; valuation of securities; financial analysis and solvency; multistate examinations and examiner and analysis training; and issues concerning insurer insolvencies and insolvency guarantees. In addition, the Committee interacts with the technical task forces.

Ongoing Support of NAIC Programs, Products or Services

1. The **Financial Condition (E) Committee** will:
 - A. Monitor all of the changes to the annual/quarterly financial statement blanks and instructions, risk-based capital (RBC) formulas, *Financial Condition Examiners Handbook*, *Accounting Practices and Procedures Manual* (AP&P Manual), *Financial Analysis Handbook*, *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), NAIC model laws, NAIC accreditation standards, and other NAIC publications.
 - B. Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.
 - C. Oversee a process to address financial issues that may compromise the consistency and uniformity of the U.S. solvency framework, referring valuation and other issues to the appropriate committees as needed.
 - D. Use the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy, and review any issues industry subsequently escalates to the Committee.

2. The **Financial Analysis (E) Working Group** will:
 - A. Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.
 - B. Interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and action(s).
 - C. Support, encourage, promote and coordinate multistate efforts in addressing solvency problems, including identifying adverse industry trends.
 - D. Increase information-sharing and coordination between state regulators and federal authorities, including through representation of state regulators in national bodies with responsibilities for system-wide oversight.

3. The **Group Capital Calculation (E) Working Group** will:
 - A. Continually review and monitor the effectiveness of the group capital calculation (GCC), and consider revisions, as necessary, to maintain the effectiveness of its objective under the U.S. solvency system.
 - B. Develop regulatory guidance related to the GCC. Complete by the 2021 Summer National Meeting.
 - C. Liaise, as necessary, with the International Insurance Relations (G) Committee on international group capital developments, and consider input from participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.

4. The **Group Solvency Issues (E) Working Group** will:
 - A. Continue to develop potential enhancements to the current regulatory solvency system as it relates to group solvency-related issues.
 - B. Critically review and provide input and drafting to the IAIS, Insurance Groups Working Group or on other IAIS material dealing with group supervision issues.
 - C. Continually review and monitor the effectiveness of the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450), and consider revisions as necessary to maintain effective oversight of insurance groups
 - D. Assess the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame), and make recommendations on its implementation in a manner appropriate for the U.S.

5. The **Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup** of the Group Solvency Issues (E) Working Group will:
 - A. Continue to provide and enhance an enterprise risk management (ERM) education program for regulators in support of the ORSA implementation.
 - B. Continually review and monitor the effectiveness of the *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) and its corresponding *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual*; consider revisions as necessary.

FINANCIAL CONDITION (E) COMMITTEE (Continued)

6. The **Mortgage Guaranty Insurance (E) Working Group** will:
 - A. Develop changes to the *Mortgage Guaranty Insurance Model Act* (#630) and other areas of the solvency regulation of mortgage guaranty insurers, including, but not limited to, revisions to *Statement of Statutory Accounting Principles (SSAP) No. 58—Mortgage Guaranty Insurance*, and develop an extensive mortgage guaranty supplemental filing. Finalize Model #630 by the 2021 Spring National Meeting.

7. The **NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group** will:
 - A. Continually review the *Annual Financial Reporting Model Regulation* (#205) and its corresponding implementation guide; revise as appropriate.
 - B. Address financial solvency issues by working with the AICPA and responding to AICPA exposure drafts.
 - C. Monitor the federal Sarbanes-Oxley Act, as well as rules and regulations promulgated by the U.S. Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board (PCAOB) and other financial services regulatory entities.
 - D. Review annually the premium threshold amount included in Section 16 of Model #205, with the general intent that those insurers subject to the Section 16 requirements would capture at least approximately 90% of industry premium and/or in response to any future regulatory or market developments.

8. The **National Treatment and Coordination (E) Working Group** will:
 - A. Increase utilization and implementation of the *Company Licensing Best Practices Handbook*.
 - B. Encourage synergies between corporate changes/amendments and rate and form filing review and approval to improve efficiency.
 - C. Continue to monitor the usage and make necessary enhancements to the Form A Database.
 - D. Maintain educational courses in the existing NAIC Insurance Regulator Professional Designation Program for company licensing regulators.
 - E. Make necessary enhancements to promote electronic submission of all company licensing applications.

9. The **Biographical Third-Party Review (E) Subgroup** of the National Treatment and Coordination (E) Working Group will:
 - A. Increase the uniformity of the third-party vendors that prepare background investigative reports to those state insurance departments that require them. Reduce the inefficiency of applications by developing procedures and approval processes.
 - B. Monitor the ongoing adherence of background investigation reports and third-party vendors.
 - C. Encourage uniformity of requirements in relation to individuals' fitness and propriety and the company's responsibility in notifying state insurance departments of concerns or changes to key individuals.

10. The **Restructuring Mechanisms (E) Working Group** will:
 - A. Evaluate and prepare a white paper that:
 1. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
 2. Summarizes the existing state restructuring statutes.
 3. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
 4. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring. Complete by the 2021 Summer National Meeting.
 - B. Identifies and addresses the legal issues associated with restructuring using a protected cell. Complete by the 2021 Summer National Meeting.
 - C. Consider requesting approval from the Executive (EX) Committee on developing changes to specific NAIC models as a result of findings from the development of the white paper. Complete by the 2021 Summer National Meeting.

11. The **Restructuring Mechanisms (E) Subgroup** of the Restructuring Mechanisms (E) Working Group will:
 - A. Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long-term liquidity needs. Also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration. Complete by the 2021 Summer National Meeting.

FINANCIAL CONDITION (E) COMMITTEE (Continued)

- B. Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff. Complete by the 2021 Fall National Meeting.
 - C. Review the various restructuring mechanisms and develop, if deemed needed, protected cell accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group. Complete by the 2021 Fall National Meeting.
12. The **Risk-Focused Surveillance (E) Working Group** will:
- A. Continually review the effectiveness of risk-focused surveillance, and develop enhancements to processes as necessary.
 - B. Continually review regulatory redundancy issues identified by interested parties, and provide recommendations to other NAIC committee groups to address as needed.
 - C. Oversee and monitor the Peer Review Program to encourage consistent and effective risk-focused surveillance processes.
 - D. Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.
13. The **Valuation Analysis (E) Working Group** will:
- A. Respond to states in a confidential forum regarding questions and issues arising during the course of annual principle-based reserving (PBR) reviews or PBR examination and which also may include consideration of asset adequacy analysis questions and issues.
 - B. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding PBR and asset adequacy analysis including actuarial guidelines or other requirements making use of or relating to PBR, such as *Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation* (AG 38), *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued Under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation* (AG 48), and the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787).
 - C. Develop and implement a plan with NAIC resources to identify outliers/concerns regarding PBR/asset adequacy analysis.
 - D. Refer questions/issues as appropriate to the Life Actuarial (A) Task Force that may require consideration of changes/interpretations to be provided in the *Valuation Manual*.
 - E. Assist NAIC resources in development of a standard asset/liability model portfolio used to calibrate company PBR models.
 - F. Make referrals as appropriate to the Financial Analysis (E) Working Group.
 - G. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

NAIC Support Staff: Dan Daveline/Julie Gann/Bruce Jensen

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

The mission of the Accounting Practices and Procedures (E) Task Force is to identify, investigate and develop solutions to accounting problems with the ultimate goal of guiding insurers in properly accounting for various aspects of their operations; modify the *Accounting Practices and Procedures Manual* (AP&P Manual) to reflect changes necessitated by Task Force action; and study innovative insurer accounting practices that affect the ability of state insurance regulators to determine the true financial condition of insurers.

Ongoing Support of NAIC Programs, Products or Services

1. The **Accounting Practices and Procedures (E) Task Force** will:
 - A. Oversee the activities of the Blanks (E) Working Group and the Statutory Accounting Principles (E) Working Group.
2. The **Blanks (E) Working Group** will:
 - A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
 1. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in reporting of financial information by insurers.
 2. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
 3. Conform the various NAIC blanks and instructions to adopted NAIC policy.
 4. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
 - B. Continue to monitor state filing checklists to maintain current filing requirements.
 - C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the *Annual Statement Instructions*.
 - D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
 - E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these task forces.
 - F. Coordinate with the Life Actuarial (A) Task Force to use any special reports developed and avoid duplication of reporting.
 - G. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Capital Adequacy (E) Task Force and its working groups.
 - H. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.
3. The **Statutory Accounting Principles (E) Working Group** will:
 - A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.
 - B. At the discretion of the Working Group chair, develop comments on exposed GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
 - C. Coordinate with the Life Actuarial (A) Task Force on changes to the AP&P Manual related to the *Valuation Manual* VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other *Valuation Manual* requirements. This process will include the receipt of periodic reports on changes to the *Valuation Manual* on items that require coordination.
 - D. Obtain, analyze and review information on permitted practices, prescribed practices or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.

NAIC Support Staff: Robin Marcotte

CAPITAL ADEQUACY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Capital Adequacy (E) Task Force** will:
 - A. Evaluate emerging “risk” issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
 - B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
 - C. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the RBC formulas.
2. The **Health Risk-Based Capital (E) Working Group, Life Risk-Based Capital (E) Working Group and Property and Casualty Risk-Based Capital (E) Working Group** will:
 - A. Evaluate refinements to the existing NAIC RBC formulas implemented in the prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C), and health RBC formulas to the Financial Condition (E) Committee by June.
 - B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than April 30 in the year of the change, and adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting or conference call. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by April 30 and results in an amended change may be considered by July 30 for those exceptions where the Capital Adequacy (E) Task Force votes to pursue by super-majority (two-thirds) consent of members present no later than June 30 for the current reporting year.
 - C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised *Accounting Practices and Procedures Manual (AP&P Manual)* to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
 - D. Review the effectiveness of the NAIC’s RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the summer and fall national meetings.
3. The **Variable Annuities Capital and Reserve (E/A) Subgroup**, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
 - A. Monitor the impact of the changes to the variable annuities reserve framework and RBC calculation, and determine if additional revisions need to be made.
 - B. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.
4. The **Longevity Risk (E/A) Subgroup**, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
 - A. Provide recommendations for the appropriate treatment of longevity risk transfers by the new longevity factors.
5. The **Catastrophe Risk (E) Subgroup** of the Property and Casualty Risk-Based Capital (E) Working Group will:
 - A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
 - B. Continue to update the U.S. and non-U.S. catastrophe event list.
 - C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
 - D. Evaluate the RBC results inclusive of a catastrophe risk charge.
 - E. Refine instructions for the catastrophe risk charge.
 - F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
 - G. Evaluate other catastrophe risks for possible inclusion in the charge.

NAIC Support Staff: Jane Barr/Lou Felice

EXAMINATION OVERSIGHT (E) TASK FORCE

The mission of the Examination Oversight (E) Task Force is to monitor, develop and implement tools for the risk-focused surveillance process. For financial examinations and analysis, this includes maintenance of the *Financial Condition Examiners Handbook* and the *Financial Analysis Handbook* to provide guidance to examiners and analysts using a risk-focused approach to solvency regulation and to encourage effective communication and coordination between examiners, analysts and other regulators. In addition, the mission of the Task Force is to: monitor and refine regulatory tools of the risk-focused surveillance process, including Financial Analysis Solvency Tools (FAST) such as company profiles and the FAST ratio scoring system; oversee financial examiner and analyst use of electronic software tools; monitor the progress of coordination efforts among the states in conducting examinations and the sharing of information necessary to solvency monitoring; establish procedures for the flow of information between the states about troubled companies; maintain an effective approach to the review of information technology (IT) general controls; and monitor the timeliness of financial examinations.

Ongoing Support of NAIC Programs, Products or Services

1. The **Examination Oversight (E) Task Force** will:
 - A. Accomplish its mission using the following groups:
 1. Electronic Workpaper (E) Working Group.
 2. Financial Analysis Solvency Tools (E) Working Group.
 3. Financial Examiners Coordination (E) Working Group.
 4. Financial Examiners Handbook (E) Technical Group.
 5. Information Technology (IT) Examination (E) Working Group.
2. The **Electronic Workpaper (E) Working Group** will:
 - A. Monitor and support the state insurance departments in using electronic workpaper software tools to conduct and document solvency monitoring activities.
 - B. Provide ongoing oversight to the NAIC's Electronic Workpaper Hosting Project.
 - C. Develop a framework to meet the long-term hosting and software needs of state insurance regulators in using electronic workpapers to conduct and document solvency monitoring activities. Ensure that solutions developed consider various state insurance regulator uses, as appropriate.
3. The **Financial Analysis Solvency Tools (E) Working Group** will:
 - A. Provide ongoing maintenance and enhancements to the *Financial Analysis Handbook* and related applications for changes to the NAIC annual/quarterly financial statement blanks, as well as enhancements developed to assist in the risk-focused analysis and monitoring of the financial condition of insurance companies and groups. Monitor the coordination of analysis activities of holding company groups, and coordinate and analyze input received from other state regulators.
 - B. Provide ongoing development maintenance and enhancements to the automated financial solvency tools developed to assist in conducting risk-focused analysis and monitoring the financial condition of insurance companies and groups. Prioritize and perform analysis to ensure that the tools remain reliable and accurate.
 - C. Coordinate with the Financial Examiners Handbook (E) Technical Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
 - D. Adjust the *Financial Analysis Handbook* and current financial analysis solvency tools for life insurance companies based on any recommendations as requested from the Life Actuarial (A) Task Force to incorporate principle-based reserving (PBR) changes.
4. The **Financial Examiners Coordination (E) Working Group** will:
 - A. Develop enhancements that encourage the coordination of examination activities regarding holding company groups.
 - B. Promote coordination by assisting and advising domiciliary regulators and exam coordinating states as to what might be the most appropriate regulatory strategies, methods and actions regarding financial examinations of holding company groups.
 - C. Facilitate communication among regulators regarding common practices and issues arising from coordinating examination efforts.
 - D. Provide ongoing maintenance and enhancements to the Financial Examination Electronic Tracking System (FEETS).

EXAMINATION OVERSIGHT (E) TASK FORCE (Continued)

5. The **Financial Examiners Handbook (E) Technical Group** will:
 - A. Continually review the *Financial Condition Examiners Handbook* and revise, as appropriate.
 - B. Coordinate with the Risk-Focused Surveillance (E) Working Group to monitor the implementation of the risk-assessment process by developing additional guidance and exhibits within the *Financial Condition Examiners Handbook*, including consideration of potential redundancies affected by the examination process, corporate governance and other guidance as needed to assist examiners in completing financial condition examinations.
 - C. Coordinate with the Financial Analysis Solvency Tools (E) Working Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
 - D. Coordinate with the IT Examination (E) Working Group and the Financial Examiners Coordination (E) Working Group to maintain specialized areas of guidance within the *Financial Condition Examiners Handbook* related to the charges of these specific working groups.
 - E. Adjust the *Financial Condition Examiners Handbook* based upon any recommendations as requested from the Life Actuarial (A) Task Force to incorporate PBR changes.

6. The **Information Technology Examination (E) Working Group** will:
 - A. Continually review and revise, as needed, the “General Information Technology Review” and “Exhibit C— Evaluation of Controls in Information Systems” sections of the *Financial Condition Examiners Handbook*.

NAIC Support Staff: Bailey Henning

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

The mission of the Receivership and Insolvency (E) Task Force shall be administrative and substantive as it relates to issues concerning insurer insolvencies and insolvency guarantees. Such duties include, without limitation, monitoring the effectiveness and performance of state administration of receiverships and the state guaranty fund system; coordinating cooperation and communication among regulators, receivers and guaranty funds; monitoring ongoing receiverships and reporting on such receiverships to NAIC members; developing and providing educational and training programs in the area of insurer insolvencies and insolvency guarantees to regulators, professionals and consumers; developing and monitoring relevant model laws, guidelines and products; and providing resources for regulators and professionals to promote efficient operations of receiverships and guaranty funds.

Ongoing Support of NAIC Programs, Products or Services

1. The **Receivership and Insolvency (E) Task Force** will:
 - A. Monitor and promote efficient operations of insurance receiverships and guaranty associations.
 - B. Monitor and promote state adoption of insurance receivership and guaranty association model acts and regulations, and monitor other legislation related to insurance receiverships and guaranty associations.
 - C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB) or other related groups on issues regarding international resolution authority.
 - D. Monitor, review and provide input on federal rulemaking and studies related to insurance receiverships.
 - E. Provide ongoing review of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook), other related NAIC publications, and the Global Receivership Information Database (GRID), and make any necessary updates.
 - F. Monitor the work of other NAIC committees, task forces and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
 - G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.
2. The **Receivership Financial Analysis (E) Working Group** will:
 - A. Monitor receiverships involving nationally significant insurers/groups to support, encourage, promote and coordinate multistate efforts in addressing problems.
 - B. Interact with the Financial Analysis (E) Working Group, domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and/or action(s) regarding potential or pending receiverships.
3. The **Receivership Law (E) Working Group** will:
 - A. Review and provide recommendations on any issues identified that may affect the states' receivership and guaranty association laws (e.g. any issues that arise as a result of market conditions; insurer insolvencies; federal rulemaking and studies; or international resolution initiatives; or as a result of the work performed by or referred from other NAIC committees, task forces and/or working groups).
 - B. Discuss significant cases that may affect the administration of receiverships.
 - C. Complete work, as assigned from the Receivership and Insolvency (E) Task Force, to address recommendations from the Financial Stability (EX) Task Force's Macroprudential Initiative (MPI) referral:
 1. Complete work related to qualified financial contracts (QFCs), including 1) explore if bridge institutions could be implemented under regulatory oversight pre-receivership to address an early termination of QFCs and, if appropriate, develop applicable guidance; 2) develop enhancements to the Receiver's Handbook guidance on QFCs; and 3) identify related pre-receivership considerations related to QFCs and, if necessary, make referrals to other relevant groups to enhance pre-receivership planning, examination and analysis guidance.
 2. Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Among other solutions, this will encompass a review of the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership.
 3. Consult with and/or make referrals to other NAIC working groups, as deemed necessary as the topic relates to affiliated intercompany agreements and pre-receivership considerations. Complete by the 2021 Fall National Meeting.

NAIC Support Staff: Jane Koenigsman

REINSURANCE (E) TASK FORCE

The mission of the Reinsurance (E) Task Force is to monitor and coordinate activities and areas of interest that overlap to some extent the charges of other NAIC groups—specifically, the International Insurance Relations (G) Committee.

Ongoing Support of NAIC Programs, Products or Services

1. The **Reinsurance (E) Task Force** will:
 - A. Provide a forum for the consideration of reinsurance-related issues of public policy.
 - B. Oversee the activities of the Reinsurance Financial Analysis (E) Working Group.
 - C. Oversee the activities of the Qualified Jurisdiction (E) Working Group.
 - D. Monitor the implementation of the 2011, 2016 and 2019 revisions to the *Credit for Reinsurance Model Law* (#785); and the 2011 and 2019 revisions to the *Credit for Reinsurance Model Regulation* (#786) and the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787).
 - E. Communicate and coordinate with the Federal Insurance Office (FIO), other federal authorities, and international regulators and authorities on matters pertaining to reinsurance.
 - F. Consider any other issues related to the revised Model #785, Model #786 and Model #787.
 - G. Monitor the development of international principles, standards and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup and the Reinsurance Transparency Group.
 - H. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
 - I. Continue to monitor the impact of reinsurance-related international agreements, including the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement).
2. The **Qualified Jurisdiction (E) Working Group** will:
 - A. Maintain the *NAIC List of Qualified Jurisdictions* and the *NAIC List of Reciprocal Jurisdictions* in accordance with the *Process for Evaluating Qualified and Reciprocal Jurisdictions*.
3. The **Reinsurance Financial Analysis (E) Working Group** will:
 - A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified Reinsurers.
 - B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
 - C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities or individuals.
 - D. Support, encourage, promote and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified reinsurers.
 - E. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.
 - F. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.
 - G. Ensure the public passporting website remains current.
 - H. For reinsurers domiciled in reciprocal jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.
 - I. Perform a yearly due diligence review of qualified jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as qualified jurisdictions.
 - J. Consider evaluations of any additional jurisdictions for inclusion on the *NAIC List of Qualified Jurisdictions*.

NAIC Support Staff: Jake Stultz/Dan Schelp

RISK RETENTION GROUP (E) TASK FORCE

The mission of the Risk Retention Group (E) Task Force is to stay apprised of the work of other NAIC groups as it relates to financial solvency regulation and the NAIC Financial Regulation Standards and Accreditation Program. The Task Force may make referrals to the Financial Regulation Standards and Accreditation (F) Committee and/or other NAIC groups, as deemed appropriate.

Ongoing Support of NAIC Programs, Products or Services

1. The **Risk Retention Group (E) Task Force** will:
 - A. Monitor and evaluate the work of other NAIC committees, task forces and working groups related to risk retention groups (RRGs). Specifically, if any of these actions affect the NAIC Financial Regulation and Accreditation Standards Program, assess whether and/or how the changes should apply to RRGs and their affiliates.
 - B. Monitor and analyze federal actions, including any U.S. Government Accountability Office (GAO) reports. Consider any action necessary as a result of federal activity.
 - C. Monitor the impacts of recent tools and resources made available to domiciliary and non-domiciliary state insurance regulators pertaining to RRGs. Consider whether additional action is necessary, including educational opportunities, updating resources and further clarifications.

NAIC Support Staff: Becky Meyer/Sara Franson

VALUATION OF SECURITIES (E) TASK FORCE

The mission of the Valuation of Securities (E) Task Force is to provide regulatory leadership and expertise to establish and maintain all aspects of the NAIC's credit assessment process for insurer-owned securities, as well as produce insightful and actionable research and analysis regarding insurer investments.

Ongoing Support of NAIC Programs, Products or Services

1. The **Valuation of Securities (E) Task Force** will:
 - A. Review and monitor the operations of the NAIC Securities Valuation Office (SVO) and the NAIC Structured Securities Group (SSG) to ensure they continue to reflect regulatory objectives.
 - B. Maintain and revise the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to provide solutions to investment-related regulatory issues for existing or anticipated investments.
 - C. Monitor changes in accounting and reporting requirements resulting from the continuing maintenance of the *Accounting Practices and Procedures Manual* (AP&P Manual), as well as financial statement blanks and instructions, to ensure that the P&P Manual continues to reflect regulatory needs and objectives.
 - D. Consider whether improvements should be suggested to the measurement, reporting and evaluation of invested assets by the NAIC as the result of: 1) newly identified types of invested assets; 2) newly identified investment risks within existing invested asset types; or 3) elevated concerns regarding previously identified investment risks.
 - E. Identify potential improvements to the credit filing process, including formats and electronic system enhancements.
 - F. Provide effective direction to the NAIC's mortgage-backed securities modeling firms and consultants.
 - G. Coordinate with other NAIC working groups and task forces—including, but not limited to, the Capital Adequacy (E) Task Force, the Statutory Accounting Principles (E) Working Group and the Blanks (E) Working Group—to formulate recommendations and to make referrals to such other NAIC regulator groups to ensure expertise relative to investments, or the purpose and objective of guidance in the P&P Manual, is reflective in the guidance of such other groups and that the expertise of such other NAIC regulatory groups and the objectives of their guidance is reflected in the P&P Manual.
 - H. Identify potential improvements to the filing exempt process (the use of credit rating provider ratings to determine an NAIC designation) to ensure greater consistency, uniformity and appropriateness to achieve the NAIC's financial solvency objectives.
 - I. Implement policies to oversee the NAIC's staff administration of rating agency ratings used in NAIC processes, including staff's discretion over the applicability of their use in its administration of filing exemption.

NAIC Support Staff: Charles Therriault

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

The mission of the Financial Regulation Standards and Accreditation (F) Committee is both administrative and substantive, as it relates to the administration and enforcement of the NAIC Financial Regulation Standards and Accreditation Program. This includes, without limitation: 1) the consideration of standards and revisions of standards for accreditation; 2) the interpretation of standards; 3) the evaluation and interpretation of the states' laws and regulations, as well as departments' practices, procedures and organizations as they relate to compliance with standards; 4) the examination of members for compliance with standards; 5) the development and oversight of procedures for the examination of members for compliance with standards; 6) the selection of qualified individuals to examine members for compliance with standards; and 7) the determination of whether to accredit members.

Ongoing Support of NAIC Programs, Products or Services

1. The **Financial Regulation Standards and Accreditation (F) Committee** will:
 - A. Maintain and strengthen the NAIC Financial Regulation Standards and Accreditation Program.
 - B. Assist the states, as requested and as appropriate, in implementing laws, practices and procedures and obtaining personnel required for compliance with the standards.
 - C. Conduct a yearly review of accredited jurisdictions.
 - D. Consider new model laws; new practices and procedures; and amendments to existing model laws, practices and procedures required for accreditation. Determine the timing and appropriateness of the addition of new model laws, practices and procedures, and amendments.
 - E. Render advisory opinions and interpretations of model laws required for accreditation and on substantial similarity of state laws.
 - F. Review existing standards for effectiveness and relevancy, and make recommendations for change, if appropriate.
 - G. Produce, maintain and update the NAIC *Accreditation Program Manual* to provide guidance to state insurance regulators regarding the official standards, policies and procedures of the program.
 - H. Maintain and update the "Financial Regulation Standards and Accreditation Program" pamphlet.
 - I. Perform enhanced pre-accreditation review services, including, but not limited to, additional staff support, increased participation, enhanced report recommendations, and informal feedback.

NAIC Support Staff: Becky Meyer

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

The mission of the International Insurance Relations (G) Committee is to coordinate NAIC participation in international discussions on and the development of insurance regulatory and supervisory standards and to promote international cooperation. The Committee also coordinates on international insurance matters with the U.S. federal government, including the U.S. Department of the Treasury (Treasury Department), the Federal Reserve Board, the Office of the U.S. Trade Representative (USTR), the U.S. Department of Commerce, and other federal agencies. In addition, the Committee provides an open forum for NAIC communication with U.S. interested parties and stakeholders on international insurance matters.

Ongoing Support of NAIC Programs, Products or Services

1. The **International Insurance Relations (G) Committee** will:
 - A. Monitor and assess international activities at forums like the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB), and the Organisation for Economic Co-operation and Development (OECD), among others, that affect U.S. insurance regulation, U.S insurance consumers, and the U.S. insurance industry.
 - B. Support and facilitate the participation of state insurance regulators and the NAIC in relevant IAIS, FSB, OECD and similar workstreams.
 - C. Develop NAIC policy on international activities, coordinating as necessary with other NAIC committees, task forces and working groups, and communicating key international developments to those NAIC groups.
 - D. Coordinate and facilitate state efforts to participate in key bilateral and multilateral dialogues, projects, conferences and training opportunities with international regulators and international organizations, both directly and in coordination with the federal government, as appropriate.
 - E. Strengthen international regulatory systems and relationships by interacting with international regulators and sharing U.S. supervisory best practices, including conducting an International Fellows Program and educational (technical assistance) seminars to provide an understanding of the U.S. state-based system of insurance regulation.
 - F. Coordinate the NAIC's participation in the International Monetary Fund (IMF)/World Bank Financial Sector Assessment Program (FSAP).
 - G. Coordinate state efforts to assist in achieving U.S. international trade objectives through reviewing relevant materials, developing input, and providing assistance and expertise on insurance matters to the USTR and/or other federal entities.

NAIC Support Staff: Ryan Workman/Ethan Sonnichsen

NAIC/CONSUMER LIAISON COMMITTEE

The mission of the NAIC/Consumer Liaison Committee is to assist the NAIC in its mission to support state insurance regulation by providing consumer views on insurance regulatory issues. The Liaison Committee provides a forum for ongoing dialogue between NAIC members and NAIC consumer representatives. The Liaison Committee's activities in 2021 will be closely aligned with the priorities of the NAIC Consumer Board of Trustees.

NAIC Support Staff: Lois E. Alexander

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE

The mission of the NAIC/American Indian and Alaska Native Liaison Committee is to provide a forum for ongoing dialogue between NAIC Members and the American Indian and Alaska Native communities concerning insurance issues of common interest. Specifically, the Liaison Committee will provide a forum for an exchange of information and views on issues surrounding the availability of insurance for American Indian and Alaska Native consumers and tribal interests, an opportunity for American Indian and Alaska Native groups to bring insurance consumer protection issues to the attention of NAIC Members, and a dialogue on best practices for dealing with insurance issues unique to sovereign tribal nations.

NAIC Support Staff: Lois E. Alexander

**AUDIT COMMITTEE
Committee Charter**

Ongoing Support of NAIC Programs, Products or Services

1. The **Audit Committee** will:
 - A. Provide continuous audit oversight, including:
 1. Provide an open avenue of communication between the independent auditor and the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.
 2. Confirm and ensure the independence of the independent auditor.
 3. Inquire of management and the independent auditor about significant risks or exposures and assess the steps management has taken to minimize such risk.
 4. Consider and review with the independent auditor:
 - A. Significant findings during the year, including the status of previous audit recommendations.
 - B. Any difficulties encountered in the course of audit work, including any restrictions on the scope of activities or access to required information.
 - C. The adequacy of internal controls, including computerized information system controls and security, as documented in the Statement on Auditing Standards (SAS) 115 letter from the independent auditor.
 - D. Related findings and recommendations of the independent auditor with management's responses, as documented in the SAS 114 letter from the independent auditor.
 5. Meet periodically with the independent auditor in separate executive sessions to discuss any matters the Committee believes should be discussed privately with the Committee.
 6. Report periodically to the Executive (EX) Committee and Internal Administration (EX1) Subcommittee on significant results of the foregoing activities.
 7. Instruct the independent auditor that the Executive (EX) Committee and Internal Administration (EX1) Subcommittee are the auditor's clients.
 - B. Provide continuous oversight of reporting policies, including:
 1. Advise financial management and the independent auditor that they are expected to provide a timely analysis of significant current financial reporting issues and practices.
 2. Inquire as to the auditor's independent qualitative judgments about the appropriateness, not just the acceptability, of the accounting principles and the clarity of the financial disclosure practices.
 3. Inquire as to the auditor's views about whether management's choices of accounting principles are conservative, moderate or aggressive from the perspective of income, asset and liability recognition, and whether those principles are common practices or minority practices.
 4. Inquire as to the auditor's views about how choices of accounting principles and disclosure practices may affect NAIC members, the insurance industry, and public views and attitudes.
 - C. Provide continuous oversight of financial management, including:
 1. Review the monthly consolidated financial statements and receive regular reports from executive management on the financial operations of the association.
 2. Meet prior to, or at, each national meeting or more frequently, as circumstances require. The Committee may ask members of management or others to attend meetings and provide pertinent information, as necessary.
 3. Report on significant results of the foregoing activities to the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee on a regular basis.
 - D. Conduct scheduled audit activities, including:
 1. Recommend the selection of the independent auditor for approval by the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, approve the compensation of the independent auditor, and review and approve the discharge of the independent auditor.
 2. Review annually the audit scope and plan of the independent auditor with management and the independent auditor, including:
 - A. The independent auditor's audit of the financial statements, accompanying footnotes, and its report thereon.
 - B. Any significant changes required in the independent auditor's audit plans.
 - C. Any difficulties or disputes with management encountered during the course of the year under audit.
 - D. Other matters related to the conduct of the audit, which are to be communicated to the Committee under generally accepted auditing standards (GAAS).
 3. Review and approve needs-based funding allocations, as needed.
 4. Review and update the Committee charter on at least an annual basis.

AUDIT COMMITTEE (*Continued*)

- E. Conduct other activities when necessary, including:
 - 1. Arrange for the independent auditor to be available to the full Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, as needed.
 - 2. Review and approve requests for any management consulting engagement to be performed by the independent auditor, and be advised of any other study undertaken at the request of management that is beyond the scope of the audit engagement letter.
 - 3. Conduct and/or authorize investigations into any matters within the Committee's scope of responsibilities. The Committee shall be empowered to retain independent counsel and other professionals to assist in the conduct of any investigation.
 - 4. Ensure that members of the Committee receive the appropriate orientation to the Committee and receive a copy of the policy manual.

NAIC Support Staff: Jim Woody

W:\National Meetings\2020\Fall\Plenary\Att Two Proposed Charges.pdf

Adopted by the Executive (EX) Committee and Plenary, Dec. 9, 2020
Adopted by the Life Insurance and Annuities (A) Committee, Nov. 10, 2020
Adopted by the Life Actuarial (A) Task Force, Aug. 27, 2020

TABLE 1
PROPOSED 2021 GRET FACTORS, BASED ON AVERAGE OF 2018/2019 DATA

Description	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	\$166	\$0.90	42%	\$50	121	2,916	194
Career	214	1.20	54%	64	63	2,517	195
Direct Marketing	195	1.10	49%	59	15	2,933	119
Niche Marketing	137	0.80	34%	41	26	590	11
Other*	126	0.70	32%	38	67	836	29
* Includes companies that did not respond to this or prior year surveys					292		

TABLE 2
CURRENT 2020 GRET FACTORS, BASED ON AVERAGE OF 2017/2018 DATA

Description	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	\$168	\$0.90	42%	\$50	118	3,263	200
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Niche Marketing	125	0.70	32%	38	21	757	13
Other*	140	0.80	35%	42	104	876	34
* Includes companies that did not respond to this or prior year surveys					326		

APPENDIX A -- DISTRIBUTION CHANNELS

The following is a description of distribution channels used in the development of recommended 2021 GRET values:

1. **Independent** – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.
2. **Career** – Business written by a company that markets insurance and investment products through a sales force primarily affiliated with one insurance company. These companies recruit, finance, train, and often house financial professionals who are typically referred to as career agents or multi-line exclusive agents.
3. **Direct Marketing** – Business written by a company that markets its own insurance policies direct to the consumer through methods such as direct mail, print media, broadcast media, telemarketing, retail centers and kiosks, internet or other media. No direct field compensation is involved.
4. **Niche Marketers** – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.
5. **Other** – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years’ surveys confirmed an “other” categorization (see below), values for the “other” category are given in the tables in this memo. It was also included to indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.

APPENDIX B – UNIT EXPENSE SEEDS

The expense seeds used in the 2014 and prior GRETs were differentiated between branch office and all other categories, due to the results of a relatively old study that had indicated that branch office acquisition cost expressed on a per Face Amount basis was about double that of other distribution channels. Due to the elimination of the branch office category in the 2015 GRET, non-differentiated unit expense seeds have been used in the current and immediately prior studies.

The unit expense seeds used in the 2021 GRET and the 2020 GRET recommendations were based on the average of the 2006 through 2010 Annual SOA expense studies. These studies differentiated unit expenses by type of individual life insurance policy (term and permanent coverages). As neither the GRET nor the Annual Statement data provided differentiates between these two types of coverage, the unit expense seed was derived by judgment based this information. The following shows the averages derived from the Annual SOA studies and the seeds used in this study. Beginning with the 2019 Annual Statement submission this information will become more readily available.

2006-2010 (AVERAGE) CLICE STUDIES:

	Acquisition/ Policy	Acquisition/ Face Amount (000)	Acquisition/ Premium	Maintenance/ Policy
Term				
Weighted Average	\$149	\$0.62	38%	\$58
Unweighted Average	\$237	\$0.80	57%	\$76
Median	\$196	\$0.59	38%	\$64
Permanent				
Weighted Average	\$167	\$1.43	42%	\$56
Unweighted Average	\$303	\$1.57	49%	\$70
Median	\$158	\$1.30	41%	\$67

CURRENT UNIT EXPENSE SEEDS:

	Acquisition/ Policy	Acquisition/ Face Amount (000)	Acquisition/ Premium	Maintenance/ Policy
All distribution channels	\$200	\$1.10	50%	\$60

TO: Reggie Mazyck, NAIC
FROM: Dale Hall, Managing Director of Research, Society of Actuaries (SOA)
Leon Langlitz, Chair, SOA Committee on Life Insurance Company Expenses
DATE: July 23, 2020
RE: 2021 Generally Recognized Expense Table (GRET) – SOA Analysis

Dear Mr. Mazyck:

As in previous years, the Society of Actuaries expresses its thanks to NAIC staff for their assistance and responsiveness in providing Annual Statement expense and unit data for the 2021 GRET analysis for use with individual life insurance sales illustrations. The analysis is based on expense and expense related information reported on companies' 2018 and 2019 Annual Statements. This project has been completed to assist the Life Actuarial Task Force (LATF) in its consideration of potential revisions to the GRET that could become effective for calendar year 2021. This memo describes the analysis and resultant findings.

NAIC staff provided Annual Statement data for life insurance companies for calendar years 2018 and 2019. This included data from 722 companies in 2018 and 776 companies in 2019. This increase breaks the trend of small decreases over the previous few years. Of the total companies, 292 were in both years and passed the outlier exclusion tests and were included as a base for the GRET factors (326 companies passed similar tests last year).

APPROACH USED

The methodology for calculating the recommended GRET factors based on this data is similar to that followed the last several years. The methodology was last altered in 2015. The changes made at that time can be found in the recommendation letter sent to LATF on July 30, 2015¹.

To calculate updated GRET factors, the average of the factors from the two most recent years (2018 and 2019 for those companies with data available for both years) of Annual Statement data was used. For each company an actual-to-expected ratio was calculated. Companies with ratios that fell outside predetermined parameters were excluded. This process was completed three times to stabilize the average rates. The boundaries of the exclusions have been modified from time to time; however, there were no adjustments made this year. Unit expense seed factors (the seeds for all distribution channel categories are the same), as shown in Appendix B, were used to compute total expected expenses. Thus, these seed factors were used to implicitly allocate expenses between acquisition and maintenance expenses, as well as among the three acquisition expense factors (on a direct of ceded reinsurance basis).

Companies were categorized by their reported distribution channel (four categories were used as described in Appendix A included below). There remain a significant number of companies for which no distribution channel was provided, as no responses to the annual surveys have been received from those companies. The characteristics of these companies vary significantly, including companies not currently writing new business or whose major line of business is not individual life insurance. Any advice or assistance from LATF

¹ <https://www.soa.org/Files/Research/Projects/research-2016-gret-recommendation.pdf>

in future years to increase the response rate to the surveys of companies that submit Annual Statements in order to reduce the number of companies in the “Other” category would be most welcomed. The intention is to continue surveying the companies in future years to enable enhancement of this multiple distribution channel information.

Companies were excluded from the analysis if (1) their actual to expected ratios were considered outliers, often due to low business volume, (2) the average first year and single premium per policy were more than \$40,000, (3) they are known reinsurance companies or (4) their data were not included in both years of the data supplied by the NAIC. To derive the overall GRET factors, the unweighted average of the remaining companies’ actual-to-expected ratios for each respective category was calculated. The resulting factors were rounded, as shown in Table 1.

THE RECOMMENDATION

The above methodology results in the proposed 2021 GRET values shown in Table 1. To facilitate comparisons, the current 2020 GRET factors are shown in Table 2. Further characteristics of the type of companies represented in each category are included in the last two columns in Table 1, including the average premium per policy issued and the average face amount (\$000s) per policy issued.

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In previous recommendations, an effort was made to reduce volatility in the GRET factors from year-to-year by limiting the change in GRET factors between years to about ten percent of the prior value. The changes from the 2020 GRET were reviewed to ensure that a significant change was not made in this year's GRET recommendation. The Direct Marketing and Other distribution channel categories experienced a change greater than ten percent so the factors for this line were capped at the ten percent level (the Acquisition per unit factor changed somewhat more than 10% because of rounding) from the corresponding 2020 GRET values. The volatility occurred due to the change in the composition of the companies in this category where a small number of companies were included.

USAGE OF THE GRET

This year's survey, responded to by companies' Annual Statement correspondent, included a question regarding whether the 2020 GRET table was used in its illustrations by the company. Last year, 26% of the responders indicated their company used the GRET for sales illustration purposes, with similar percentage results by size of company; this contrasted with about 28% in 2018. This year, 29% of responding companies indicated that they used the GRET in 2019 for sales illustration purposes. The range was from 22% for Direct Marketing to 48% for career carriers. Based on the information received over the last several years, the variation in GRET usage appears to be in large part due to the relatively small sample size and different responders to the surveys.

We hope LATF finds this information helpful and sufficient for consideration of a potential update to the GRET. If you require further analysis or have questions, please contact Dale Hall at 847-273-8835.

Kindest personal regards,



Dale Hall, FSA, MAAA, CERA, CFA
Managing Director of Research
Society of Actuaries



Leon Langlitz, FSA, MAAA
Chair, SOA Committee on
Life Insurance Company Expenses

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Adopted by the Executive (EX) Committee and Plenary, Dec. 9, 2020
Adopted by the Life Insurance and Annuities (A) Committee, Nov. 10, 2020
Adopted by the Life Actuarial (A) Task Force on Oct. 29, 2020.

Actuarial Guideline XLIX

THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST

Background

The *Life Insurance Illustrations Model Regulation* (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an external index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

- (1) Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
- (2) Limits the policy loan leverage shown in an illustration.
- (3) Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective as follows:

- i. Sections 4 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.
- ii. Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in-force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.
- iii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.
- iv. This actuarial guideline shall not apply for any new business or in force life insurance illustrations on policies sold on or after December 14, 2020.
- v. Notwithstanding part iv of this section, an insurer may choose to utilize AG-49A guidance for new illustrations on policies sold prior to the effective date of AG49A provided that, one, the insurer utilizes AG-49A guidance for all new product illustrations subject to AG49, and, two, the insurer does not revert back to the AG-49 guidance.

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

- i. The policy is subject to Model #582.
- ii. Interest credits are linked to an external index or indices.

3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

- i. The credited rate for each Index Account does not exceed the lesser of the maximum credited rate for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the credited rate for each Index Account shall not exceed the average of the maximum credited rate for the illustrated scale and the guaranteed credited rate for that account. However, the credited rate for each Index Account shall never be less than the guaranteed credited rate for that account.
- ii. If the illustration includes a loan, the illustrated rate credited to the loan balance does not exceed the illustrated loan charge.
- iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Benchmark Index Account: An Index Account with the following features:

- i. The interest calculation is based on the percent change in S&P 500[®] Index value only, over a one-year period using only the beginning and ending index values. (S&P 500[®] Index ticker: SPX)
- ii. An annual cap is used in the interest calculation.
- iii. The annual floor used in the interest calculation shall be 0%.
- iv. The participation rate used in the interest calculation shall be 100%.
- v. Interest is credited once per year.
- vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy's Index Accounts, subject to the requirements of 5.D.. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.
- vii. Additional amounts credited are not less than the additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 4 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values, including but not limited to experience refunds or bonuses.
- viii. There are no limitations on the portion of account value allocated to the account.

C. Fixed Account: An account where the credited rate is not tied to an external index or indices.

D. Index Account: An account where the credited rate is tied to an external index or indices.

4. Illustrated Scale

The credited rate for the illustrated scale for each Index Account shall be limited as follows:

- A. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.
 - i. If the insurer offers an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the applicable Benchmark Index Account in 4 (A).
 - ii. If the insurer does not offer an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of a Benchmark Index Account, and shall use that cap in 4 (A).
- B. For each applicable Benchmark Index Account, the arithmetic mean of the geometric average annual credited rates calculated in 4 (A) shall be the maximum credited rate(s) for the illustrated scale.
- C. For other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgment to determine the maximum credited rate for the illustrated scale. The determination shall reflect the fundamental characteristics of the Index Account and the parameters shall have the appropriate relationship to the expected risk and return of the applicable Benchmark Index Account. In no event shall the credited rate for the illustrated scale exceed the applicable rate calculated in 4 (B).
- D. At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale

The earned interest rate for the disciplined current scale shall be limited as follows:

- A. If an insurer engages in a hedging program for index-based interest, the assumed earned interest rate underlying the disciplined current scale shall not exceed 145% of the annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the general account assets (excluding hedges for index-based credits) allocated to support the policy.
- B. If an insurer does not engage in a hedging program for index-based interest, the assumed earned interest rate underlying the disciplined current scale shall not exceed the annual net investment earnings rate of the general account assets allocated to support the policy.
- C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all benefits including illustrated bonuses.
- D. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

6. Policy Loans

If the illustration includes a loan, the illustrated rate credited to the loan balance shall not exceed the illustrated loan charge by more than 100 basis points.

7. Additional Standards

The basic illustration shall also include the following:

- A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.
- B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).
- C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period.

PROJECT HISTORY

ACTUARIAL GUIDELINE XLIX

***THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION
TO POLICIES WITH INDEX-BASED INTEREST (AG 49)***

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

The guideline is being sunset for policies issued on and after Dec. 14, 2020, the effective date of *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies With Index-Based Interest Sold On or After November 25, 2020* (AG 49-A). *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies With Index-Based Interest* (AG 49) was also revised to allow companies to apply the requirements of AG 49-A to in-force illustrations for policies issued prior to Dec. 14.

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

The members of the Life Actuarial (A) Task Force were: Texas, Chair; Ohio, Vice Chair; Alabama; California; Colorado; Connecticut; Illinois; Indiana; Iowa; Kansas; Minnesota; Missouri; Nebraska; New Jersey; New Mexico; New York; Oklahoma; Utah; and Virginia.

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

The revision to AG 49 was necessitated by the adoption of AG 49-A. AG 49-A was developed in response to the Life Insurance and Annuities (A) Committee charge to modify AG 49 such that products with multiplier features illustrate no better than products without multiplier features.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

AG 49 was primarily drafted by the Life Actuarial (A) Task Force. Contributors to the drafting process were the American Council of Life Insurers (ACLI) and the Center for Economic Justice (CEJ).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Task Force chair exposed the AG 49 revisions for public comment on Sept. 8. During deliberations during its Oct. 22 meeting, the Task Force agreed to a re-exposure that incorporated an amendment proposed by the CEJ that allows companies to apply AG 49-A for in-force illustration for policies issued prior to the effective date of AG 49-A. The Task Force adopted the guideline on Oct. 29. The Life Insurance and Annuities (A) Committee adopted the guideline on Nov. 10, which was followed by NAIC adoption at the 2020 Fall National Meeting.

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

The issue of allowing companies to use AG 49-A for new in-force illustrations of policies issued prior to the AG 49-A effective date was raised by the CEJ. The Task Force exposed language proposed by the CEJ for public comment. The version of AG 49 the Task Force adopted included the CEJ language.

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

None.

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Approved by the Life Insurance and Annuities (A) Committee, July 10, 2020

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC's Executive Committee is required. The NAIC's Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: New Model Law or Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

Life Actuarial (A) Task Force

2. NAIC staff support contact information:

Reggie Mazyck

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

The *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805) sets the floor for the nonforfeiture interest rate at 1 percent. The current low interest rate environment necessitates lowering the nonforfeiture interest rate to 0 percent to allow companies to support the nonforfeiture guarantees in their deferred annuity contracts. The Life Actuarial (A) Task Force proposal seeks to amend Section 4B(3) of #805 to lower the 1 percent interest rate floor to 0 percent.

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

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

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

If yes, please explain why

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

Yes or No (Check one)

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

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

No

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

No

Adopted by the Life Actuarial (A) Task Force, Oct. 8, 2020
Adopted by the Life Insurance and Annuities (A) Committee, Nov. 10, 2020

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

Table of Contents

Section 1.	Title
Section 2.	Applicability
Section 3.	Nonforfeiture Requirements
Section 4.	Minimum Values
Section 5.	Computation of Present Value
Section 6.	Calculation of Cash Surrender Values
Section 7.	Calculation of Paid-Up Annuity Benefits
Section 8.	Maturity Date
Section 9.	Disclosure of Limited Death Benefits
Section 10.	Inclusion of Lapse of Time Considerations
Section 11.	Proration of Values; Additional Benefits
Section 12.	Rules
Section 13.	Effective Date

Section 1. Title

This Act shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

Section 2. Applicability

- A. This Act shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.
- B. Sections 3 through 8 shall not apply to contingent deferred annuities.
- C. Notwithstanding Subsection B, the commissioner shall have the authority to prescribe, by regulation, nonforfeiture benefits for contingent deferred annuities that are, in the opinion of the commissioner, equitable to the policyholder, appropriate given the risks insured, and to the extent possible, consistent with general intent of this law.

Drafting Note: It is expected that any regulation prescribing specific nonforfeiture requirements for the CDAs and promulgated by the commissioner under Subsection C above would apply only to the CDA contracts issued subsequent to the effective date of such regulation.

Section 3. Nonforfeiture Requirements

- A. In the case of contracts issued on or after the operative date of this Act as defined in Section 13, no contract of annuity, except as stated in Section 2, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:
 - (1) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in Sections 5, 6, 7, 8 and 10;

- (2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of a paid-up annuity benefit a cash surrender benefit of such amount as is specified in Sections 5, 6, 8 and 10. The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefor with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;
 - (3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and
 - (4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.
- B. Notwithstanding the requirements of this section, a deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than \$20 monthly, the company may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis on the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under the contract.

Section 4. Minimum Values

The minimum values as specified in Sections 5, 6, 7, 8 and 10 of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

- A. (1) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in Subsection B of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of Paragraphs (a) through (d) below:
- (a) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Subsection B;
 - (b) An annual contract charge of \$50, accumulated at rates of interest as indicated in Subsection B;
 - (c) Any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in Subsection B; and
- Drafting Note:** The premium tax credit is only permitted if the tax is actually paid by the company. If the tax is paid and subsequently credited back to the company, such as upon early termination of the contract, the tax credit may not be taken.
- (d) The amount of any indebtedness to the company on the contract, including interest due and accrued.
- (2) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the contract during that contract year.
- B. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:

- (1) The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest 1/20th of one percent, specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under Section 4B(4);
 - (2) Reduced by 125 basis points;
 - (3) Where the resulting interest rate is not less than 15 basis points (0.15%); and
 - (4) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.
- C. During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in Subsection B(2) above by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.
- D. The commissioner may adopt rules to implement the provisions of Section 4C and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines adjustments are justified.

Section 5. Computation of Present Value

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

Section 6. Calculation of Cash Surrender Value

For contracts that provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

Section 7. Calculation of Paid-up Annuity Benefits

For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any additional amounts credited by the company to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

Section 8. Maturity Date

For the purpose of determining the benefits calculated under Sections 6 and 7, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

Section 9. Disclosure of Limited Death Benefits

A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

Section 10. Inclusion of Lapse of Time Considerations

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

Section 11. Proration of Values; Additional Benefits

For a contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Sections 5, 6, 7, 8 and 10, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this Act. The inclusion of such benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

Section 12. Rules

The commissioner may adopt rules to implement the provisions of this Act.

Section 13. Effective Date

After the effective date of this Act, a company may elect to apply its provisions to annuity contracts on a contract form-by-contract form basis before the second anniversary of the effective date of this Act. In all other instances, this Act shall become operative with respect to annuity contracts issued by the company after the second anniversary of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1977 Proc. I 26, 28, 317, 479, 484-487 (adopted).

1977 Proc. II 555-557 (corrected).

2003 Proc. 1st Quarter:15-17, 113-114, 965, 970-973 (amended and reprinted).

2017 3rd Quarter (amended).

PROJECT HISTORY

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES (#805)

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

In late 2012, the Life Insurance and Annuities (A) Committee charged the Contingent Deferred Annuity (A) Working Group with evaluating the adequacy of existing laws and regulations as applied to contingent deferred annuities (CDAs) and whether additional solvency and consumer protection standards are required. The Working Group submitted its report, findings and recommendations to the Committee at the 2013 Spring National Meeting. Among its findings, the Working Group found that: 1) CDAs do not easily fit into the category of fixed or variable annuity; 2) review of solvency and consumer protection standards are necessary; and 3) tools to assist states in reviewing CDA product filings and solvency oversight of CDAs should be established. The Working Group also identified issues that would be more appropriately addressed by other existing NAIC groups with the specific subject-matter expertise.

At the 2013 Fall National Meeting, the Life Insurance and Annuities (A) Committee gave the Life Actuarial (A) Task Force a charge to recommend a manner to specifically exempt CDAs from the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805). The Executive (EX) Committee approved the Request for NAIC Model Law Development to Model #805 at the 2016 Summer National Meeting.

At the 2016 Fall National Meeting, the Life Insurance and Annuities (A) Committee adopted amendments to Model #805 recommended by the Life Actuarial (A) Task Force to exempt CDAs from certain sections of Model #805, with which, due to their structure, they cannot comply. The revisions to Model #805 exempt CDAs from the sections of the Model #805 that prescribe computational methods and minimum nonforfeiture values for deferred annuities, but would allow the insurance commissioner to specify separate nonforfeiture standards, if needed, at a later time.

In November 2020, the Life Insurance and Annuities (A) Committee adopted an amendment to Model #805 recommended by the Life Actuarial (A) Task Force to reduce the nonforfeiture interest rate floor from 1% to 15 basis points (bps) (0.15%) in response to the historic low interest rate environment.

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

The Life Actuarial (A) Task Force. The following states participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Tynesia Dorsey, Vice Chair, represented by Peter Weber (OH); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Russell Toal (NM); Linda A. Lacewell represented by Bill Carmello and Mona Bhalla (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

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

The Life Actuarial (A) Task Force charges require the group to provide recommendations and changes, as appropriate, to other reserve and nonforfeiture requirements to address issues. The recommendation to reduce the minimum nonforfeiture interest rate floor was provide in response to the low interest rates for five-year constant maturity treasuries, which was as low as 25 bps during the period of Task Force deliberations. The Executive (EX) Committee approved the Request for NAIC Model Law Development to Model #805 at the 2020 Summer National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Life Actuarial (A) Task Force, chaired by Mr. Boerner, drafted the change to Model #805.

The following interested parties participated: American Council of Life Insurers (ACLI); American Academy of Actuaries (Academy); Allianz Life Insurance Company of North America (Allianz); and the Interstate Insurance Product Regulation Commission (Compact).

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited).

The Task Force began working on the charge during open meetings beginning in the summer of 2020. The initial Request for NAIC Model Law Development submitted to the Life Insurance and Annuities (A) Committee recommended reduction of the minimum nonforfeiture interest rate floor from 1% to 0%. When approving the request, the Committee asked the Task Force to consider rates between 0% and 50 bps, inclusive. At the Summer National Meeting, the Task Force voted to expose a revision to the model for public comment. The revision asked stakeholders to provide comments on potential rates of 0.15%, 0.25%, 0.35% and 0.50%, in addition to the originally proposed 0% with approved the request. The Task Force held public discussions on the potential revision on Oct. 8, Oct. 1 and Sept. 24. The Task Force adopted the proposed revision, which recommended reducing the Model #805 minimum nonforfeiture interest rate to 15 bps, on Oct. 8. The Life Insurance and Annuities (A) Committee adopted the revisions to the model on Nov. 10.

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

The revision is intended to provide companies relief from a minimum nonforfeiture interest rate floor that was considered unsupportable in the environment of historically low interest rates. The feedback received from commenters was that retaining with the 1% minimum nonforfeiture interest rate floor would likely result in the limited availability of indexed annuity products or possibly an exodus of companies from the indexed annuity market. The Task Force members, with the exception of Missouri, New York and Oklahoma, agreed that a significant reduction in the minimum nonforfeiture interest rate floor was warranted.

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

None.

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Adopted by the Health Insurance and Managed Care (B) Committee, June 11, 2019
Adopted by the Regulatory Framework (B) Task Force, May 15, 2019
Adopted by the HMO Issues (B) Subgroup, April 29, 2019

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC's Executive Committee is required. The NAIC's Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: New Model Law or Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

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

2. NAIC staff support contact information:

Jolie Matthews jmatthews@naic.org

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

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

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

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

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

If yes, please explain why

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

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

Yes or No (Check one)

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: The current subgroup would target completion of a model within one year.

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

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

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

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

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

No

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

No.

Adopted by the Health Insurance and Managed Care (B) Committee – Nov. 2, 2020
Adopted by the Regulatory Framework (B) Task Force – Sept. 24, 2020
Adopted by the HMO Issues (B) Subgroup – July 13, 2020

Draft: 7/6/20
Revisions to Model #430

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

Table of Contents

Section 1.	Short Title
Section 2.	Purpose and Intent
Section 3.	Definitions
Section 4.	Applicability and Scope
Section 5.	Establishment of Health Maintenance Organizations
Section 6.	Issuance or Denial of Certificate of Authority
Section 7.	Powers of Health Maintenance Organizations
Section 8.	Contract Requirements
Section 9.	Risk Bearing Entity Registration and Contracting Requirements
Section 10.	Form and Rate Filing Requirements
Section 11.	Evidence of Coverage
Section 12.	Marketing and Advertising Materials
Section 13.	Information to Enrollees and Covered Persons
Section 14.	Coordination of Benefits
Section 15.	Initial Net Worth and Capital
Section 16.	Ongoing Net Worth and Capital
Section 17.	Deposit Requirements
Section 18.	Hold Harmless Provision Requirements for Covered Persons
Section 19.	Investment Powers
Section 20.	Accounting Practices
Section 21.	Fiduciary Responsibilities
Section 22.	Annual and Quarterly Financial Statement Filing Requirements
Section 23.	Reporting Requirements
Section 24.	Powers of Insurers and [Hospital and Medical Service Corporations]
Section 25.	Examinations
Section 26.	Suspension or Revocation of Certificate of Authority
Section 27.	Summary Orders and Supervision
Section 28.	Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations
Section 29.	Penalties and Enforcement
Section 30.	Regulations
Section 31.	Statutory Construction and Relationship to Other Laws
Section 32.	Filings and Reports as Public Documents
Section 33.	Holding Company System Regulatory Act
Section 34.	Separability
Section 35.	Effective Date
Appendix A.	Former Section 3HH, Section 14 and Section 20

Section 1. Short Title

This Act may be cited as the Health Maintenance Organization Act of [insert year].

Section 2. Purpose and Intent

The purpose of this Act is to provide for a system of regulation for health maintenance organizations that is fair and efficient, and promotes the continued solvency of health maintenance organizations. This Act is designed to operate in conjunction with and as a companion to other state laws that establish standards for the regulation of health maintenance organizations, such as [insert state law equivalent to the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) the *Quality Assessment and Improvement Model Act* (#71), the *Health Care Professional Credentialing Verification Model Act* (#70), the *Utilization Review and Benefit Determination Model Act* (#73), the *Health Carrier Grievance Procedure Model Act* (#72), the *Health Carrier External Review Model Act* (#75), the *Health Information Privacy Model Act* (#55), the *Unfair Trade Practices* (#880), the *Unfair Claims Settlement Practices Model Act* (#900), the *Insurance Holding Company System Regulatory Act* (#440) and the *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315)].

Drafting Note: This model act presumes the existence of state laws that are based on the listed NAIC model acts described in this section. States that have not already adopted these laws should consider adopting them to ensure that a comprehensive system of regulation for health maintenance organizations is in place.

Drafting Note: Former Section 14—Continuation of Benefits and Section 20—Uncovered Expenditures provide consumer protections for health maintenance organization enrollees in the event of a health maintenance organization insolvency in the absence of guaranty association protection for health maintenance organization enrollees. Those sections (along with Section 3HH, defining the term “uncovered expenditures”) have been repealed to reconcile this Act with the *Life and Health Insurance Guaranty Association Model Act* (#520), which was amended in 2017 to make health maintenance organizations members of the guaranty association. States that continue to exclude health maintenance organizations from guaranty association membership should retain provisions, comparable to former Sections 3HH, 14 and 20, requiring health maintenance organizations to develop advance insolvency plans that include procedures to facilitate continuation of benefits after an insolvency, and to post deposits to secure any uncovered expenditures in excess of 10% of total health care expenditures. The language from former Section 14, former Section 20 and the former definition of “uncovered expenditures” in Section 3HH can be found in Appendix A. Former Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency was repealed as obsolete due to the provisions of the federal Affordable Care Act (ACA).

Section 3. Definitions

- A. “Adverse determination” means a determination by a health maintenance organization or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health maintenance organization’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.
- B. “Basic health care services” includes the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.
- C. “Capitated basis” means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.
- D. “Coinsurance” means the percentage amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

Drafting Note: States that do not allow HMOs to impose a coinsurance requirement should not adopt this definition nor include the term when it is referenced throughout the model.

- E. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of health maintenance organizations lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- F. “Copayment” means a specified dollar amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.
- G. “Covered benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- H. “Covered person” means any person eligible to receive covered benefits under the terms of a health benefit plan.
- I. “Deductible” means the amount a covered person is responsible to pay out-of-pocket before the health maintenance organization begins to pay the covered expenses associated with treatment.
- J. “Enrollee” means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.
- K. “Evidence of coverage” means a statement that sets out the coverage and other rights to which the covered person is entitled under the health benefit plan and that may be issued by the health maintenance organization or by the group contract holder to an enrollee electronically or, upon request, in writing.
- L. “Extension of benefits” means the continuation of coverage under a particular benefit provided under a contract following termination with respect to a covered person who is totally disabled on the date of termination.
- M. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- N. “Grievance” means a written complaint submitted by or on behalf of a covered person regarding:
 - (1) The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
 - (2) Claims payment, handling or reimbursement for health care services; or
 - (3) Matters pertaining to the contractual relationship between a covered person and a health maintenance organization.
- O. “Group contract” means a contract for health care services, which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.
- P. “Group contract holder” means a person, other than an individual, to which a group contract has been issued.
- Q. “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- R. “Health care professional” means a physician or other health care practitioner license, accredited or certified to perform specified health services consistent with state law.
- S. “Health care provider” or “provider” means a health care professional or facility.
- T. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

- U. “Health carrier” or “carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, managed care organization, health maintenance organization, a nonprofit hospital or medical service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: The term “hospital or medical service corporation,” as used in the model act, is intended to apply to any nonprofit health, hospital or medical service corporation or similar organization. In order to include such organizations in this section, which are also commonly referred to as “Blue Cross Blue Shield-type” plans, each state should identify these organizations in accordance with its statutory terminology for such plans or by specific statutory citation. Some states also may have to amend other laws to bring these organizations within the scope of this section since the portions of state law applicable to these organizations may provide that no other portion of the insurance code applies to these organizations without a specific reference to the other provision.

- V. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for a covered person’s responsibility for copayments, coinsurance or deductibles.
- W. “Individual contract” means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the enrollee.
- X. “Insolvent” or “insolvency” shall mean that the health maintenance organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.
- Y. “Intermediary organization” means a person, other than an individual, authorized to negotiate and execute provider contracts with health maintenance organizations on behalf of a group of health care providers or on behalf of a network, but does not include a provider or group of providers negotiating on its own behalf.
- Z. “Network” means the group of participating providers providing services to a health maintenance organization.
- AA. “Net worth” means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.
- BB. “Participating provider” means a provider that, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments, coinsurance or deductibles, from the health maintenance organization or other organization under contract with the health maintenance organization to provide payment in accordance with the terms of the contract.
- CC. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or a combination of the foregoing.
- DD. “Policyholder” means, for individual contracts, the individual in whose name the contract is issued, and for group contracts, the group contract holder.
- EE. “Qualified actuary” means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the commissioner may require.
- FF. “Replacement coverage” means the benefits provided by a succeeding carrier.
- GG. “Risk bearing entity” means an intermediary organization that is at financial risk for services provided through contractual assumption of the obligation for the delivery of specified health care services to covered persons of the health maintenance organization.

- HH. “Utilization review” means a set of formal techniques utilized by or on behalf of the health maintenance organization designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Section 4. Applicability and Scope

This Act applies to all health maintenance organizations and risk bearing entities doing business in this state.

Section 5. Establishment of Health Maintenance Organizations

Option A:

- A. Notwithstanding any law of this state to the contrary, any person other than an individual may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this Act. A foreign corporation may qualify under this Act, subject to its registration to do business in this state as a foreign corporation under [insert reference to applicable state law] and compliance with all provisions of this Act and other applicable state laws.

Drafting Note: State laws differ as to whether a health maintenance organization is required to be a domestic corporation. This provision should be adopted if your state wants to permit a foreign corporation to qualify under this Act if it registers to do business in a state as a foreign corporation and complies with all provisions of this Act and other applicable state laws.

Option B:

- A. Notwithstanding any law of this state to the contrary, any organization may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. A person shall not establish or operate a health maintenance organization in this state without obtaining a certificate of authority under this Act.

Drafting Note: State laws differ as to whether a health maintenance organization may be a foreign corporation. This option does not differentiate between foreign and domestic corporations. Whether or not to allow foreign corporations to become health maintenance organizations should be determined in light of a particular state’s regulatory framework.

- B. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall demonstrate, set forth or be accompanied by the following:
- (1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;
 - (2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

- (3)
 - (a) A disclosure of the internal organizational structure identifying senior management employees;
 - (b) A disclosure of the external organizational structure identifying all parent, subsidiary and affiliate organizations; and
 - (c) If the applicant is a member of a holding company:
 - (i) Identification of the holding company; and
 - (ii) A copy of the most recent holding company Form B that includes current financial information for the ultimate controlling party;
- (4) The applicant's federal identification number, NAIC number if applicable, corporate address and mailing address;
- (5)
 - (a) The names, addresses, official positions and biographical affidavit of the individuals who are to be responsible for the conduct of the affairs of the applicant, including, but not limited to all members of the board of directors, executive committee, and the principal officers accompanied by a completed release of information for each of these individuals, on forms acceptable to the commissioner; and
 - (b) A disclosure of any person owning or having the right to acquire five percent (5%) or more of the voting securities or subordinated debt of the applicant;
- (6) A detailed plan of operation for [insert state name];
- (7) A description of the applicant and its personnel, and, where applicable, its facilities, including, but not limited to, location, hours of operation and telephone numbers;
- (8) A copy of:
 - (a) Any contract made or to be made between the applicant and an affiliated or unaffiliated person for managerial or administrative services, including, third party administrators, marketing consultants or persons listed in Paragraph (5); and
 - (b) Sample contract forms proposed for use between the applicant and persons providing health care services to covered persons, including, participating providers and intermediary organizations.

Drafting Note: Section 11A of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) requires the filing of substantially similar information to the filing of sample provider contracts required in Paragraph (8)(b). States that have adopted the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) should consider whether it is necessary to include a similar requirement in this Act as well.

- (9) A copy of each type of evidence of coverage and identification card or similar document to be issued to the enrollees;
- (10) A copy of each type of individual or group policy, contract or agreement to be used;
- (11) A copy of all marketing materials;
- (12) A copy, if applicable, of the most recent financial examination report made of the health maintenance organization within the previous three (3) years, certified by the insurance regulatory agency of the applicant's state of domicile;

- (13) (a) A copy of the applicant's financial statements showing the applicant's assets, liabilities and sources of financial support, including a copy of the applicant's most recent audited financial statement that complies with [insert reference to state law equivalent to *Model Regulation Requiring Annual Audited Financial Reports*] and an unaudited current financial statement; or
- (b) If the information in Subparagraph (a) of this paragraph is not applicable to the applicant, a list of the assets representing the initial net worth of the applicant;

Drafting Note: States should ensure that the state law equivalent to the *Model Regulation Requiring Annual Audited Financial Reports* is applicable to health maintenance organizations before referencing it in Paragraph (13)(a).

- (14) A financial plan that provides a three-year projection of operating results, including:
 - (a) A projection of balance sheets;
 - (b) Income and expense statements anticipated from the start of operations until the organization has had net income for at least one year;
 - (c) Cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state;
 - (d) Detailed enrollment projections;
 - (e) The methodology for determining premium rates to be charged that has been certified by a qualified actuary; and
 - (f) A statement as to the sources of working capital as well as any other sources of funding;
- (15) The names and addresses of the applicant's qualified actuary and external auditors;
- (16) If the applicant has a parent company and the commissioner determines that additional solvency guarantees are necessary, the parent company's guaranty, on a form acceptable to the commissioner, that the applicant will maintain the minimum net worth required under this Act. If no parent company exists, a statement regarding the availability of future funds if needed;
- (17) A description of the nature and extent of any reinsurance program to be implemented, including a detailed risk retention schedule indicating direct, assumed, ceded and net maximum risk exposures on any one risk;
- (18) A demonstration that errors and omission insurance or other arrangements satisfactory to the commissioner will be in place upon the applicant's receipt of a certificate of authority;
- (19) Information regarding the proposed fidelity bond required pursuant to Section 21B of this Act;
- (20) If the applicant is a foreign corporation, a statement from the appropriate regulatory agency of the applicant's state of domicile stating that:
 - (a) The applicant is authorized to operate as a health maintenance organization in the state of domicile;
 - (b) The regulatory agency has no objection to the applicant applying for a certificate of authority in this state; and
 - (c) The applicant is in good standing in the applicant's state of domicile;

- (21) The name and address of the applicant's [insert state name] statutory agent for service of process, notice, or demand, or if not domiciled in this state, a power of attorney duly executed by the applicant, appointing the commissioner and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;
- (22) A description of the proposed policies, standards and procedures for the management of health information, including proposed policies, standards and procedures that guard against the unauthorized collection, use or disclosure of protected health information, that complies with [insert reference to state law equivalent to the *Health Information Privacy Model Act* (#55)];
- (23) A description of the proposed quality assessment and improvement activities that comply with [insert reference to state law equivalent to the *Quality Assessment and Improvement Model Act* (#71)] regarding the maintenance and improvement of the quality of health care services provided to covered persons;
- (24) If the health maintenance organization will not operate statewide, a statement or map describing the service area;
- (25) A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements;
- (26) A description of the proposed network adequacy standards that assure the adequacy, accessibility and quality of health care that complies with [insert reference to state law equivalent to the *Health Benefit Plan Network Access and Adequacy Model Act* (#74)];
- (27) A description of the proposed health care provider credentialing program in compliance with [insert reference to state law equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70)];
- (28) If the health maintenance organization will provide or perform utilization review services, a description of the proposed utilization review procedures that comply with [insert reference to state law equivalent to the *Utilization Review and Benefit Determination Model Act* (#73)] regarding the ongoing assessment and management of health care services;
- (29) A description of the proposed internal grievance procedures that comply with [insert reference to state law equivalent to the *Health Carrier Grievance Procedure Model Act* (#72)] regarding the investigation and resolution of covered persons' complaints and grievances;
- (30) A description of the proposed external review procedures that comply with [insert reference to state law equivalent to the *Health Carrier External Review Model Act* (#75)] regarding the external independent review of covered persons' grievances; and
- (31) Any other information the commissioner may require.

Section 6. Issuance or Denial of Certificate of Authority

- A. Within ninety (90) days of receipt of a completed application, the commissioner shall issue a certificate of authority when the commissioner is satisfied that:
 - (1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;
 - (2) The name of the health maintenance organization is not the same as, or deceptively similar to, the name of a domestic insurer, or of a foreign or alien company authorized to transact business in this state, nor does the name of the health maintenance organization tend to deceive or mislead as to the authorization of the health maintenance organization to engage in a specific line of business;

- (3) The health maintenance organization will provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments, coinsurance or deductibles; and
 - (4) The health maintenance organization is in compliance with the requirements of this Act.
- B. A certificate of authority shall be denied only after the commissioner complies with the requirements of Section 26 of this Act.

Section 7. Powers of Health Maintenance Organizations

- A. The powers of a health maintenance organization include, but are not limited to, the following:
- (1) The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and property reasonably required for its principal office or for purposes necessary to the transaction of the business of the organization;
 - (2) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts (provider, subscriber, etc.) between affiliates or between the health maintenance organization and its parent;
 - (3) The furnishing of health care services through providers, provider associations, intermediary organizations or agents for providers which are under contract with or employed by the health maintenance organization;
 - (4) The contracting with a person for the performance on its behalf of certain functions such as marketing, enrollment and administration;
 - (5) The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;
 - (6) The offering of other health care services, in addition to basic health care services. Non-basic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual;
 - (7) The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

Drafting Note: States that allow health maintenance organizations to offer a point of services contract may wish to consider additional requirements for those organizations, including but not limited to, additional ongoing net worth and capital, additional deposits, more detailed annual and quarterly financial statement filings, limitations on out-of-plan expenditures and additional reinsurance coverage.

- B.
- (1) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in Subsection A(1), (2) or (4) that may affect the financial soundness of the health maintenance organization. The commissioner shall disapprove the exercise of power only if, in the commissioner's opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove within thirty (30) days of the filing, it shall be deemed approved.
 - (2) The commissioner may promulgate rules and regulations exempting from the filing requirement of Paragraph (1) those activities having a *de minimis* effect.
 - (3) Transactions between affiliated entities shall be subject to [insert reference to state law equivalent to NAIC *Insurance Holding Company System Regulatory Act* (#440)].

Section 8. Contract Requirements

- A. Each group or individual contract holder is entitled to a group or individual contract within thirty (30) days of the effective date of a new or amended contract.

- B. The contract shall not contain provisions or statements that:
 - (1) Are unjust, unfair, inequitable, misleading, or deceptive; or
 - (2) Encourage misrepresentation as defined by [reference to state law equivalent to the NAIC *Unfair Trade Practices Act* (#880)].

- C. (1) The contract shall contain a clear statement of the following:
 - (a) Name and address of the health maintenance organization;
 - (b) Eligibility requirements;
 - (c) Benefits and services within the service area;
 - (d) Emergency care benefits and services;
 - (e) Out of area benefits and services (if any);
 - (f) Copayments, coinsurance, deductibles or other out-of-pocket expenses, the financial responsibility of the covered person and how the covered person's obligation is determined;
 - (g) Provider hold harmless provisions;
 - (h) Limitations and exclusions;
 - (i) covered person termination;
 - (j) covered person reinstatement (if any);
 - (k) Claims procedures;
 - (l) Utilization review procedures;
 - (m) Grievance procedures;
 - (n) Procedures for requesting independent external review;
 - (o) Continuation of coverage;
 - (p) Conversion;
 - (q) Extension of benefits (if any);
 - (r) Coordination of benefits (if applicable);
 - (s) Subrogation (if any);
 - (t) Description of the service area;
 - (u) Procedures for obtaining a provider directory;

- (v) The existence of a formulary and procedures for obtaining a copy of the formulary list (if applicable);
 - (w) Entire contract provision;
 - (x) Term of coverage;
 - (y) Cancellation of group or individual contract holder;
 - (z) Renewal;
 - (aa) Reinstatement of group or individual contract holder (if any);
 - (bb) Grace period; and
 - (cc) Conformity with state law.
- (2) An evidence of coverage may be filed as part of the group contract to describe the provisions required in Paragraph (1).
- D. (1) In addition to the provisions required in Subsection C(1), an individual contract shall provide for a ten-day period to examine and return the contract and have the premium refunded.
- (2) If services were received during the ten-day period, and the individual returns the contract to receive a refund of the premium paid, the individual must pay for those services.
- E. The commissioner may adopt regulations establishing readability standards for individual and group contract forms.

Drafting Note: The commissioner may adopt standards in the NAIC *Life and Health Insurance Policy Language Simplification Act*.

Section 9. Risk Bearing Entity Registration and Contracting Requirements

- A. Registration Requirements.
- (1) All risk bearing entities shall register annually with the commissioner in this state unless already subject to state insurance regulation.

Drafting Note: A state may wish to exempt a risk bearing entity from the registration requirements of this subsection, or modify the provisions of this subsection as they apply to a risk bearing entity, where a risk bearing entity accepts risk exclusively from a single health maintenance organization, provides direct care to covered persons of that health maintenance organization, and where detail of claims payments is available for examination from the health maintenance organization. A state may want to require the health maintenance organization to demonstrate to the commissioner that the contractual arrangement with the risk bearing entity will allow it to fulfill the provisions of its contract for the contract year. Health maintenance organizations contracting with risk bearing entities that are exempt from this subsection, or subject to modified registration requirements, should be subject to Subsections C and D of this section and Section 18 of this Act.

- (2) The registration shall be in a form approved by the commissioner and shall include:
- (a) The name of the risk bearing entity;
 - (b) The business address of the risk bearing entity;
 - (c) The principal contact person for risk bearing entity;
 - (d) The names and positions of senior officers of risk bearing entity, including, President, Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Executive Vice Presidents, Treasurer and Secretary;

- (e) A list of all entities on whose behalf the risk bearing entity has contracts or agreements to provide health care services;
 - (f) A matrix listing of all major categories of health care services provided by the risk bearing entity;
 - (g) An approximate number of total covered persons served in all the risk bearing entity's contracts or agreements;
 - (h) An annual audited Generally Accepted Accounting Principles (GAAP) financial statement;
 - (i) A list of all subcontractors of the risk bearing entity;
 - (j) Sample contract forms proposed for use between subcontractors and the risk bearing entity;
 - (k) A list of all stop loss arrangements; and
 - (l) Any other information or financial information requested by the commissioner.
- (3) The commissioner may charge a registration fee sufficient to cover the cost of implementing this section.
- (4) The risk bearing entity shall permit the commissioner to:
- (a) Inspect the risk bearing entity's books and records; and
 - (b) Examine, under oath, any officer or agent of the risk bearing entity with respect to the use of its funds and compliance with the terms and conditions of its contracts to provide covered benefits under the health benefit plan.
- (5) A risk bearing entity shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this section, together with such supporting documents as are necessary to explain the modification.

B. Contracting Requirements

- (1) Except as provided in Paragraph (2), a health maintenance organization shall not contract with a risk bearing entity that has not registered in accordance with this section.
- (2) The requirements of this section shall apply to any contract entered into, amended or renewed after the effective date of this section and shall apply to all contracts no later than two (2) years after the effective date of this section.
- (3) A health maintenance organization shall:
- (a) Unless already specified in the contract with the risk bearing entity, provide the following, upon request, to the risk bearing entity with which it contracts:
 - (i) At the time the contract is entered into, a written statement describing the amount or method of remuneration to be paid to the risk bearing entity. If any part of the remuneration is a calculated amount based on variable factors, the payment methodology upon which the calculated amount will be determined. The statement shall specify the services and expenses for which the risk bearing entity is financially liable in whole or part;
 - (ii) At the time payment is made, the basis of the calculation of that payment;

- (iii) For health benefit plans in which the covered persons are assigned to the risk bearing entity under a capitated payment arrangement, a list of enrollees and payments due to the risk bearing entity, to be provided monthly if not already available to the risk bearing entity;
 - (iv) At the time the contract is entered into, a copy of the health maintenance organization's most recent annual statement filed with the NAIC;
 - (v) Once the contract is in effect, the quarterly or annual statement filed with the NAIC; and
 - (vi) Any other information requested by the commissioner.
- (b) Include in its contracts with a risk bearing entity a provision that requires the risk bearing entity to provide to the health maintenance organization at the time a contract is entered into and annually thereafter:
- (i) Annual audited GAAP report;
 - (ii) Documentation that satisfies the health maintenance organization that the risk bearing entity has sufficient ability to accept risk; and
 - (iii) Documentation that satisfies the health maintenance organization that the risk bearing entity has appropriate management expertise and infrastructure;
- (c) Include in its contracts with a risk bearing entity a provision that requires the risk bearing entity to provide to the health maintenance organization a quarterly status report that includes:
- (i) GAAP financial statements;
 - (ii) An aging report of the percentage of claims that have been paid, pending or denied, across all contracts with risk bearing entities; and
 - (iii) On a monthly basis, a report of the estimated reported claims and incurred but not reported claims liability of the risk bearing entity; and
- (d) Require that a risk bearing entity with which the health maintenance organization contracts provide notice within thirty (30) days to the health maintenance organization of:
- (i) Any changes involving the ownership structure of the risk bearing entity;
 - (ii) Financial or operational concerns regarding the financial viability of the risk bearing entity; or
 - (iii) Loss of registration.
- (4) A health maintenance organization shall provide to the commissioner on a quarterly basis a list of all risk bearing entities with which it has an agreement or contract and the number of covered persons assigned or selected by each risk bearing entity, and any additional information the commissioner may require.
- (5) A health maintenance organization shall include in its contracts with a risk bearing entity a provision that allows the commissioner, in the event that a risk bearing entity fails to comply with any provision of this Act, to assign for six (6) months, the risk bearing entity's contract with providers to furnish covered services.

C. Oversight Responsibility

- (1) A health maintenance organization shall have procedures in place to notify the commissioner within a reasonable time that a risk bearing entity has materially failed to perform under its contract with the health maintenance organization. A health maintenance organization is not in violation of this paragraph if it acts in good faith in its attempt to comply. The commissioner may by rule enumerate more specific circumstances under which a report may be filed.
- (2) A health maintenance organization shall maintain systems and controls for, including but not limited to, reviewing the information provided to the health maintenance organization by the risk bearing entity pursuant to this Act.
- (3) Any information that has been provided to the commissioner by a health maintenance organization pursuant to this subsection is confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act and as allowed by state law, regardless of whether the information is in the form of paper, is preserved on microfilm or is stored in computer readable form. If the information is disclosed pursuant this subsection, the health maintenance organization providing the notice shall not be liable for the disclosure or any subsequent use or misuse of the information. The health maintenance organization shall be entitled to claim any statutory privileges against disclosure that the entity that provided the information to the health maintenance organization is entitled to claim.
- (4) Any person acting as a director, officer, employee, contractor or agent of a health maintenance organization, who, in good faith and without malice, makes any decision or takes any action to provide a notice of the type contemplated by this subsection shall not be subject to liability for civil damages or any legal action in consequence of that decision or action, nor shall the health maintenance organization, or any other director, officer, employee, contractor or agent be liable for the activities of the person.
- (5) In the event that a health maintenance organization has been notified that the registration of a risk bearing entity has been terminated, revoked, non- renewed or forfeited for any reason, a health maintenance organization shall terminate its contract with the risk bearing entity unless specific permission is provided by the commissioner to maintain the contract at the request of both parties, or enter into an agreement pursuant to which the risk bearing entity ceases to bear risk. The commissioner may set conditions on any agreements between the risk bearing entity and the health maintenance organization.
- (6) This subsection is not intended to create a private right of action.

D. Continuity of Care.

Notwithstanding any agreement to the contrary, the health maintenance organization shall:

- (1) Retain full responsibility on a prospective basis for the provision of health care services pursuant to any applicable health benefit plan; and
- (2) At all times, be able to demonstrate to the satisfaction of the commissioner that the health maintenance organization can fulfill its non-transferable obligation to provide health care services to covered persons in any event, including the failure, for any reason, of a risk bearing entity.

E. Enforcement Against Risk Bearing Entities.

- (1) If the commissioner determines that a risk bearing entity has not complied with any provision of this Act, the commissioner may terminate the risk bearing entity's registration, institute a corrective action against the risk bearing entity, or use any of the commissioner's other enforcement powers to obtain compliance with this Act.
- (2) The commissioner shall, within five (5) business days, inform each health maintenance organization with which a risk bearing entity contracts, in writing:
 - (a) Of any corrective action undertaken by the commissioner against a risk bearing entity; and

- (b) If the registration of a risk bearing entity has been revoked, non-renewed, forfeited or terminated.
- (3) The commissioner may, in the event that a risk bearing entity fails to comply with any provision of this Act, require the assignment of the risk bearing entity's contract to furnish covered services for a period not to exceed six (6) months.
- (4) The commissioner may assess fines on a risk bearing entity for every day that the entity has failed to meet the registration requirements of this section.

Section 10. Form and Rate Filing Requirements

Drafting Note: States that require prior approval of policy forms and premium rates should adopt Option A. States that have a system of file and use for policy forms and premium rates should adopt Option B.

Option A. Prior Approval

- A. Subject to Subsections B and C, no group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed with and approved by the commissioner.
- B.
 - (1) Every form required by this section shall be filed with the commissioner not less than thirty (30) days prior to delivery or issue for delivery in this state. At any time during the initial thirty-day period, the commissioner may extend the period for review for an additional thirty (30) days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the commissioner has taken no action. The filer must notify the commissioner in writing prior to using a form that is deemed approved.
 - (2) At any time, after thirty (30) days notice and for cause shown, the commissioner may withdraw approval of a form, effective at the end of the thirty-day period.
 - (3) Whenever the commissioner disapproves a form or withdraws approval of a form, the commissioner shall notify the health maintenance organization in writing of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing.
- C.
 - (1) A health maintenance organization shall not use a premium rate until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner.
 - (2) Any schedule of premium rates or rating methodology submitted pursuant to this subsection shall clearly state any copayments, coinsurance or deductibles to be paid by the covered person.
 - (3) Either a specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of covered persons, provided that the premium applicable to a covered person shall not be individually determined based on the status of the covered person's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

Drafting Note: States may wish to vary the type of information required to accompany a rate filing based on the type of rating mechanism in use. For instance, requiring that only the rating methodology for setting premium rates accompany the rate filing may be sufficient for experience rated groups, while requiring the rate filing to include both the schedule of rates and the rating methodology used to set the rates may be more appropriate for community rated or pooled groups. Regardless of whether a rating methodology or schedule of rates is required to accompany the rate filing, states should require that adequate supporting documentation be included.

- (4) The commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of Paragraph (2) are met. If the commissioner disapproves the filing, the commissioner shall notify the health maintenance organization, in writing, of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. If the commissioner does not take action on the schedule or methodology within thirty (30) days of the date of the filing of the schedule or methodology, it shall be deemed approved.

- D. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a form or rate filing made pursuant to this section.

Option B. File and Use

- A. No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form and rates have been filed with the commissioner at least thirty (30) days prior to its issuance or delivery.
- B.
 - (1) At any time, after its issuance and delivery, and for cause shown, the commissioner may disapprove the use of a form. The disapproval shall be effective thirty (30) days after the health maintenance organization receives the notice described in Paragraph (2).
 - (2) The commissioner shall notify the health maintenance organization, in writing, of the reasons for disapproval of the form. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. A written request for hearing shall stay the effect of the disapproval.
- C.
 - (1) A health maintenance organization shall not use a premium rate unless the premium rate or a methodology for determining the premium rate has been filed with the commissioner at least thirty (30) days prior to its use.
 - (2) The health maintenance organization shall certify that the rates meet the requirements of Paragraph (4).
 - (3) Any schedule of premium rates or rating methodology submitted pursuant to this subsection shall clearly state any copayments, coinsurance or deductibles to be paid by the covered person.
 - (4) A specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of covered persons, provided that the premium applicable to a covered person shall not be individually determined based on the status of the covered person's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A qualified actuary or other qualified person acceptable to the commissioner must certify the appropriateness of the use of the methodology, based on reasonable assumptions, backed by adequate supporting information.

Drafting Note: States may wish to vary the type of information required to accompany a rate filing based on the type of rating mechanism in use. For instance, requiring that only the rating methodology for setting premium rates accompany the rate filing may be sufficient for experience rated groups, while requiring the rate filing to include both the schedule of rates and the rating methodology used to set the rates may be more appropriate for community rated or pooled groups. Regardless of whether a rating methodology or schedule of rates is required to accompany the rate filing, states should require that adequate supporting documentation be included.

- (5) At any time after its implementation, and for good cause shown, the commissioner may disapprove the use of a specific rate or rating methodology. The commissioner shall notify the health maintenance organization, in writing, of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. A written request for a hearing shall stay the effect of the disapproval.

Section 11. Evidence of Coverage

- A.
 - (1) Every enrollee shall receive an evidence of coverage from the group contract holder or the health maintenance organization.
 - (2) The evidence of coverage shall not contain provisions or statements that are unfair, unjust, inequitable, misleading, deceptive, or that encourage misrepresentation as defined by [insert reference to state law equivalent to the NAIC *Unfair Trade Practices Act* (#880)].
 - (3) The evidence of coverage shall contain a clear statement of the provisions required in Section 8C of this Act.
- B. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the commissioner of this state for approval.

Section 12. Marketing and Advertising Materials

- A. The advertising and marketing materials of health maintenance organizations are subject to the requirements of [insert reference to state law equivalent to the NAIC *Advertisements of Accident and Sickness Insurance Model Regulation* (#40)].
- B. The advertising and marketing materials of health maintenance organizations marketing Medicare supplement insurance are subject to the requirements of [insert reference to state law equivalent to the NAIC *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651)].
- C. The advertising and marketing materials of health maintenance organizations marketing long-term care insurance are subject to the requirements of [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Regulation* (#641)].

Section 13. Information to Enrollees and Covered Persons

- A. A health maintenance organization shall provide, within thirty (30) days, notice to enrollees of any material change in the operation of the organization that will affect them directly.
- B.
 - (1) The health maintenance organization shall make written copies of provider directories available to enrollees upon enrollment and re-enrollment.
 - (2) The health maintenance organization shall provide written copies of provider directories to covered persons upon request.

- (3) The health maintenance organization shall provide the directory and any updates to enrollees, in writing or by electronic means, in accordance with the terms of its contract.
- C.
 - (1) A health maintenance organization shall notify covered persons of the termination of the primary care provider who currently provides health care services to that covered person.
 - (2) A health maintenance organization shall establish a method to permit a covered person, at the option of the covered person, to receive notice in writing or by electronic means, of the termination of the primary care provider who currently provides health care services to that covered person.
 - (3) The health maintenance organization shall provide assistance to the covered person in transferring to another participating primary care provider.
- D. The health maintenance organization shall establish a method to permit a covered person, at the option of the covered person, to obtain information in writing or by electronic means, on how services may be obtained, where additional information on access to services may be obtained and a telephone number where covered persons may contact the health maintenance organization, at no cost to the covered person.

Drafting Note: For the purpose of this section any major change in the provider network is considered a material change.

Section 14. Coordination of Benefits

- A. Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two (2) or more group health insurance or health benefit plans.
- B. If a health maintenance organization adopts coordination of benefits provisions, the provisions shall be consistent with [insert reference to state law equivalent to NAIC *Coordination of Benefits Model Regulation* (#120)] in general use in the state for coordinating coverage between two (2) or more group health insurance or health benefit plans.
- C. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination consistent with [insert reference to state law equivalent to NAIC *Coordination of Benefits Model Regulation* (#120)], health maintenance organizations shall make payments for services that are:
 - (1) Received from non-participating providers;
 - (2) Provided outside their service areas; or
 - (3) Not covered under the terms of their group contracts or evidence of coverage.

Section 15. Initial Net Worth and Capital Requirements

- A. Before the commissioner issues a certificate of authority in accordance with Section 6 of this Act, an applicant seeking to establish or operate a health maintenance organization shall have the greater of:
 - (1) The amount of capital required under [insert reference in state law equivalent to the *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315)];
 - (2) An initial net worth of \$3,000,000; or
 - (3) At the commissioner's discretion, an amount greater than required under Paragraph (1) or (2), as indicated by a business plan and a projected risk-based capital calculation after the first full year of operation based on the most current NAIC Health Annual Statement Blank.

Section 16. Ongoing Net Worth and Capital Requirements

- A. A health maintenance organization shall maintain minimum net worth equal to the greater of \$2,500,000 or the amount necessary to maintain capital required pursuant to [insert reference to state law equivalent to the

Risk-Based Capital (RBC) for Health Organizations Model Act (#315)].

- B. The amount in Subsection A may be adjusted annually for inflation, at the commissioner's discretion.

Drafting Note: The following definition of "managed hospital payment basis" and formulation for ongoing net worth, based on the 1989 amended version of HMO Model Act, have been included for the benefit of states that have not adopted the *Risk-Based Capital (RBC) for Health Organizations Model Act (#315)*:

"Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services. Examples of managed hospital payment basis agreements include but are not limited to payments on a DRG or per diem basis or where there is an agreement between a hospital and a health maintenance organization and which are under common ownership or control.

- C. A health maintenance organization shall maintain a minimum net worth equal to the greater of \$2,500,000; or an amount equal to the sum of:
- (1) Eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and
 - (2) Four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

Section 17. Deposit Requirements

- A. Unless otherwise provided in this section, a health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a market value of not less than \$1,000,000.
- B. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

- C. All income from deposits shall be an asset of the health maintenance organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited or substituted.
- D. The deposit shall be used to protect the interests of the health maintenance organization's covered persons and to assure continuation of health care services to covered persons of a health maintenance organization that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a rehabilitation, receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the liquidation act.
- E. The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, commissioner, or other official body of the state or jurisdiction of domicile for the protection of all covered persons, wherever located, of the health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

Section 18. Hold Harmless Provision Requirements for Covered Persons

- A. Except for coinsurance, deductibles or copayments as specifically provided in the evidence of coverage, in no event, including but not limited to nonpayment by the health maintenance organization, insolvency of the health maintenance organization or breach of contract among the health maintenance organization, risk bearing entity or participating provider, shall a risk bearing entity or participating provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization) acting on behalf of the covered person for covered services provided. No risk bearing entity or participating provider, nor any agent, trustee or assignee of the risk bearing entity or participating provider may maintain an action at law against a covered person to collect sums owed by the health maintenance organization.
- B. All contracts among health maintenance organizations, risk bearing entities, and participating providers shall include a hold harmless provision specifying protection for covered persons. Any attempted waiver or amendment in a manner materially adverse to the interests of covered persons of a hold harmless provision shall be null and void and unenforceable.
- C. The requirement of Subsection B shall be met by including a provision substantially similar to the following:

“Provider agrees that in no event, including but not limited to nonpayment by the health maintenance organization or intermediary organization, insolvency of the health maintenance organization or intermediary organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization or intermediary organization) acting on behalf of the covered person for covered services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, copayments or services in excess of limits, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons.”
- D.
 - (1) Any statement sent to a covered person shall clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.
 - (2) All contracts among health maintenance organizations, risk bearing entities, and participating providers shall require that all statements sent to covered persons clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

- (3) The notice requirements in this subsection shall be met by including in the statement to covered persons a provision substantially similar the following:

**NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY AMOUNTS OWED
BY YOUR HEALTH MAINTENANCE ORGANIZATION**

- E. Any violation of the provisions of this section shall constitute an unfair trade practice pursuant to [insert reference to state insurance fraud statute] and shall subject the health care provider to monetary penalties in accordance with [insert reference to state insurance fraud statute] and notification to the [insert reference to appropriate licensing entity for type of provider].

Drafting Note: States that do not authorize insurance departments to take action against providers should not adopt Subsection E and should consider other options such as contacting the state attorney general's office or other appropriate state official.

Drafting Note: States with consumer protection acts that provide covered persons with a private right of action should consider including a reference in Subsection E.

Section 19. Investment Powers

With the exception of investments made in accordance with Section 7A(1) of this Act, the investment practices of a health maintenance organization shall be governed by [insert reference to state law equivalent to the NAIC *Health Maintenance Organization Investment Guidelines*].

Section 20. Accounting Practices

Every health maintenance organization shall maintain its financial records in accordance with [insert reference to state law equivalent to NAIC *Accounting Practices and Procedures Manual*].

Section 21. Fiduciary Responsibilities

- A. A director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of the health maintenance organization shall be responsible for the funds in a fiduciary relationship to the health maintenance organization.
- B. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on these employees and officers, directors and partners in an amount not less than \$1,000,000 for each health maintenance organization or a maximum of \$10,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or the sum prescribed by the commissioner.

Drafting Note: As an optional additional subsection, language may be included that would make the appropriate provisions of the state's insurance laws governing prohibitions or restrictions on activities of directors, officers and certain shareholders applicable to health maintenance organizations.

Section 22. Annual and Quarterly Financial Statement Filing Requirements

- A. (1) Every health maintenance organization shall file annual and quarterly financial statements, as provided in Paragraph (2), with the commissioner and with the National Association of Insurance Commissioners (NAIC).
- (2) The annual statement shall be filed by March 1 for the preceding year and a quarterly financial statement by May, August and November 15 for the preceding quarter.
- B. The annual and quarterly financial statements shall be prepared on the most current NAIC Health Annual Statement Blank in accordance with the NAIC Annual Statement Instructions and the NAIC *Accounting Practices and Procedures Manual*.

Section 23. Reporting Requirements

- A. (1) Every health maintenance organization shall annually, on or before March 1, file a report verified by at least two principal officers with the commissioner covering the preceding calendar year. The report shall be on forms prescribed by the commissioner.
- (2) In addition, the health maintenance organization shall file by March 1, unless otherwise stated:
 - (a) Audited financial statements on or before June 1;
 - (b) A list of participating providers in a form approved by the commissioner; and
 - (c) (i) A description of the grievance procedures; and
 - (ii) The total number of grievances handled through these procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.
- B. (1) Unless otherwise provided in this Act, a health maintenance organization shall file notice with the commissioner within thirty (30) days of the effective date of a change, describing any material modifications to the documents required to be filed with the application for a certificate of authority as set forth in Section 5B(1) and (2) of this Act.
- (2) Unless otherwise provided in this Act, a health maintenance organization shall file with the commissioner advance notice, or if advance notice is not practicable, notice filed as soon as possible, but in no event more than thirty (30) days after the effective date of a change, describing any material modifications to the health maintenance organization's operations as set forth in the information required by Section 5B of this Act that affects any of the following:
 - (a) The solvency of the health maintenance organization;
 - (b) The health maintenance organization's continued provision of health care services that it has contracted to provide;
 - (c) The manner in which the health maintenance organization conducts its business; or
 - (d) Any other matters the commissioner may prescribe by regulation.
- C. The commissioner may require additional reports as necessary to carry out the commissioner's duties under this Act.

Section 24. Powers of Insurers and [Hospital and Medical Service Corporations]

- A. An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this Act. Notwithstanding any other law, which may be inconsistent, any two (2) or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care services by a health maintenance organization owned or operated by an insurer or its subsidiary.
- B. Notwithstanding any provision of insurance and hospital or medical service corporation laws [citations], an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The covered persons of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

Section 25. Examinations

- A. The commissioner may make an examination of the affairs of a health maintenance organization, providers and risk bearing entities with which the health maintenance organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state, but not less frequently than once every five (5) years.
- B. An examination conducted under this section shall be performed in accordance with the provisions of [insert reference to state law equivalent to the NAIC *Model Law on Examinations*].
- C. The expenses of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the commissioner.
- D. In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state provided that the provisions of [insert state law equivalent to Section 3C of the NAIC *Model Law on Examinations*] are satisfied.

Section 26. Suspension or Revocation of Certificate of Authority

- A. A certificate of authority issued under this Act may be suspended or revoked, and an application for a certificate of authority may be denied, if the commissioner finds that any of the conditions listed below exist:
 - (1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 5 of this Act, unless amendments to those submissions have been filed with and approved by the commissioner;
 - (2) The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 8 and 9 of this Act;
 - (3) The health maintenance organization does not provide or arrange for basic health care services;
 - (4) The health maintenance organization is unable to fulfill its obligations to furnish health care services;
 - (5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to covered persons or prospective covered persons;
 - (6) The health maintenance organization has failed to correct any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

Drafting Note: States that have not adopted *Risk Based Capital (RBC) for Health Organizations Model Act* (#315) should consider including a provision that provides for early warning and correction of insufficient net worth by a health maintenance organization.

- (7) The health maintenance organization has failed to implement internal grievance procedures in compliance with [insert reference to state law equivalent to the *Health Carrier Grievance Procedure Model Act* (#72)];
- (8) The health maintenance organization has failed to implement the external review procedures required by [insert reference to state law equivalent to the *Health Carrier External Review Model Act* (#75)];

Drafting Note: States that have adopted Options 1 or 2 of the NAIC *Health Carrier External Review Model Act* (#75) should not adopt this provision.

- (9) The health maintenance organization, or any person acting on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;
- (10) The continued operation of the health maintenance organization would be hazardous to its covered persons;

- (11) The health maintenance organization has otherwise failed substantially to comply with this Act or any regulation adopted pursuant to this Act; or
- (12) The health maintenance organization or applicant has violated any other provision of the state insurance code.

Drafting Note: States that have adopted an Administrative Procedures Act should adopt Option A. States that have not adopted an Administrative Procedures Act should adopt Option B.

Option A.

- B. The provisions of the [insert reference to state Administrative Procedure Act] of this state shall apply to proceedings under this section.

Option B.

- B. (1) Suspension or revocation of a certificate of authority or the denial of an application pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail. The written order shall state the grounds, charges or conduct on which the suspension, revocation or denial or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty (30) days from the date of mailing of the order. If no written request is made, the order shall be final upon the expiration of the thirty (30) day period.
- (2) If the health maintenance organization or applicant requests a hearing pursuant to this subsection the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail stating:
 - (a) A specific time for the hearing, which may not be less than twenty (20) days nor more than thirty (30) days after mailing of the notice of hearing; and
 - (b) A specific place for the hearing, which may be either in [location of regulatory body] or in the county where the health maintenance organization's or applicant's principal place of business is located.
- C. (1) With respect to individual contracts, when the certificate of authority of a health maintenance organization is suspended, during the period of suspension, the health maintenance organization shall not:
 - (a) Enroll any additional covered persons except newborn children or other newly acquired dependents of existing covered persons; and
 - (b) Engage in any advertising or solicitation.
- (2) With respect to group contracts, when the certificate of authority of a health maintenance organization is suspended, during the period of suspension, the health maintenance organization shall enroll additional enrollees and their eligible dependents and newly acquired eligible dependents of existing enrollees, including individuals who become newly acquired eligible dependents of an enrollee through marriage, birth or adoption or placement for adoption, who meet the requirements for special enrollment in accordance with [cite section of state law or regulation implementing the provisions of Section 2701(f) of the Public Health Service Act] or are otherwise eligible under the health benefit plan.

Drafting Note: Under Section 2701(f) of the Public Health Service Act, as amended by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for the group market, health maintenance organizations are required during special enrollment periods to enroll individual eligible employees and dependents of eligible employees and newly acquired dependents of already enrolled eligible employees, including individuals who become dependents through marriage, birth or adoption or placement for adoption. The language in Paragraph (2) is intended to reflect this requirement.

- D. When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit further operation of the organization found to be in the best interest of covered persons, to the end that covered persons will be afforded the greatest practical opportunity to obtain continuing health

care coverage.

- E. A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

Section 27. Summary Orders and Supervision

- A. Whenever the commissioner determines that the financial condition of a health maintenance organization is such that its continued operation might be hazardous to covered persons, creditors, or the general public, or that it has violated any provision of this Act, the commissioner may, after notice and hearing, order the health maintenance organization to take action reasonably necessary to rectify the condition or violation, including but not limited to one or more of the following:
 - (1) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;
 - (2) Reduce the volume of new business being accepted;
 - (3) Reduce expenses by specified methods;
 - (4) Suspend or limit the writing of new business for a period of time;
 - (5) Increase the health maintenance organization's capital and surplus by contribution; or
 - (6) Take other steps the commissioner may deem appropriate under the circumstances.
- B. For purposes of this section, the violation by a health maintenance organization of any law of this state to which the health maintenance organization is subject shall be deemed a violation of this Act.
- C. The commissioner is authorized to adopt regulations to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to covered persons, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization. The standards shall be consistent with the purposes expressed in Subsection A.
- D. The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of [insert reference to state law equivalent to Section 10 of the NAIC *Rehabilitation and Liquidation Model Act*].

Section 28. Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations

- A. A rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in [insert reference to state rehabilitation law], or when in the commissioner's opinion the continued operation of the health maintenance organization would be hazardous either to the covered persons or to the people of this state. Covered persons shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.
- B. For purpose of determining the priority of distribution of general assets, claims of covered persons shall have the same priority as established in [insert reference to state law relating to liquidation of insurers] for policyholders and beneficiaries of insureds of insurance companies. If a covered person is liable to a provider for services provided pursuant to and covered by the health benefit plan, that liability shall have the status of a covered person claim for distribution of general assets. A provider who is obligated by statute or agreement to hold covered persons harmless from liability for services provided pursuant to and covered by a health benefit plan shall have a priority of distribution of the general assets immediately following that of covered persons as described herein, and immediately preceding the priority of distribution described in [insert reference to state liquidation procedures].

Section 29. Penalties and Enforcement

- A. In addition to or in lieu of suspension or revocation of a certificate of authority or the denial of an application pursuant to Section 26 of this Act, the applicant or the health maintenance organization may be subjected to an administrative penalty of up to \$[insert number] for each cause for suspension or revocation or application denial.
- B.
 - (1) If the commissioner shall for any reason have cause to believe that a violation of this Act has occurred or is threatened, the commissioner may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation; and, in the event it appears that a violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.
 - (2) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section of this Act are satisfied.
- C. Notwithstanding any other provisions of this Act, if a health maintenance organization fails to comply with the net worth requirement of this Act or fails to correct its net worth to bring it into compliance with the requirements of this Act, the commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its covered persons.

Drafting Note: In addition to the actions provided in this section that a commissioner may use to enforce a health maintenance organization's compliance with the provisions of this Act, some states may authorize the commissioner to issue an order to a health maintenance organization or a representative of the health maintenance organization to cease and desist from engaging in an act or practice that is violation of this Act. In addition, the commissioner may also be authorized to institute an action seeking to obtain injunctive or other relief if the health maintenance organization fails to comply with the order to cease and desist. When the commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the attorney general or other appropriate state official.

Section 30. Regulations

The commissioner may promulgate regulations to carry out the provisions of this Act. The rules and regulations shall be subject to review in accordance with [insert reference to state law relating to administrative rulemaking and review of rules].

Section 31. Statutory Construction and Relationship to Other Laws

- A. Except as otherwise provided in this Act or in other laws expressly referring to health maintenance organizations, provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be applicable to a health maintenance organization granted a certificate of authority under this Act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this Act.
- B. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health care professionals.
- C. Any health maintenance organization authorized under this Act shall not be deemed to be practicing medicine and shall be exempt from the provision of [insert reference to state law relating to the practice of medicine].

Section 32. Filings and Reports as Public Documents

All applications, filings and reports required under this Act shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section 23 of this Act, and any other information that is considered privileged or confidential under state or federal law.

Section 33. Insurance Holding Company System Regulatory Act

All health maintenance organizations shall meet the requirements of [insert reference to state law equivalent to NAIC *Insurance Holding Company System Regulatory Act* (#440)].

Drafting Note: States that have not included health maintenance organizations within the scope of their state law equivalent to the NAIC *Insurance Holding Company System Regulatory Act* (#440) should not adopt this section.

Section 34. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 35. Effective Date

This Act shall be effective [insert date].

APPENDIX A

Former Section 3HH, Section 14 and Section 20

Below are the sections deleted to reconcile the provisions of this model with the 2017 revisions to the *Life and Health Insurance Guaranty Association Model Act* (#520), which added health maintenance organizations as members of the guaranty association.

Section 3HH. Definition of Uncovered Expenditures

“Uncovered expenditures” means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which a covered person may also be liable in the event of the health maintenance organization’s insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

Section 14. Continuation of Benefits

- A. The commissioner shall require that each health maintenance organization have a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.
- B. In considering such a plan, the commissioner may require:
 - (1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;
 - (2) Provisions in provider contracts that obligate the provider, after the health maintenance organization’s insolvency, to provide covered services through the period for which premium has been paid to the health maintenance organization on behalf of the covered person or until the covered person’s discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency will continue until their confinement in an inpatient facility is no longer medically necessary;
 - (3) Insolvency reserves;
 - (4) Acceptable letters of credit; or
 - (5) Any other arrangements to assure that benefits are continued as specified above.

Section 20. Uncovered Expenditures Deposit

- A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of 120 percent of the health maintenance organization’s outstanding liability for uncovered expenditures for covered persons in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.
- B. The deposit required under this section is in addition to the deposit required under Section 18 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.
- C. (1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

- (a) A substitute deposit of cash or securities of equal amount and value is made;
 - (b) The fair market value exceeds the amount of the required deposit; or
 - (c) The required deposit under Subsection A is reduced or eliminated.
- (2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.
- D. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of covered persons of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.
- E. The commissioner may by regulation prescribe the time, manner and form for filing claims under Subsection D.
- F. The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

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Project History

HEALTH MAINTENANCE ORGANIZATION MODEL ACT (#430)

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

In May 2018, the Health Insurance and Managed Care (B) Committee received a referral from the Receivership and Insolvency (E) Task Force. The Task Force requested the Committee to review all NAIC models involving health maintenance organizations (HMOs) to determine if conforming changes are needed to provide options for the states that have adopted or are adopting the 2017 revisions to the *Life and Health Insurance Guaranty Association Model Act* (#520), which added HMOs as members of the life and health insurance guaranty association.

In June 2018, the Committee decided to accept the referral from Receivership and Insolvency (E) Task Force to review relevant HMO NAIC models to determine if revisions need to be made for consistency with the 2017 revisions to Model #520. The Committee directed the Regulatory Framework (B) Task Force to conduct this review and report back to the Committee with any recommendations. At the 2018 Summer National Meeting, the Regulatory Framework (B) Task Force formed a new subgroup, the Health Maintenance Organization (HMO) Issues (B) Subgroup, to carry out this work. Kentucky volunteered to chair the Subgroup.

To assist the Subgroup in carrying out its work, NAIC staff reviewed several NAIC models having the most potential for being affected by the Model #520 revisions, including the *Health Maintenance Organization Model Act* (#430). NAIC staff recommended that the Subgroup review the following Model #430 provisions to develop its recommendations to the Committee regarding any potential revisions because of the Model #520 revisions:

- Section 3—Definitions, specifically the definition of “uncovered expenditures” in Section 3HH.
- Section 5—Establishment of Health Maintenance Organizations, specifically the provisions in Option B: Section 5B(16).
- Section 14—Continuation of Benefits.
- Section 18—Deposit Requirements.
- Section 19—Hold Harmless Provision Requirements for Covered Persons.
- Section 20—Uncovered Expenditures Deposit.
- Section 21—Open Enrollment and Replacement Coverage in Event of Insolvency.
- Section 31—Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations.

The Subgroup met Oct. 18, 2018, and Nov. 1, 2018, via conference call to discuss whether it was necessary to revise Model #430 and if so, the scope of the potential revisions, such as revising Model #430 narrowly to address any inconsistencies with the revised Model #520 or revising Model #430 more broadly to include other revisions not related to the revised Model #520. The Subgroup recommended to the Regulatory Framework (B) Task Force that Model #430 be opened for revision, but the Subgroup decided to defer to the Task Force the scope of the revisions.

The Regulatory Framework (B) Task Force presented the Subgroup’s recommendation to the Committee. The Committee accepted the Task Force’s recommendation to open Model #430 to address any conflicts and inconsistencies with the 2017 revisions to Model #520 during its Feb. 14, 2019, meeting. During its Feb. 26, 2019, meeting, the Task Force directed the Subgroup to move forward with developing and adopting a 2019 charge to revise Model #430 and pursue adoption of a Request for NAIC Model Law Development to revise Model #430. Virginia volunteered to chair the Subgroup to complete its work to revise Model #430 to address any conflicts and inconsistencies with the 2017 revisions to Model #520.

During its April 29, 2019, meeting, the Subgroup adopted its 2019 charge to revise Model #430 to revise provisions in Model #430 to address conflicts and redundancies with the provisions in Model #520. The Subgroup also developed a Request for NAIC Model Law Development to revise Model #430 consistent with its charge. The Regulatory Framework (B) Task Force adopted the Subgroup’s 2019 charge and its Request for NAIC Model Law Development May 15, 2019. The Committee adopted the Task Force’s 2019 revised charges and the Request for NAIC Model Law Development in June 2019. The Executive (EX) Committee adopted the Request for NAIC Model Law Development at the 2019 Summer National Meeting.

The Subgroup met May 16, 2019, and June 24, 2019 via conference call to discuss its next steps for moving forward while waiting for adoption of its Request for NAIC Model Law Development. The Subgroup requested comments from stakeholders. The Subgroup met Sept. 16, 2019, and Nov. 21, 2019, via conference call to discuss proposals from the Virginia Insurance

Bureau and the Maine Department of Insurance (DOI) for revising Model #430 consistent with its charge. The Subgroup decided to use the Maine DOI approach.

In late December 2019, the Subgroup exposed a draft for a public comment period ending March 18, 2020. The Subgroup discussed the comments received on the draft June 11, 2020, via conference call. The Subgroup decided to accept some of the suggested revisions and exposed a revised draft for comment. The Subgroup adopted the revised draft July 13, 2020, via conference call. The Regulatory Framework (B) Task Force adopted the proposed revisions to Model #430 Sept. 24, 2020, via conference call. The Committee adopted the revisions Nov. 2, 2020, via conference call.

The revisions delete several provisions in Model #430 to reconcile it with the 2017 revisions to Model #520. The deleted provisions include Section 14—Continuation of Benefits, Section 20—Uncovered Expenditures Deposit and Section 3HH, the definition of “uncovered expenditures.” For states that do not intend to adopt the 2017 revisions to Model #520, for reference, a new appendix to the model includes these deleted provisions. The Subgroup also deleted Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency because the section’s provisions are obsolete due to the federal Affordable Care Act (ACA).

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

The Health Maintenance Organization (HMO) Issues (B) Subgroup of the Regulatory Framework (B) Task Force drafted the proposed revisions to Model #430. The members of the Subgroup were: Colorado, Florida, Illinois, Kentucky, Maine, Missouri, Nebraska, Virginia, Washington, West Virginia and Wisconsin. Kentucky chaired the Subgroup in 2018. Virginia chaired the group in 2019 and 2020.

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

The Regulatory Framework (B) Task Force established the Health Maintenance Organization (HMO) Issues (B) Subgroup in 2019 to carry out the charge below:

“Revise provisions in the *Health Maintenance Organization Model Act* (#430) to address conflicts and redundancies with provisions in the *Life and Health Insurance Guaranty Association Model Act* (#520).”

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.; include any parties outside the members that participated)

Beginning in March 2019 and ending in July 2020, the Subgroup reviewed and discussed all the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers and guaranty association representatives. Each draft of proposed revisions was posted to the Subgroup’s web page on the NAIC website. All comment letters received also were posted. The Subgroup met via conference call in open meetings throughout the drafting process.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

Beginning in March 2019 and ending in July 2020, the Subgroup reviewed and discussed all the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers and guaranty association representatives. Each draft of proposed revisions was posted to the Subgroup’s web page on the NAIC website. All comment letters received also were posted. The Subgroup met via conference call in open meetings throughout the drafting process.

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

There were no significant items of controversy raised during the drafting process. However, the Subgroup extensively discussed what approach to take to revising Model #430 given that some states will not adopt the 2017 revisions to Model #520 and preserving those sections removed from Model #430 for those states. The Subgroup considered a few options, including: 1) retaining the sections that needed to be deleted to reconcile Model #430 with Model #520 and add explanatory drafting notes; or 2) deleting the necessary sections and adding explanatory drafting notes. The Subgroup decided the best approach to address this issue was to delete the section and include the deleted sections in a new appendix to Model #430.

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

None.

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Workers' Compensation Policy and the Changing Workforce

ABSTRACT

This paper explores how changes in work and the evolving landscape of legal employment are shifting responsibility for coverage and benefits for occupational injuries, illnesses, and fatalities. Policymakers and regulators need to understand how these changes may create gaps in coverage for workers and leave employers vulnerable to uncertain liability for injuries and deaths on the job. The paper also explores alternative policy solutions to ensure workers have access to benefits if they suffer workplace injury.

INTRODUCTION

Today's workforce and workplace look very different from the workforce and workplace when the first workers' compensation laws were passed. The cumulative impact of these changes has made it important to consider the role public policy plays in protecting workers from the health and economic consequences of an occupational injury, illness, or fatality. For most of the past century, a significant portion of workers in the U.S. labor force were protected against economic strain and physical harm through state workers' compensation laws. As work relationships have grown increasingly complex, there is uncertainty in workers' compensation protections for some in the labor force. The changes and discussions in this paper are a part of broader discussions on how employment benefits and protections might be revised, redesigned, or reimagined to reflect the contemporary work environment more accurately.

The twenty-first century workforce is more diverse, more de-centralized and more mobile than ever before. This is often at odds with employment classification laws, which were adopted when workers were predominately male and work was conducted in centralized facilities with a rigidly defined management hierarchy. Increasing work fluidity and the application of often conflicting state and federal law are resulting in business uncertainty and legislative proposals across the country. This paper presents an overview of the existing employment classification models and describes the latest legislation aimed at clarifying employment status.

Finally, the paper raises important policy questions that must be considered in light of the new work environment. Policymakers, in addition to business and labor leaders, will also appreciate the description of models and pilot programs that seek to deliver health and economic benefits to injured workers beyond the traditional workers' compensation system. Discussion and development of solutions is essential for continued economic prosperity and social stability.

Part I: Changing Relationships with Work

Background

An individual's connection to work shapes his or her life in visible and invisible ways – from lifestyle habits to self-esteem to social benefits. Throughout the last two centuries, those connections to work have become more formal and enshrined in local, state, and federal law. This work, or employment relationship, is important to individuals and their families as benefits and social protections are frequently gained through employment.¹

The first workers' compensation laws in the United States arose out of changes in the nature and connection to work. The Industrial Revolution saw workers move from farms and villages to cities, transitioning from farm and community-based work to manufacturing and industrial jobs. These changes resulted in more workers in employee/employer relationships with defined wages, hours, and job requirements.

Workers' compensation insurance prevents employees from taking legal action against their employers for workplace injuries, illnesses and deaths. In return, employees get defined benefits for covered injuries, illnesses and deaths regardless of fault or liability.²

Industrial work was dangerous, and work injuries and fatalities rose, reaching more than 61,000 deaths at work in the U.S. in 1914.³ Recognizing the economic and social cost of these injuries and deaths, state policymakers successfully passed workers' compensation laws in the majority of states by 1920. Workers' compensation was no-fault, providing guaranteed wage replacement and medical benefits for employees injured or killed at work.

A Century of Change

The past century has witnessed a transformation across the workforce and the workplace. The number of women in the labor force has steadily increased since 1948. Women represented 57.1% of the U.S. labor force in 2018.⁴ The labor force has increased in ethnic diversity. Hispanics represented 17% of the U.S. labor force in 2016 and all minorities (African-Americans, Asian-Americans, Hispanics/Latinos, and Native Americans) are projected to make up 37% of the working-age population by 2020.⁵ The labor force is steadily getting older. Workers 55 and older are projected to be close to 25% of the labor force by 2024. Union participation has been in decline; 10.7% of wage and salary workers were union members in 2017 (Figure 1).⁶ Higher education has also played a part in the labor force. Between 1992 and 2016, workers with college degrees, including advanced degrees, has increased steadily.⁷

¹ Employment benefits can include health, disability, and/or life insurance, retirement contributions, paid time off, flexible spending accounts, and/or tuition reimbursement. Social protections can include unemployment, workers' compensation, accommodations, equal opportunity, etc.

² Workers' Compensation: Overview and Issues, <https://fas.org/sgp/crs/misc/R44580.pdf>

³ Bureau of Labor Statistics.

⁴ <https://www.bls.gov/opub/reports/womens-databook/2019/home.htm#:~:text=Women's%20labor%20force%20participation%20was%2057.1%20percent%20in%202018%2C%20little,unchanged%20from%20the%20previous%20year.>

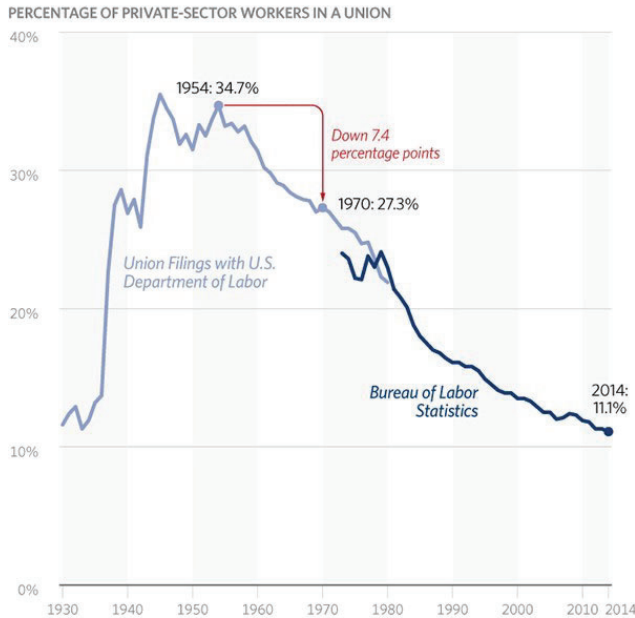
⁵ The National Center for Public Policy and Higher Education, figure 1. See:

https://www.google.com/url?sa=i&source=images&cd=&ved=2ahUKewi7iJymr9jlAhWOqp4KHcycDgUQjRx6BAGBEAQ&url=http%3A%2F%2Fwww.highereducation.org%2Freports%2Fpa_decline%2Fdecline-fl.shtml&psig=AOvVaw3uOJhMnZZkdRlImJCFoRP_&ust=1573225338643184

⁶ Union Rates: <https://www.bls.gov/news.release/union2.nr0.htm>

⁷ <https://www.bls.gov/spotlight/2017/educational-attainment-of-the-labor-force/pdf/educational-attainment-of-the-labor-force.pdf>

Figure 1. Union Membership Rates Began Falling in Mid-1950s



Sources: Data for 1930-1980: U.S. Department of Labor, assorted labor union reports/Haver Analytics. Note these figures exclude employee associations. Data for 1977-2014: Barry T. Hirsch and David A. Macpherson, "Union Membership and Coverage Database from the Current Population Survey," Unionstats.com, <http://www.unionstats.com> (accessed February 23, 2015), and U.S. Department of Labor, Bureau of Labor Statistics. Data was interpolated for 1982.

The workplace is physically different. Offices that had rows of desks with telephones and typewriters have been replaced by flex workstations and collaboration rooms. It is estimated that 4.3 million employees, close to 3% of the U.S. labor force, worked at home at least half the time in 2016. Additionally, regular work-at-home by employees have grown 140% over the last decade.⁸ Manufacturing facilities have moved from manually operated heavy equipment to technology-run, highly automated processing. <https://globalworkplaceanalytics.com/telecommuting-statistics>

<https://qz.com/work/1392302/more-than-5-of-americans-now-work-from-home-new-statistics-show/>

The kind of work is changing. The last century saw steady decline in agricultural work, manufacturing has remained steady, and service work has dramatically increased. The U.S. Bureau of Labor Statistics (BLS) projects that nine out of 10 new jobs in the next decade will be in the service-providing sector.⁹ Healthcare, personal care, community and social services, and computer and mathematical employment are some of the expected fastest-growing occupations.

These changes have dramatically impacted the way people work and live across the U.S. The cumulative impact of these changes is an expansion of the U.S. economy. Real gross domestic product (GDP) has grown from approximately \$3 trillion in 1957 to \$19 trillion in 2019.¹⁰ Labor productivity was 3.8 times higher in 2016 than in 1950 (Figure 2).¹¹

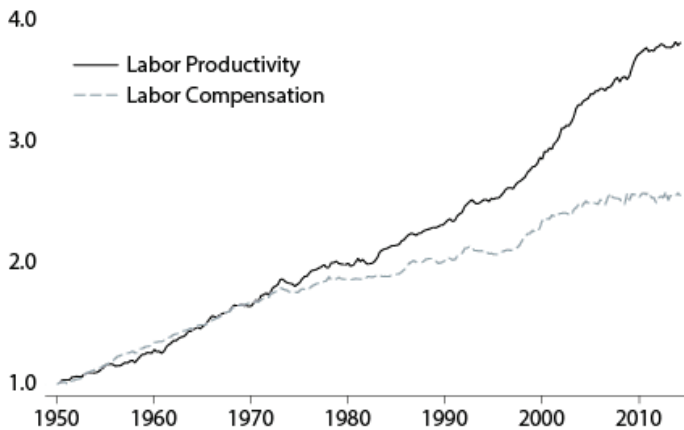
⁸ Work at home: <http://globalworkplaceanalytics.com/telecommuting-statistics>

⁹ <https://www.bls.gov/news.release/pdf/ecopro.pdf>

¹⁰ Data source found at: <https://www.thebalance.com/us-gdp-by-year-3305543>

¹¹ Data source found at: <https://research.stlouisfed.org/publications/economic-synopses/2016/08/12/labor-compensation-and-labor-productivity-recent-recoveries-and-the-long-term-trend/>

Figure 2. Compensation and Productivity: Long-Term Trend



NOTE: Both lines are normalized to 1 at 1950:Q1. Labor productivity equals real total output divided by total hours worked. Labor compensation equals real total labor compensation divided by total hours worked.
SOURCE: BLS Labor Productivity and Costs dataset for the nonfarm business sector.

Over the century, work has also gotten safer. Workplace injuries and fatalities have declined dramatically. The workplace fatality rate was 3.5 workers per 100,000 in 2018¹² contrasted with 61 workers per 100,000 in 1914¹³. The rate of injuries/illnesses requiring time away from work was 2.8 per 100 workers in 2018 contrasted with five per 100 workers in 1914.¹⁴

The decrease in occupational injuries, illnesses, and fatalities is especially good for workers' compensation. These declines are keeping more employees engaged in the labor force and making it more affordable for businesses to obtain coverage. However, demographic and work changes have raised other challenges for the workers' compensation system. The kinds of injuries and illnesses are different, compensability questions are different, and treatment options are different. These, taken with the evolving employment relationship landscape, raise important questions about the central principles of workers' compensation and if and how they should evolve in the future.

Connections to Work

Another significant change happening within the U.S. labor force is how individuals are connected to work. From the legal perspective, there are two classifications of workers - employees and independent contractors. The common picture of an independent contractor is a person with specialized skills, talents, or expertise who works on a project basis. Independent contractors would typically have multiple clients and conduct their work with a fair degree of autonomy. Businesses would use independent contractors to supplement knowledge or experience of their existing workforce on a temporary basis to meet demand or deadlines.

Employee or Independent Contractor

Workers' compensation is generally compulsory for employers,¹⁵ and each state has rules that define employees for the purpose of workers' compensation coverage. Securing workers' compensation coverage for each of its employees is a direct business cost. In contrast, independent contractors are generally not required to have workers' compensation coverage.

¹² <https://www.bls.gov/news.release/pdf/cfoi.pdf>

¹³ <https://www.bls.gov/opub/mlr/2016/article/the-life-of-american-workers-in-1915.htm>

¹⁴ Bureau of Labor Statistics.

¹⁵ All states, except Texas and South Dakota, have compulsory workers' compensation requirements for employers. Exclusions for certain employers or kinds of employees exist in most states. The IAIABC/WCRI Inventory of Workers' Compensation laws describes coverage exclusions for each of the states.

Defining an employee or independent contractor has been a challenge within state workers' compensation systems, but classification has become more difficult as employment relationships have increased in complexity. These changes have important implications for workers' compensation, including which workers should be covered under workers' compensation and who should bear the costs of coverage. Additionally, policymakers are needed to explore how coverage requirements align incentives for businesses and workers.

While many businesses use independent contractors for highly specialized or project-based work, many organizations have made contract labor a more permanent part of their workforce. July 2018 headlines noted that the number of contractors now exceeds the number of employees at Google.¹⁶ Countless large businesses, including Apple, Facebook, and Amazon, have noted the same trend. Contract labor is used by businesses for everything from security and food service to coding and sales.

The decision by a business in how to classify its workers is significant as many protections and benefits for workers are tied to employment, including workers' compensation coverage requirements. Businesses weigh many factors when considering utilizing employees or independent contractors, but the direct cost to businesses for employees is estimated at 20-30% higher than independent contractors.

Table 1. Employee vs. Independent Contractor Status

	Business Considerations		Worker Considerations	
	Pros	Consequences	Pros	Consequences
Employees	<ul style="list-style-type: none"> Control over how, when, and where work is conducted. Less turnover Reduced litigation from employment classification disputes 	<ul style="list-style-type: none"> Higher cost (contributions to Medicare, SS, UI, WC, other payroll contributions) Compliance and enforcement with employment protections (ADA, minimum wage, FMLA, anti-discrimination, etc.) 	<ul style="list-style-type: none"> Employer contributions to Medicare, SS, UI, WC, other payroll contributions Employment protections (ADA, minimum wage, FMLA, anti-discrimination, etc.) Stability and security 	<ul style="list-style-type: none"> Diminished flexibility in how, when, and where work is conducted Limited ability to work for multiple businesses
Independent Contractors	<ul style="list-style-type: none"> Reduced cost More flexibility (on-demand labor) Gain specialized skills or experience 	<ul style="list-style-type: none"> Less control over how, when, and where work is conducted. Increased turnover Potential liability for injuries/illnesses/deaths by contractor Increased exposure to employment classification lawsuits 	<ul style="list-style-type: none"> Flexibility in how, when, and where work is conducted Ability to work with multiple businesses/clients 	<ul style="list-style-type: none"> Responsible for all required payroll contributions Not covered by many employment protections

¹⁶ <https://www.bloomberg.com/news/articles/2018-07-25/inside-google-s-shadow-workforce>

Alternative Work Arrangements

Whether a worker benefits from the protection of a workers’ compensation policy depends on whether he or she is classified as an employee or an independent contractor. However, several alternative work relationships exist that fall along the spectrum of employee and independent contractor. These alternative work relationships create additional complexity in determining employment classification. The following alternative work arrangements are defined and tracked by the BLS:

- Independent contractors:** Workers identified as independent contractors, independent consultants, or freelance workers, regardless of whether they are self-employed or wage and salary workers.
- On-call workers:** Workers called to work only as needed, although they can be scheduled to work for several days or weeks in a row.
- Temporary help agency workers:** Workers paid by a temporary help agency, whether or not their job is temporary.
- Workers provided by contract firms:** Workers employed by a company that provides them or their services to others under contract, are usually assigned to only one customer, and usually work at the customer’s work site.

For the purposes of this paper, alternative work arrangements refer to any work performed by anyone not legally defined as an “employee.” Alternative work arrangements raise important questions about coverage for injuries, illnesses, or fatalities occurred while working.

Platform Work

Alternative work arrangements are not new; however, expanded internet connectivity has created new ways to connect to work. Companies allowing workers or service providers to connect to clients or customers via the internet are often described as online platforms. Online platforms have created additional complexity in defining the legal work relationship. The rise of online platforms is often seen as being synonymous with the sharing or “gig” economy; however, these platforms reflect an example of a way to facilitate an alternative work arrangement.

Some platform workers may use this type of work as supplemental income while having a full-time job. Others work for multiple platforms at one time, piecing together a living wage.¹⁷ Platform work has expanded broadly across industries, with many types of work and services offered.

Table 2. Examples of Online Platforms

Industry	Companies
Human Intelligence Tasks	Amazon Mechanical Turk
Service (cleaning, installation, etc.)	Taskrabbit, Handy, Shiftgig
Transportation	Uber, Lyft, Sidecar
Shipping/Logistics	Postmates, Airmule
Legal	UpCounsel, PowerUp Legal,
Design/Communications	Upwork, 99designs, freelancer

By the Numbers

Quantifying the number of individuals within these various work arrangements is important in understanding how many workers are not covered if they have an occupational injury, illness or fatality. A rising number of individuals in alternative work arrangements could necessitate the need for new private or public solutions to address coverage gaps. Design and implementation of new programs will be influenced by who and how many workers they will serve.

Numerous public and private research efforts have attempted to quantify individuals in various work arrangements. Estimates range from less than 3% to more than 40% of the workforce. There are many

¹⁷ It is estimated that 40% of platform workers work for multiple platforms at one time. *2015 1099 Economy Report* by Requests for Startups published May 2015.

reasons for the significant difference in estimates, including data sources, survey methodology, definitions of work arrangements, and counting primary or supplemental income.¹⁸

Estimates of Alternative Work Arrangements

Date	Publication	Description	Estimate
May 2019	MBO Partners: The State of Independence in America	Report by MBO Partners measures independent workers in the U.S. economy.	12.3% of workforce engages in “full-time independent work.”
June 2018	BLS Contingent Worker Supplement	Published by the Bureau of Labor Statistics, the supplement measures workers in contingent (short-term or temporary) or alternative arrangements (independent contractors, temporary, on-call, or contract) as their primary source of income.	10.1% workforce in alternative arrangements for “primary income source”
May 2018	Report on Economic Well-Being of U.S. Households in 2017	Released by the Federal Reserve System, the survey measures adults engaged in “gig work” including both offline and online services and sales. ¹⁹	31% adults engaged in “gig work”
2018	State of Independence in America 2018	Longitudinal study by MBO Income that quantifies workers with independent work arrangements, including consultants, freelancers, contractors, temporary and on-call workers.	26.9% of employed population in independent work
October 2017	Freelancing in America, 2017	Published by the Freelancers Union and Upwork, the publication estimates the number of workers in supplemental, temporary, project or contract-based work.	36% of the workforce in alternative work

This broad range and lack of research consensus has resulted in inconsistent focus and no clear mandate for policy change.

Beyond measuring the number of individuals in different types of work arrangements, it is also useful to examine multi-year trends. Besides the 2017 BLS Contingent Workforce Supplement, most studies have charted an increase over the last decade in the percentage of individuals engaged in independent or alternative work for primary or supplemental income. If this trend continues it may have important implications for labor and employment policy, including workers’ compensation programs.

Impact of Change

These changes and continued technological advancement will influence the U.S. workforce and workplace in the years to come.

Some of these changes have a direct impact on workers’ compensation systems. The long-term trend of declining injuries and illnesses has translated to stable or reduced premiums for employers and robust private insurance markets in most states. Other changes have influenced how care is delivered and return-to-work opportunities for those displaced from work.

Other changes, including labor force demographics and new work environments, could influence workers’ compensation both directly and indirectly. Demographic changes are influencing who, how, and where individuals are connecting to work. The differing needs (flexibility, portability, supplemental income, debt repayment, etc.) of these diverse workers may result in accelerating growth in alternative work arrangements. The ability to engage and perform services in new ways, virtual and remote, blurs lines between control and the direction of work.

Taken in whole, these changes are increasing the need to examine existing labor law and how social benefits and protections are delivered in the future. The workers’ compensation system does not exist in a vacuum. Coverage for an occupational injury, illness, or fatality must be considered in the context of the large-scale changes within the

¹⁸ Cornell University’s School of Industrial and Labor Relations and the Aspen Institute’s Future of Work Initiative maintain the Gig Economy Data Hub which catalogues public and private research efforts to quantify various alternative work arrangements.

¹⁹ Offline services could include caregiving or house-cleaning and offline sales could include flea markets or thrift sales; online services could include platform or app work and online sales could include selling items online.

economy. At the heart of this discussion is how workers are connecting to work and who will bear responsibility for any occupational injury, illness, or fatality that occurs.

Part II: Determining Employment Status

Employment status is essential for understanding the benefits and protections to which a worker is entitled and the financial obligations a business must pay. The rules for this determination are found in federal and state statute. This is a complex and nuanced area of the law, with determinations of employment status dependent on the application of various tests and characteristics.²⁰ There is no coordination of employment determination between federal and state law.

Federal Standard

Federal statutes define “employee” in many different ways. Employment related tests are considered by the Internal Revenue Service (IRS), U.S. Social Security system, Federal Insurance Contributions Act (FICA), federal Fair Labor Standards Act (FLSA), federal Civil Rights Act, federal Age Discrimination in Employment Act (ADEA), Americans with Disabilities Act (ADA), Federal Unemployment Tax Act (FUTA), and many others.

Three tests have been used in employment determination under federal law. Depending on the law, test used, and case-specific facts, a worker could be considered an employee under one law and an independent contractor under another. Employee determination under federal law does not influence workers’ compensation coverage obligations under state law. However, there are similarities in the many characteristics considered at the state and federal level. In addition, continued changes in how workers connect to work may result in pressure to clarify and/or align employment under various areas of the law.

Tests for Employment Determination under Federal Law²¹

Common law (control): The common law test hinges on control of the means and methods of work. This can include a variety of different factors including direction and supervision of work activities, tools and materials, payment, and intent of the relationship. The IRS uses the common law test and advises three broad categories of consideration: 1) behavioral control; 2) financial control; and 3) relationship of the parties.²²

Economic realities: The economic realities test looks at the financial dependence of a worker on services performed for a specific business. This can include a variety of different factors, including the level of financial risk, whether services are integral to the business operation, and investment in facilities and equipment. The economic realities test is commonly applied under the FLSA which governs minimum wage and overtime requirements. The economic realities test is broader than the control test and generally favors employee status.

Hybrid: The hybrid test looks at both economic and common law factors. Under the hybrid test, economic realities are more heavily weighted than common law characteristics. The hybrid test has been applied in employment determinations under Title VII of the Civil Rights Act. (*see* <https://www.bls.gov/opub/mlr/2002/01/art1full.pdf>)

Numerous cases have tested the interpretation of federal law in determining employment status. A series of FedEx cases across 20 states²³ found the company improperly classified ground delivery drivers as independent contractors. The decisions hinged largely on the direction and control of drivers. Factors considered included requirements by FedEx drivers to wear uniforms, adhere to appearance standards, drive approved vehicles, and deliver packages on specific days and within certain times.

Decisions of the National Labor Relations Board (NLRB) have also been influential in the interpretation of federal law in this area. Most recently, a January 2019 ruling overturned a 2014 decision²⁴ in favor of employee status based on the application of factors related to entrepreneurial opportunity. The NLRB decision in SuperShuttle DFW noted the independence of drivers in setting hours, ownership/lease of vans, and control of payment methods results in

²⁰ Even the courts have expressed frustration in the lack of clarity in employment determinations. The Supreme Court, for example, has referred to the definition of an employee under the Americans with Disabilities Act as a “mere ‘nominal definition,’” *Clackamas Gastroenterology Assocs. v. Wells*, 538 U.S. 440, 444 (2003), and has stated that the definition of an employee under the Employee Retirement Income Security Act is “completely circular and explains nothing,” *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 323 (1992)

²¹ See [https://www.law.upenn.edu/journals/jbl/articles/volume14/issue3/Rubinstein14U.Pa.J.Bus.L.605\(2012\).pdf](https://www.law.upenn.edu/journals/jbl/articles/volume14/issue3/Rubinstein14U.Pa.J.Bus.L.605(2012).pdf)

²² See IRS at <https://www.irs.gov/newsroom/understanding-employee-vs-contractor-designation>

²³ Numerous lawsuits against FedEx were filed beginning in 2004. Two class action lawsuits were heard and decided by the Seventh Circuit Court of Appeals and the Ninth Circuit Court. The decisions resulted in mediated settlements with FedEx of more than \$400 million.

²⁴ NLRB in a 2014 FedEx case found in favor of employee status for drivers based on application of the common law test emphasizing direction and control.

significant entrepreneurial opportunity. The greater the entrepreneurial opportunity the more likely it is an independent business which would favor independent contractor status. (*see SuperShuttle DFW, Inc. and Amalgamated Transit Union Local 1338.*)

This decision was influential in shaping the NLRB Advice Memorandum related to Uber and Uber drivers' ability to unionize. The memo finds drivers for Uber are independent contractors based on the factors discussed in SuperShuttle DFW, with significance placed on control over manner and means and how the driver is compensated. Both decisions cite entrepreneurial independence as a key consideration in independent contractor status.

The NLRB notes, "Whether to take advantage of these opportunities were among the many entrepreneurial judgments UberX drivers made due to their freedom to set their work schedules, choose log-in locations, and pursue earnings opportunities outside the Uber system." The ability to work for competitors beyond Uber outweighed other factors of control asserted by the platform, including baseline fares, inability to subcontract work or repeated rejection of trips. Additionally, they noted that minimum service standards and driver ratings had little impact on the driver's earning potential. (*see Uber Technologies, Inc. Cases 13-CA-163062, 14-CA-158833, and 29-CA-177483.*)

In considering platform workers, the U.S. Department of Labor (DOL) issued an opinion letter in April 2019 which designated service providers of one platform as independent contractors under the FLSA. In applying the "economic realities" test, the U.S. DOL considered six factors²⁵ of service providers who secured jobs through the virtual platform. The opinion letter described the platform as a referral service not an employer.

These recent opinions have been interpreted by many as a signal of the current administration's leaning toward liberal application of independent contractor status. It is noted again these interpretations have no bearing in employment classification status under state workers' compensation laws. It remains to be seen if state courts will evaluate control or economic realities tests in similar ways.

State Standards

In 2017, more than 140 million U.S. jobs were covered under state workers' compensation systems (NASI, Workers' Compensation Benefits, Cost, and Coverage, 2019). State law defines workers' compensation coverage requirements across the U.S. In all states but Texas and South Dakota,²⁶ coverage is compulsory for employers. However, coverage exemptions are common. Many states do not require that workers' compensation coverage be purchased for domestic and agricultural workers²⁷ and small employers.²⁸

The general trend over the past century has been expansion of coverage to increase the number of workers protected under the workers' compensation system. The rise of alternative employment relationships may signal a reversal of this trend. The more workers that find themselves in alternative work arrangements, the more likely they will fall outside the protection of workers' compensation.

Much like federal law, there may be multiple definitions of "employee" within a state that apply to different areas of the law. This can include intra-state variation across the department of revenue, unemployment insurance, and/or workers' compensation.

In an effort to simplify and reduce confusion from differing "employment" determinations across state agencies, some states have sought to develop a statewide definition of "employee." One such effort was in Maine, when the governor created a cross-agency task force comprised of the Maine DOL, Maine Workers' Compensation Board, and the Maine Attorney General's Office, to develop a single definition of "employee." The result was the following:

Services performed by an individual for remuneration are considered to be employment subject to this chapter unless it is shown to the satisfaction of the bureau, that the individual is free from the essential direction and control of the employing unit, both under the individual's contract of service and in fact, the employing unit proves that the individual meets all of the criteria in Number 1 and three (3) of the criteria in Number 2 as listed below. (See https://www.maine.gov/labor/misclass/employment_standard.shtml)

²⁵ The six factors included control; permanency of relation; investment in facilities, equipment, and helpers; skill, initiative, judgment, or foresight required; opportunity for profit and loss; and integrality.

²⁶ Workers' compensation is voluntary in both Texas and South Dakota. In both states, employers lose the right to the exclusive remedy if they fail to purchase coverage.

²⁷ Recently, exemptions for agricultural workers have been challenged. The New Mexico Supreme Court ruled in 2016 that the agricultural exemption was unconstitutional

²⁸ A list of state-by-state exemptions can be found in Table 2 of the WCRI/IAIABC Workers' Compensation Laws as of January 1, 2019.

A similar effort is underway in Alaska, which is in response to the adoption of a new eight-part independent contractor test passed in 2018. (See HB 79).

State Employment Classification

Classification of a worker as an employee or independent contractor is essential for the workers' compensation system as it determines the coverage obligation²⁹. From the legal perspective, states are varied in their approach to employment classification. In general, states fall into the following categories:

“Employee” Presumption: Twenty-five states presume a worker is an employee unless they meet the requirements of an independent contractor. A worker may be found to be an independent contractor by meeting certain criteria as defined by law (i.e. they meet all nine provisions set forth in statute) or as determined by an opinion of a judicial body (i.e., determination by a commissioner or judge based on case specific facts).

“Independent Contractor” Presumption: Two states presume independent contractor status for those workers who have completed necessary requirements before beginning work. These requirements generally include a written contract/form filed with the state confirming independent contractor status. The presumption of independent contractor status can be overcome.

Silent: Twenty-three states have no presumption of status for a worker. The criteria for determining employment status may be described but are applied to cases individually.

Appendix A compiles the state standards used to determine employment classification status for purposes of workers' compensation coverage.

State Employment Tests

Similar to federal law, states have developed a variety of tests and/or criteria that are used in the decision of employment status. There are numerous factors considered in state law but generally states evaluate based on:

Control of the means, manner, and methods of work: Rooted in common-law, decisions about *what work must be accomplished* and *how it should be done* are central to considering control in the employment relationship. Factors of control vary across states but include who sets days/hours of work, manner in how work is conducted, service standards, appearance requirements, quality specifications or other factors interpreted as giving direction to a worker.

Relative nature of work: Considers the type of work and how it relates to core business functions. Examines how fundamental the work is to what the business does or how it operates.

Hybrid: Weighs factors of both control and the relative nature of work.

Each state has a body of case law that interprets statutes and rules based on case-specific facts. A single decision may be precedential, resulting in more or less workers considered employees for purposes of workers' compensation coverage. The opinion of the California Supreme Court in *Dynamex* demonstrates the time, cost, complexities and impact a case can have with respect to employment classification.

In 2004, *Dynamex* converted its delivery drivers to independent contractors. The company was sued, and the final ruling was issued in 2018, which found the delivery drivers were in fact employees of the company. In the decision, the California Supreme Court applied the ABC test, which requires **all** three factors be met to be considered an independent contractor. The three factors include:

- (1) Freedom from control or direction in the performance of work under the contract or engagement.
- (2) Work is outside the work of the hiring entities normal business.
- (3) Worker is engaged in an independently established trade, occupation or business of which they are performing the work.

Many have interpreted the application of the ABC test as significantly expanding those workers considered employees³⁰ in California.

²⁹ Employment status may also affect the funding mechanism of state worker' compensation agencies. In many states, the agency is funded through a maintenance tax or surcharge of gross workers' compensation insurance premiums. Typically, workers' compensation premium is calculated based on an employer's payroll. The lower the payroll, the lower the premium, which results in less maintenance tax collected to support the workers' compensation system administration in the state.

³⁰ The ABC test standard for employment classification in California took effect on January 1, 2020 as a result of the passage of House Bill 5.

In contrast, courts in other states did not find an employer-employee relationship based on similar factors. In 2018, the New York Appellate Division held there was no employer-employee relationship in *Vega vs. Postmates Inc.* because couriers failed to provide sufficient proof of Postmates' control over the way work was performed. *Sebago vs. Boston Cab Dispatch* in 2015 found that taxicab drivers were independent contractors because they were free from control and direction of the cab companies.

Marketplace Contractors

The state-by-state nature of employment law, uncertainty, cost and time to confirm employment status creates a volatile business environment. In the past several years, platform companies have worked to change laws to clarify the status of platform service providers as independent contractors. A new term of art, marketplace contractors, was defined, which applies to service providers who are connecting to work through a virtual platform.

Between 2016 and 2018, eight states successfully passed legislation or rule related to marketplace contractors. The eight states are: Arizona, Florida, Indiana, Iowa, Kentucky, Tennessee, Texas,³¹ and Utah. Under these new laws, platform service providers are independent contractors if they meet certain requirements. Common marketplace contractor criteria include:

- Written agreement between the platform and the marketplace contractor that says the marketplace contractor is providing services as an independent contractor and not an employee. Most of the legislation granted retroactive status if these agreements were in place previously.
- The platform must be virtual: a web, mobile application or software program. Some legislative language specifically excludes phone or fax services or prohibits services being carried out in a physical location within the state.
- Payment for services performed must be paid on a contract or rate basis. The marketplace contractor is responsible for all tax obligations.
- The marketplace contractor is responsible for providing their own tools or materials to complete the work.
- The marketplace contractor can set his or her own hours.

Some states may have exclusions include transportation networking companies (TNCs), freight transportation, political subdivisions, religious/charitable/educational organizations, and American Indian tribes.

Impact of Legal Uncertainty of Employment Classification

Changes in the workforce noted in Part I raise questions about the application and applicability of current methods of determining employment status, especially as related to control of means and methods of work. Work is being organized and performed in ways that allow both independence and oversight in ways that does not fit neatly within current legal frameworks described in Part II. The continued evolution of workers connecting and performing work in new ways may require revision³² or a redesigned framework for employment classification.

Part III: Alternative Coverage Models

Changes in work relationships raise important public policy questions about the protections and benefits currently linked to employment. A continued increase in alternative work arrangements may necessitate new models and programs for social protections, including wage replacement and medical care for occupational injuries, illnesses and fatalities. New programs might exist within the current workers' compensation system or outside of it. Regardless, consideration of the human, economic and social costs of injuries, illnesses and fatalities at work is an important element to be included in future policy conversations.

Several ideas have emerged that consider benefits and protections in new forms. The following are strategies considered for protecting workers and businesses from the health and economic costs of a work injury:

Independent Contractor Coverage

One way to extend coverage is to amend the state workers' compensation statute to allow a business to optionally provide workers' compensation coverage to designated independent contractors. Elective coverage for an independent contractor would extend exclusive remedy for the business and be considered

³¹ The Texas Workforce Commission adopted a rule (40 T.A.C. § 815.134) which defines a "Marketplace Contractor" as an independent contractor and makes those individuals ineligible for unemployment benefits. Since workers' compensation is optional in Texas it has no impact on workers' compensation coverage.

³² There have been discussion papers on alternative options for employment classification. Some have argued for dependent contractor and others have lobbied for independent workers. Any new direction would clearly need to identify which benefits and protections, including workers' compensation, would be conferred by that status.

a benefit for the contractor. If properly structured, this would not affect the individual's independent contractor status for unemployment insurance and wage purposes. Texas allows this option for hiring contractors in Texas Labor Code, Section 406.144.

Black Car Fund

The **Black Car Fund** is a mechanism that provides workers' compensation coverage for more than 70,000 black car drivers in New York. The Fund was created in 1999 and is funded by a surcharge paid by the customer on each ride provided by an eligible driver.³³ Drivers obtain coverage through their dispatch organizations, which are members of the Fund. The unique statutory nature of the Black Car Fund designates drivers as "employees," so they are eligible for workers' compensation benefits under New York state law. They retain independent contractor status for all other purposes.

More generically, this concept could be considered a "guild model" where workers providing services in a specific industry (transportation, hairdressing, engineering, etc.) could access workers' compensation coverage collectively. This could be an attractive alternative for platform companies because the statutory nature of the fund gets around paying "benefits" that could be interpreted as "employee status."

Occupational Accident Insurance

The private insurance market offers **occupational accident insurance** policies for those workers not eligible for workers' compensation. These policies are often associated with high-risk industries with a significant number of independent operators/contractors (i.e. long-haul trucking). An occupational accident insurance policy offers defined coverage for a work-related injury or fatality by the policyholder. Coverage can be purchased directly by an operator/independent contractor or offered by a platform/contracting company.

As a general matter, occupational accident insurance typically includes coverages and benefits associated with workers' compensation insurance including medical, wage replacement and death benefits. However, there are important differences in a workers' compensation policy and an occupational accident policy. Occupational accident policies generally have a total benefits cap: a cap on medical benefits, and a cap on wage replacement. In addition, there may be no compensation for permanent impairment or consideration of vocational rehabilitation. There are often exclusions for kinds of injuries/illnesses covered, and abbreviated injury or claim reporting requirements. While there is limited access to an external dispute resolution system, occupational accident insurance is subject to the standard insurance claim dispute processes (e.g., a claimant is permitted to file a complaint with his/her state insurance department, and the insurer is subject to fair claims handling and bad faith laws).

One example is the **driver injury protection** policy offered to Uber drivers by Aon and Atlantic Specialty Insurance. Uber drivers pay \$0.03 per mile, and coverage includes medical benefits, wage replacement benefits and death benefits if they suffer a covered injury while on the app is on. Likewise, as of June 2019, DoorDash now maintains occupational accident insurance on behalf of all U.S. "Dashers" while on a delivery.

Occupational accident insurance is regulated under a different line of insurance than workers' compensation. This may create a disconnect or confusion for both businesses and workers regarding benefits across the two types of coverage.

Disability Insurance

Another mechanism for providing coverage is expanded use of disability insurance. Disability insurance provides wage replacement benefits for an individual who suffers a sickness or injury. Disability insurance has both private and public insurance options, and five states³⁴ have mandatory disability insurance programs.

There are key differences between disability insurance and workers' compensation: Disability insurance does not pay medical benefits, wage replacement is capped, and there is no consideration of either permanent partial or total disability or fatalities.

Portable Benefits

³³ The current surcharge is 2.5%, <https://www.nybcf.org/faqs>

³⁴ California, Hawaii, New Jersey, New York, and Rhode Island

Portable Benefit accounts de-couple social protections from the employer and offer coverages to an individual worker. An account is funded, and can then be used to obtain various coverages including healthcare, disability or occupational accident insurance, and/or workers' compensation. Funding of the account could be designed in many ways but could include contributions from an employer(s), platform(s), contract organization(s), client(s), and/ or the worker.

Portable benefit accounts have been conceptually supported by policymakers, businesses, labor leaders, and think tank organizations but have not been widely piloted. Important policy, design, and administrative questions must be defined in order to understand if portable accounts would be effective in deliver benefits for work-related injuries, illnesses, and fatalities.

Each of these mechanisms could serve as a model for extending work-related injury, illness and fatality coverage for workers in alternative work arrangements.

Policy Questions and Considerations

Exclusive remedy: One of the central principles of workers' compensation is exclusive remedy. Employees who have a work-related injury, illness or fatality receive the medical and wage replacement benefits afforded to them by state law. Once those have been received, employers have no further liabilities. If alternative coverage mechanisms are developed, should exclusive remedy be afforded to those businesses? What provisions or standards must be met to have exclusive remedy?

Universal coverage: Workers' compensation started off as a voluntary program but trended toward universal coverage (with some exceptions). Coverage had clear benefit for both employers and employees. If universal coverage is desirable, you must decouple the mandate from the employment relationship (i.e., employee only) and determine how coverage can be delivered in different environments (i.e., Do independent contractors have to purchase a workers' compensation policy?).

Standard benefits: Workers' compensation benefits (wage replacement and medical) are defined in state statute and applied in the same way for all employees in a state. The advantage of a statutory benefit scheme is that it creates equity across all employees/employers and promotes societal stability (given adequacy of benefits). The disadvantage of this scheme is that benefits may not always be "fair" (i.e., account for pain/suffering; maximums penalize high income earners, etc.).

Funding/Delivery: Workers' compensation policies are funded by employers who pay premiums or self-fund. In nonstandard work arrangements, the financial responsibility for an occupational injury is ambiguous and, therefore, who funds coverage bears discussion. Is it the contracting firm's responsibility (i.e. for all workers regardless of employment status), or is there a cost-sharing obligation by classification or work type?

Market Access: Workers' compensation has developed market solutions for businesses who are unable to purchase coverage in the voluntary market (residual market or insurer of last resort). Is a solution like this required or desired for workers in alternative work arrangements? Should the cost of coverage be a consideration in developing or determining solutions (i.e., if you are making \$1,000 a year in additional income should you have to buy a policy that costs you some fraction of that?).

Safe Harbor: Should safe harbor provisions exist for businesses who purchase or offer some coverages (health, workers' compensations, etc.) to ensure they are not interpreted as employment status? What provisions would need to be met for safe harbor? What liabilities would the business and worker face in these situations?

Conclusions

Workers' compensation is an essential element of the protections and benefits businesses and workers have had in the last century. Employers gain certainty and limit their liability to injuries, illnesses, or fatalities that occur at work. Employees receive healthcare and wage replacement to heal and recover with lessened financial burden. This fragile balance has resulted in sustained stability and equity for most American businesses and their workers.

The employee-employer framework on which the U.S. workers' compensation system is built has become increasingly complex. Businesses are relying more and more on a labor force that does not neatly fit within legally defined employees and independent contractors. These external changes have the potential for significantly changing employment related protections and benefits.

This presents real questions for the workers' compensation system. Policymakers, labor, management, and other system stakeholders need to begin considering and preparing for these impacts. 100 years ago, workers' compensation was adopted after countless lives were lost or seriously damaged by a work injury. Proactively

addressing new changes in work and the workplace are the key to responding without more lives lost by American workers.

Appendix A: State Standards Used to Determine Independent Contractor Status (2019)

State	Presumption employee status	Special Rules Specific Occupations	General Description of Criteria
AL	No provision	ALA. CODE § 25-5-50 (2017)	<p>If the employer’s right of control over the individual extends no further than directing what is to be ultimately accomplished, the individual is an independent contractor. The employer must not retain the right to dictate the manner of operation or how the work should be done. The factors to be considered in determining whether an individual or an entity has retained the right of control include:</p> <ol style="list-style-type: none"> (1) Direct evidence demonstrating a right or an exercise of control. (2) The method of payment for services. (3) Whether equipment is furnished. (4) Whether the other party has the right to terminate the employment. <p>ALA. CODE § 25-5-1 (2017); <i>Atchison v. Boone Newspapers, Inc.</i>, 981 So.2d 427 (Ala. Civ. App. 2007).</p>
AK	No <i>Alaska Pulp Corp. v. United Paperworkers Int’l Union</i> , 791 P.2d 1008 (Alaska 1990)	ALASKA STAT. § 23.30.230 (2017)	<p>The Alaska Supreme Court has adopted the “relative nature of the work” test for distinguishing between employees and independent contractors. The test first considers the character of the individual’s work or business, which is determined by considering three factors:</p> <ol style="list-style-type: none"> (1) The degree of skill involved. (2) Whether the individual holds himself out to the public as a separate business. (3) Whether the individual bears the accident burden. <p>The test then considers the relationship of the individual’s work or business to the purported employer’s business, which is also broken into three factors:</p> <ol style="list-style-type: none"> (1) The extent to which the individual’s work is a regular part of the employer’s regular work. (2) Whether the individual’s work is continuous or intermittent. (3) Whether the duration of the work is such that it amounts to hiring of continuous services rather than a contract for a specific job. <p><i>Odsather v. Richardson</i>, 96 P.3d 521 (Alaska 2004).; ALASKA STAT. § 23.30.055 (2017).</p> <p>The Alaska Workers’ Compensation Board applies a similar “relative nature of the work” test. The test weighs six factors, the first two being the most important; at least one of these two factors must be resolved in favor of an “employee” status for the board to find that a person is an employee. The six factors are whether the work:</p> <ol style="list-style-type: none"> (1) Is a separate calling or business. If the person performing the services has the right to hire or terminate others to assist in the performance of the service for which the person was hired, there is an inference that the person is not an employee. If the employer: <ol style="list-style-type: none"> (a) Has the right to exercise control of the manner and means to accomplish the desired results, there is a strong inference of employee status. (b) And the person performing the services has the right to terminate the relationship at will, without cause, there is a strong inference of employee status. (c) Has the right to extensive supervision of the work, then there is a strong inference of employee status. (d) Provides the tools, instruments and facilities to accomplish the work and they are of substantial value, there is an inference of employee status; if the tools, instruments and facilities to accomplish the work are not significant, no inference is created regarding the employment status. (e) Pays for the work on an hourly or piece rate wage rather than by the job, there is an inference of employee status.

			<p>(f) And person performing the services entered into either a written or oral contract, the employment status the parties believed they were creating in the contract will be given deference. However, the contract will be construed in view of the circumstances under which it was made and the conduct of the parties while the job is being performed.</p> <p>(2) Is a regular part of the employer’s business or service. If it is a regular part of the employer’s business, there is an inference of employee status.</p> <p>(3) Can be expected to carry its own accident burden. This element is more important than factors (4)-(6). If the person performing the services is unlikely to be able to meet the costs of industrial accidents out of the payment for the services, there is a strong inference of employee status.</p> <p>(4) Involves little or no skill or experience. If so, there is an inference of employee status.</p> <p>(5) Is sufficient to amount to the hiring of continuous services, as distinguished from contracting for the completion of a particular job. If the work amounts to hiring of continuous services, there is an inference of employee status.</p> <p>(6) Is intermittent, as opposed to continuous. If the work is intermittent, there is a weak inference of no employee status.</p> <p>ALASKA ADMIN. CODE tit. 8, § 45.890 (2017); ALASKA STAT. § 23.30.395 (2017).</p>
AZ	<p>Rebuttable presumption of independent contractor status created upon the execution of a written agreement compliant with ARIZ. REV. STAT. ANN. § 23-902 (2017).</p>	<p>ARIZ. REV. STAT. ANN. § 23-909-910 (2017)</p>	<p>An independent contractor is a person engaged in work for a business who is:</p> <p>(1) Independent of that business in the execution of the work and not subject to the rule or control of the business for which the work is done.</p> <p>(2) Engaged only in the performance of a definite job or piece of work.</p> <p>(3) Subordinate to that business only in effecting a result in accordance with that business design.</p> <p>As for the first element, Arizona courts have adopted the “right to control” test, which examines the following factors:</p> <p>(1) The duration of the employment.</p> <p>(2) The method of payment.</p> <p>(3) Who furnishes necessary equipment.</p> <p>(4) The right to hire and fire.</p> <p>(5) The extent to which the employer may exercise control over the details of the work.</p> <p>(6) Whether the work was performed in the usual and regular course of the employer’s business.</p> <p>Home Ins. Co. v. Indus. Comm’n, 599 P.2d 801 (Ariz. 1979).</p> <p>A business or independent contractor may prove the existence of an independent contractor relationship by executing a written agreement stating that the business:</p> <p>(1) Does not require the independent contractor to perform work exclusively for the business.</p> <p>(2) Does not provide the independent contractor with any business registrations or licenses required to perform the specific services set forth in the contract.</p> <p>(3) Does not pay the independent contractor a salary or hourly rate instead of an amount fixed by contract.</p> <p>(4) Will not terminate the independent contractor before the expiration of the contract period, unless the independent contractor breaches the contract or violates the Arizona law.</p> <p>(5) Does not provide tools for the independent contractor.</p> <p>(6) Does not dictate the time of performance.</p> <p>(7) Pays the independent contractor in the name appearing on the written agreement.</p> <p>(8) Will not combine business operations with the person performing the services rather than maintaining these operations separately.</p> <p>ARIZ. REV. STAT. ANN. § 23-902 (2017).</p>

AR	<p>Yes</p> <p><i>Silvicraft, Inc. v. Lambert</i>, 661 S.W.2d 403 (Ark. Ct. App. 1983)</p>	<p>ARK. CODE ANN. § 11-9-102 (2017)</p>	<p>Various factors are considered to determine the status of a worker:</p> <ol style="list-style-type: none"> (1) The right to control the means and the method by which the work is done. (2) The right to terminate the employment without liability. (3) The method of payment. (4) The furnishing, or the obligation to furnish, the necessary tools, equipment, and materials. (5) Whether the person employed is engaged in a distinct occupation or business. (6) The skill required in a particular occupation. (7) Whether the employer is a business. (8) Whether the work is an integral part of the regular business of the employer. (9) The length of time for which the person is employed. <p>However, the “right to control” test is usually sufficient to decide most disputes. The ultimate question in these cases is whether the employer has the right to control over the doing of the work, not whether the employer actually exercises such control.</p> <p>ARK. CODE ANN. § 11-9-102 (2017); <i>Riddell Flying Service v. Callahan</i>, 206 S.W.3d 284 (Ark. Ct. App. 2005).</p>
CA	<p>Yes</p> <p>CAL. LAB. CODE § 2750.5 (2017)</p>	<p>CAL. LAB. CODE § 3352 (2017)</p>	<p>California adopted Assembly Bill No. 5, effective Jan. 1, 2020.</p> <p>This bill addresses employment status when a hiring entity claims that the person it hired is an independent contractor. AB 5 requires the application of the “ABC test” to determine if workers are employees or independent contractors.</p> <p>Under the ABC test, a worker is considered an employee and not an independent contractor, unless the hiring entity satisfies all three of the following conditions:</p> <ol style="list-style-type: none"> (1) The worker is free from the control and direction of the hiring entity in connection with the performance of the work, both under the contract for the performance of the work and in fact. (2) The worker performs work that is outside the usual course of the hiring entity’s business. (3) The worker is customarily engaged in an independently established trade, occupation or business of the same nature as that involved in the work performed. <p>Cal. Labor Code § 2750.3 (West 2019)</p>
CO	<p>Yes</p> <p>COLO. REV. STAT. ANN. § 8-40-202 (West 2017)</p>	<p>COLO. REV. STAT. ANN. § 8-40-202 (West 2017)</p>	<p>Colorado courts have adopted both the “control” test and the “relative nature of the work” test for purposes for determining a worker’s status. If either test is met, the worker is considered an employee for workers’ compensation purposes.</p> <p>The “control” test primarily considers whether the alleged employer exercises control over the means and methods of accomplishing the contracted service. Other factors include:</p> <ol style="list-style-type: none"> (1) Whether compensation is measured by time or lump sum. (2) Which party furnishes the necessary tools and equipment to perform the work. <p>The “relative nature of the work” test considers the following factors:</p> <ol style="list-style-type: none"> (1) The character of the individual’s work. (2) The relationship of the individual’s work to the alleged employer’s business. <p>COLO. REV. STAT. ANN. § 8-40-202 (West 2017); <i>Brighton Sch. Dist. v. Lyons</i>, 873 P.2d 26 (Colo. App. 1993); <i>Frank C. Klein & Co. v. Colo. Comp. Ins. Auth.</i>, 859 P.2d 323 (Colo. App. 1993).</p>

CT	No provision	CONN. GEN. STAT. § 31-275 (2017)	<p>Connecticut courts have adopted the “right to control” test to determine a worker’s status. The test asks whether the employer has “the right to control the means and methods” used by the worker in the performance of his or her job. As such, an independent contractor is defined as one who, exercising an independent employment, contracts to do a piece of work according to his or her own methods and without being subject to the control of his employer, except as to the result of his work.</p> <p>Hanson v. Transp. Gen. Inc., 716 A.2d 857 (Conn. 1998); Chute v. Mobil Shipping & Transportation Co., 627 A.2d 956 (Conn. App. Ct. 1993); CONN. GEN. STAT. § 31-275 (2017).</p>
DE	No provision	DEL. CODE ANN. tit. 19, §§ 2301; 2307; 2308; 2316 (2017)	<p>Delaware courts have adopted § 220 of the Restatement (Second) of Agency in determining a worker’s status. The Restatement requires consideration of the following factors:</p> <ol style="list-style-type: none"> (1) The extent of control, which, by the agreement, the master may exercise over the details of the work. (2) Whether or not the one employed is engaged in a distinct occupation or business. (3) The kind of occupation, with reference to whether, in the locality, the work is usually done under the discretion of the employer or by a specialist without supervision. (4) The skill required in the particular occupation. (5) Whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work. (6) The length of time for which the person is employed. (7) The method of payment, whether by the time or by the job. (8) Whether or not the work is a part of the regular business of the employer. (9) Whether or not the parties believe they are creating the relation of master and servant. (10) Whether the principal is or is not in business. <p>Falconi v. Coombs & Coombs, Inc., 902 A.2d 1094 (Del. 2006); Restatement (Second) of Agency § 220 (1958); DEL. CODE ANN. tit. 19, § 2301 (2017).</p>
DC	No provision	D.C. CODE § 32-1501 (2017)	<p>The Department of Employment Services (DOES) applies the “relative nature of the work” test to determine a worker’s status, which focuses on whether the individual is hired to do work in which the company specializes. There are two prongs to the test. First, the nature and character of the individual’s work or business is considered by analyzing three factors:</p> <ol style="list-style-type: none"> (1) The degree of skill involved. (2) The degree to which it is a separate calling or business. (3) The extent to which it can be expected to carry its own accident burden. <p>The second prong analyzes the relationship of the individual’s work to the purported employer’s business. 3 factors are considered:</p> <ol style="list-style-type: none"> (1) The extent to which the individual’s work is a regular part of the employer’s regular work. (2) Whether individual’s work is continuous or intermittent. (3) Whether the duration is sufficient to amount to the hiring of continuous services, as distinguished from contracting for the completion of a particular job. <p>D.C. CODE § 32-1501 (2017); Gross v. D.C. Dept. of Emp’t Serv., 826 A.2d 393 (D.C. 2003).</p>
FL	No provision	FLA. STAT. § 440.02 (2017)	<p>A worker is considered an independent contractor provided at least 4 of the following criteria are met:</p> <ol style="list-style-type: none"> (1) The independent contractor maintains a separate business with his or her own work facility, truck, equipment, materials, or similar accommodations. (2) The independent contractor holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not required to obtain a federal employer identification number under state or federal regulations. (3) The independent contractor receives compensation for services rendered or work performed, and such compensation is paid to a business rather than to an individual.

			<p>(4) The independent contractor holds one or more bank accounts in the name of the business entity for purposes of paying business expenses or other expenses related to services rendered or work performed for compensation.</p> <p>(5) The independent contractor performs work or is able to perform work for any entity in addition to or besides the employer at his or her own election without the necessity of completing an employment application or process.</p> <p>(6) The independent contractor receives compensation for work or services rendered on a competitive-bid basis or completion of a task or a set of tasks as defined by a contractual agreement, unless such contractual agreement expressly states that an employment relationship exists.</p> <p>If four of the criteria above do not exist, an individual may still be presumed to be an independent contractor and not an employee based on full consideration of the nature of the individual situation with regard to satisfying any of the following conditions:</p> <p>(1) The independent contractor performs or agrees to perform specific services or work for a specific amount of money and controls the means of performing the services or work.</p> <p>(2) The independent contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform.</p> <p>(3) The independent contractor is responsible for the satisfactory completion of the work or services that he or she performs or agrees to perform.</p> <p>(4) The independent contractor receives compensation for work or services performed for a commission or on a per-job basis and not on any other basis.</p> <p>(5) The independent contractor may realize a profit or suffer a loss in connection with performing work or services.</p> <p>(6) The independent contractor has continuing or recurring business liabilities or obligations.</p> <p>(7) The success or failure of the independent contractor's business depends on the relationship of business receipts to expenditures.</p> <p>FLA. STAT. § 440.02 (2017).</p>
GA	No provision	GA. CODE ANN. § 34-9-2 (2017)	<p>An individual is an independent contractor if such person meets all of the following criteria:</p> <p>(1) Is a party to a contract which intends to create an independent contractor relationship.</p> <p>(2) Has the right to exercise control over the time, manner, and method of the work to be performed.</p> <p>(3) Is paid on a set price per job or a per unit basis, rather than on a salary or hourly basis.</p> <p>GA. CODE ANN. § 34-9-2 (2017).</p>
HI	No provision	HAW. REV. STAT. § 386-1 (2017)	<p>Both the "control" and "relative nature of the work" tests are used to determine an individual's status.</p> <p>Under the "control" test, an employment relationship exists when the person in whose behalf the work is done has the power to dictate the means and methods by which the work is to be accomplished. Conversely, "[o]ne who contracts with another to do a specific piece of work for him [or her], and who furnishes and has the absolute control of his [or her] assistants, and who executes the work entirely in accord with his [or her] ideas, or with a plan previously given him [or her] by the person for whom the work is done, without being subject to the latter's orders in respect of the details of the work, with absolute control thereof...is an independent contractor."</p> <p>The "relative nature of the work test" involves a balancing of factors regarding the general relationships which the employee has with regard to the work performed for each of his employers. Relevant factors include:</p> <p>(1) Whether the work done is an integral part of the employer's regular business.</p> <p>(2) Whether the worker, in relation to the employer's business, is in a business or profession of his own.</p>

			HAW. REV. STAT. §§ 386-73.5; 386-1 (2017); Locations, Inc. v. Haw. Dept. of Labor, 900 P.2d 784 (Haw. 1995).
ID	Yes Moore v. Moore, 269 P.3d 802 (Idaho 2011)	IDAHO CODE ANN. §§ 72-102; 72-212 (2017)	The test to determine an individual's status is whether the contract gives, or the employer assumes, the right to control the time, manner and method of executing the work, as distinguished from the right merely to require certain definite results. The Idaho courts use a four-factor test to determine an individual's status: <ol style="list-style-type: none"> (1) There must be evidence of the employer's right to control the employee. (2) The method of payment. (3) Whether the employer or individual furnishes major items of equipment. (4) Whether either party has the right to terminate the relationship at will, or whether one is liable to the other in the event of a preemptory termination. IDAHO CODE ANN. § 72-102 (2017); Shriner v. Rausch, 108 P.3d 375 (Idaho 2005); Kiele v. Steve Henderson Logging, 905 P.2d 82 (Idaho 1995).
IL	No provision	820 ILL. COMP. STAT. 305/1 (2017)	A number of factors are considered in determining an individual's status. The most important factor is whether the purported employer has a right to control the actions of the individual, followed by the nature of the work performed by the individual in relation to the general business of the employer. Additional relevant, albeit less important, factors include: <ol style="list-style-type: none"> (1) The method of payment. (2) The right to discharge. (3) The skill the work requires. (4) Which party provides the needed instrumentalities. (5) Whether income tax has been withheld. (6) The label the parties place upon their relationship. 820 ILL. COMP. STAT. 305/1 (2017); Esquinca v. Ill. Workers' Comp. Comm'n, 51 N.E.3d 5 (Ill. App. Ct. 2016).
IN	Yes Walker v. State, 694 N.E.2d 258 (Ind. 1998)	IND. CODE §§ 22-3-2-9; 22-3-6-1 (2017)	The Indiana Supreme Court has adopted the test articulated in § 220 of the Restatement (Second) of Agency in determining a worker's status. The Restatement requires consideration of the following factors: <ol style="list-style-type: none"> (1) The extent of control which, by the agreement, the master may exercise over the details of the work. (2) Whether or not the one employed is engaged in a distinct occupation or business. (3) The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision. (4) The skill required in the particular occupation. (5) Whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work. (6) The length of time for which the person is employed. (7) The method of payment, whether by the time or by the job. (8) Whether the work is a part of the regular business of the employer. (9) Whether the parties believe they are creating the relation of master and servant. (10) Whether the principal is or is not in business. Moberly v. Day, 757 N.E.2d 1007 (Ind. 2001); Restatement (Second) of Agency § 220 (1958); IND. CODE § 22-3-6-1 (2015).
IA	Yes Daggett v. Nebraska-Eastern Exp., Inc., 107 N.W.2d 102 (Iowa 1961)	IOWA CODE § 85.61 (2016)	Iowa courts have adopted two tests for determining a worker's status. First, in determining the existence of an employer-employee relationship, the courts analyze the following five factors: <ol style="list-style-type: none"> (1) The right of selection, or to employ at will. (2) Responsibility for payment of wages by the employer. (3) The right to discharge or terminate the relationship. (4) The right to control the work. (5) The identity of the employer as the authority in charge of the work or for whose benefit it is performed. Second, in determining whether a worker qualifies as an independent contractor, the courts consider the following eight factors:

			<ol style="list-style-type: none"> (1) The existence of a contract for the performance by a person of a certain piece or kind of work at a fixed price. (2) The independent nature of the business or of a distinct calling. (3) The employment of assistants, with the right to supervise their activities. (4) The obligation to furnish necessary tools, supplies and materials. (5) The right to control the progress of the work, except as to final result. (6) The time for which the worker is employed. (7) The method of payment, whether by time or by job. (8) Whether the work is part of the regular business of the employer. <p>Above all, the “right to control” is the most important consideration.</p> <p>The parties’ intent may also be considered as a factor in the analysis, although the courts have warned that this analysis should not be determinative and should only be considered if the “right to control” factor is debatable.</p> <p>IOWA CODE § 85.61 (2016); Stark Constr. v. Lauterwasser, 847 N.W.2d 612 (Iowa Ct. App. 2014).</p>
KS	No provision	KAN. STAT. ANN. § 44-508 (2014)	<p>Kansas courts have adopted the Restatement factors in determining a worker’s status. However, the single most important factor is whether the employer controls, or has the right to control, the manner and methods of the worker in doing the particular task. Additional considerations include:</p> <ol style="list-style-type: none"> (1) Whether or not the one employed is engaged in a distinct occupation or business. (2) The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision. (3) The skill required in the particular occupation. (4) Whether the employer or the workman supplies the instrumentalities, tools and the place of work for the person doing the work. (5) The length of time for which the person is employed. (6) The method of payment, whether by the time or by the job. (7) Whether the work is part of the regular business of the employer. (8) Whether the parties believe they are creating the relation of master and servant. (9) Whether the principal is or is not in business. <p>Travelers Indem. Co. of Ill. v. Challenger Fence Co., Inc., 119 P.3d 666 (Kan. Ct. App. 2005); Restatement (Second) of Agency § 220 (1958); KAN. STAT. ANN. § 44-508 (2014).</p>
KY	Yes KY. REV. STAT. ANN. § 342.640 (2014)	KY. REV. STAT. ANN. § 342.640 (2014)	<p>Kentucky courts analyze four predominant factors to determine a worker’s status:</p> <ol style="list-style-type: none"> (1) The alleged employer’s right to control the details of the work. (2) The nature of the work as related to the business generally carried on by the alleged employer. (3) The professional skill of the individual. (4) The true intent of the parties. <p>The “right to control” factor is the most important in the analysis, which is determined by analyzing the following factors:</p> <ol style="list-style-type: none"> (1) Method of payment. (2) Which party furnishes the equipment. (3) Whether the alleged employer has the right to discharge the individual performing the work. <p>Steinrock v. Cook, No. 2011-SC-000032-WC (Ky. Aug. 25, 2011); Uninsured Emp’rs’ Fund v. Garland, 805 S.W.2d 116 (Ky. 1991).</p>
LA	Yes LA. REV. STAT. ANN. § 23:1021 (2013)	LA. REV. STAT. ANN. § 23:1021 (2013)	<p>Louisiana courts consider the following factors in determining a worker’s status:</p> <ol style="list-style-type: none"> (1) Whether there is a valid contract between the parties. (2) Whether the work being done is of an independent nature such that the individual may employ non-exclusive means in accomplishing it. (3) Whether the contract calls for specific piecework as a unit to be done according to the individual’s own methods without being subject to the control and direction of the principal, except as to the result of the services to be rendered. (4) Whether there is a specific price for the overall undertaking.

			<p>(5) Whether the specific time or duration is agreed upon and not subject to termination at the will of either side without liability for breach.</p> <p>Steinfelds v. Villarubia, 53 So.3d 1275 (La. Ct. App. 2010); LA. REV. STAT. ANN. § 23:1021 (2013).</p>
ME	<p>Yes</p> <p>ME. REV. STAT. tit. 39-A, § 102 (2013)</p>	<p>ME. REV. STAT. tit. 39-A, § 102 (2013)</p>	<p>An individual is presumed to be an employee unless the employing unit proves that the person is free from the essential direction and control of the employing unit. In order for an individual to be an independent contractor, the following criterial must be met:</p> <ol style="list-style-type: none"> (1) The person has the essential right to control the means and progress of the work except as to final results. (2) The person is customarily engaged in an independently established trade, occupation, profession or business. (3) The person has the opportunity for profit and loss as a result of the services being performed for the other individual or entity. (4) The person hires and pays the person's assistants, if any, and, to the extent such assistants are employees, supervise the details of the assistants' work. (5) The person makes the person's services available to some client or customer community even if the person's right to do so is voluntary not exercised or is temporarily restricted. <p>Additionally, at least three of the following criteria must be met:</p> <ol style="list-style-type: none"> (1) The person has a substantive investment in the facilities, tools, instruments, materials and knowledge used by the person to complete the work. (2) The person is not required to work exclusively for the other individual or entity. (3) The person is responsible for satisfactory completion of the work and may be held contractually responsible for failure to complete the work. (4) The parties have a contract that defines the relationship and gives contractual rights in the event the contract is terminated by the other individual or entity prior to completion of the work. (5) Payment to the person is based on factors directly related to the work performed and not solely on the amount of time expended by the person. (6) The work is outside the usual course of business for which the service is performed. (7) The person has been determined to be an independent contractor by the federal Internal Revenue Service (IRS). <p>ME. REV. STAT. tit. 39-A, § 102 (2013).</p>
MD	<p>Yes</p> <p>MD. CODE ANN. LAB. & EMP. § 9-202 (2009)</p>	<p>MD. CODE ANN. LAB. & EMP. §§ 9-203 to 9-236 (2009)</p>	<p>Maryland courts consider five criteria in determining a worker's status. The decisive consideration is the "control" test: whether the employer has the right to control and direct the employee in the performance of the work and in the manner in which the work is done. The following factors are also relevant:</p> <ol style="list-style-type: none"> (1) The power to select and hire the employee. (2) The payment of wages. (3) The power to discharge. (4) Whether the work is part of the regular business of the employer. <p>Injured Workers' Ins. Fund v. Orient Exp. Delivery Serv., Inc., 988 A.2d 1120 (Md. Ct. Spec. App. 2010); MD. CODE ANN. LAB. & EMP. § 9-202 (2009).</p>
MA	<p>Yes</p> <p>MASS. GEN. LAWS ch. 149, § 148B (2004)</p>	<p>MASS. GEN. LAWS ch. 152, § 1 (2011)</p>	<p>The standard in determining a worker's status is the same as the common law agency standard, the primary factor being the right to control. Massachusetts courts consider the factors set out in the Restatement (Second) of Agency, which are as follows:</p> <ol style="list-style-type: none"> (1) The extent of control which, by the agreement, the master may exercise over the details of the work. (2) Whether or not the one employed is engaged in a distinct occupation or business. (3) The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision. (4) The skill required in the particular occupation.

			<p>(5) Whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work.</p> <p>(6) The length of time for which the person is employed.</p> <p>(7) The method of payment, whether by the time or by the job.</p> <p>(8) Whether or not the work is part of the regular business of the employer.</p> <p>(9) Whether the parties believe they are creating the relation of master and servant.</p> <p>(10) Whether the principal is or is not in business.</p> <p>Travelers Prop. Cas. Co. of Am. v. Universal Drywall, LLC., 10 N.E.3d 178 (Mass. App. Ct. 2014); Restatement (Second) of Agency § 220 (1958); MASS. GEN. LAWS ch. 152, § 1 (2011).</p>
MI	No provision	MICH. COMP. LAWS §§ 418.115 to 418.120; 418.161 (2017)	<p>In order for a worker to be considered an employee, three criteria must be met. The worker must not:</p> <ol style="list-style-type: none"> (1) Maintain a separate business. (2) Hold himself or herself out to and render service to the public. (3) Be an employer subject to the worker’s compensation act. <p>MICH. COMP. LAWS § 418.161 (2012); Auto-Owners Ins. Co. v. All Star Lawn Specialists Plus, Inc., 857 N.W.2d 520 (Mich. 2014).</p>
MN	No provision	<p>Minnesota regulations set forth criteria for 34 specific occupations. Minn. R. 5224.0010 to 5224.0340 (2017).</p> <p>MINN. STAT. § 181.723 (2009) sets forth criteria for construction contractors.</p> <p>MINN. STAT. § 176.043 (2009) sets forth criteria for trucking and messenger/courier industries.</p>	<p>Minnesota courts have adopted a five-factor test to determine the status of workers not specifically engaged in the occupations enumerated in MINN. R. 5224.0010 to 5224.0340 (2017):</p> <ol style="list-style-type: none"> (1) The right to control the means and manner of performance. (2) The mode of payment. (3) The furnishing of tools and materials. (4) Control over the premises where the work was done. (5) The right of discharge. <p>Of the factors, the right to control is the most important. A number of considerations are used to determine whether the employer possesses such a right to control, including:</p> <ol style="list-style-type: none"> (1) Employer’s authority over the individual’s assistants. (2) The individual’s compliance with instructions. (3) Whether oral or written reports are required to be submitted to the employer. (4) Whether the work is performed on the employer’s premises. (5) Whether services must be personally rendered to the employer. (6) Whether there exists a continuing relationship between the parties. (7) Whether the employee has set hours of work. (8) Whether the individual has been trained by the employer. (9) The amount of time the individual dedicates to the work. (10) Whether the individual has simultaneous contracts with different firms. (11) Whether tools and materials have been furnished by the employer. (12) Whether the individual’s expenses are reimbursed. (13) Whether the employer is required to enforce standards or restrictions imposed by regulatory and licensing agencies. <p>Guhlke v. Roberts Truck Lines, 128 N.W.2d 324 (Minn. 1964); Hunter v. Crawford Door Sales, 501 N.W.2d 623 (Minn. 1993); MINN. R. 5224.0330 (2017); Minn. Dept. of Lab. And Indus., Workers’ Compensation – Determining Independent Contractor or Employee Status, https://www.dli.mn.gov/business/workers-compensation/work-comp-independent-contractor-or-employee</p>
MS	No provision	MISS. CODE ANN. §§ 71-3-3; 71-3-5 (West 2017)	<p>Mississippi courts have adopted the “right to control” test to determine a worker’s status. The test consists of the following factors:</p> <ol style="list-style-type: none"> (1) Direct evidence of right or exercise of control. (2) The method of payment. (3) The furnishing of equipment. (4) The employer’s right to fire. <p>Se. Auto Brokers v. Graves, 210 So.3d 1012 (Miss. Ct. App. 2015); MISS. CODE ANN. § 71-3-3 (West 2011).</p>
MO	No	MO. REV. STAT. § 287.020 (2017)	<p>The primary test to determine a worker’s status is the right to control. If an employer has the right to control the means and manner of a worker’s service, the</p>

	<p>McCracken v. Wal-Mart Stores East, LP, 298 S.W.3d 473 (Mo. 2009)</p>		<p>worker is an employee rather than an independent contractor. A number of factors are considered in this analysis:</p> <ol style="list-style-type: none"> (1) The extent of control. (2) The actual exercise of control. (3) The duration of the employment. (4) The right to discharge. (5) The method of payment. (6) The degree to which the alleged employer furnished equipment. (7) The extent to which the work is the regular business of the employer. (8) The employment contract. <p>Where the control analysis does not settle the issue, the “relative nature of the work” test is also applied. This test analyzes the economic and functional relationship between the nature of the work and a business’ operation. The following factors are considered:</p> <ol style="list-style-type: none"> (1) The amount of skill the worker’s job requires. (2) The degree to which the work is a separate calling or enterprise. (3) The extent to which the job might be expected to carry its own accident burden. (4) The relation of the job to the employer’s business. (5) Whether the job being performed is continuous or intermittent. (6) Whether the job’s duration amounts to the hiring of continuous services rather than a contract for the completion of a particular job. <p>Missouri law allows some independent contractors to recover under worker’s compensation law. Individuals having work done under contract on or about their premises that is an operation of the usual business that they carry are considered an employer and are liable to all workers, regardless of status, for worker’s compensation.</p> <p>Leach v. Bd. of Police Comm’rs of Kansas City, 118 S.W.3d 646 (Mo. Ct. App. 2003); MO. REV. STAT. § 287.040 (2017).</p>
<p>MT</p>	<p>Yes</p>	<p>MONT. CODE ANN. § 39-71-118 (2017)</p>	<p>In determining whether an individual is an independent contractor, the court will consider the following factors:</p> <ol style="list-style-type: none"> (1) Direct evidence of right or exercise of control. (2) Method of payment. (3) Furnishing of equipment. (4) Right of employer to fire. <p>Under MONT. CODE ANN. § 39-71-417 (2011), a worker can apply for an “Independent Contractor Certification” if, among other things, the worker swears to and acknowledges:</p> <ol style="list-style-type: none"> (1) That the applicant has been and will continue to be free from control or direction over the performance of the person’s own services, both under contract and in fact. (2) That the applicant is engaged in an independently established trade, occupation, profession or business and will provide sufficient documentation of that fact to the department. <p>Doig v. Graveley, 809 P.2d 12 (Mont. 1991); MONT. CODE ANN. §§ 39-71-118 (2017); 39-71-417 (2011).</p>
<p>NE</p>	<p>Yes</p>	<p>NEB. REV. STAT. § 48-106 (2010) Industry Exceptions</p>	<p>Nebraska’s workers’ compensation law and case law suggest there is no single test for determining whether one is an employee or independent contractor, but instead the following factors will be considered in the determination of status:</p> <ol style="list-style-type: none"> (1) The extent of control that the employer may exercise over the details of the work. (2) Whether the one employed is engaged in a distinct occupation or business. (3) The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision. (4) The skill required in the particular occupation. (5) Whether the employer or the one employed supplies the instrumentalities, tools, and the place of work for the person doing the work. (6) The length of time for which the one employed is engaged. (7) The method of payment, whether by time or by the job.

			<p>(8) Whether the work is part of the regular business of the employer.</p> <p>(9) Whether the parties believe they are creating an agency relationship.</p> <p>(10) Whether the employer is or is not in business.</p> <p>NEB. REV. STAT. § 48-101 (2010); Omaha World-Herald v. Dernier, 570 N.W.2d 508 (Neb. 1997).</p>
NV	No	NEV. REV. STAT. §§ 616A.105 to 616A.360 (2013)	<p>Nevada's worker's compensation law defines an independent contractor as any person who renders service for a specified recompense for a specified result, under the control of the person's principal as to the result of the person's work only and not as to the means as to which the result is accomplished.</p> <p>Under Nevada's Industrial Insurance Act, if a worker meets three or more of the following criteria, there is a presumption that the worker is an independent contractor:</p> <ol style="list-style-type: none"> (1) The person has control and discretion over the means and manner of the performance of any work and the result of the work, rather than the means or manner by which the work is performed, and is the primary item bargained for by the principal in the contract. (2) The person generally has control over the time the work is performed. (3) The person is not required to work exclusively for one principal unless a law, regulation or ordinance otherwise prohibits the person from providing services to more than one principal or the person has entered into a written contract to provide services to only one principal. (4) The person is free to hire employees to assist with the work. (5) The person contributes a substantial investment of capital in the business of the person, including without limitation: <ol style="list-style-type: none"> (a) Purchase or lease of ordinary tools, material and equipment. (b) Obtaining of a license or other permission from the principal to access any work space of the principal to perform the work. (c) Lease of any work space from the principal required to perform the work for which the person was engaged. <p>The fact that a person does not satisfy three or more of the listed criteria does not automatically create a presumption that the person is an employee.</p> <p>NEV. REV. STAT. §§ 608.0155 (2015); 616A.255.</p>
NH	Yes	N.H. REV. STAT. ANN. § 281-A:2 (2017)	<p>Under New Hampshire's worker's compensation law, the presumption of employee status can be rebutted if a person meets all of the following criteria:</p> <ol style="list-style-type: none"> (1) The person possesses or has applied for a federal employer identification number or a social security number, or in the alternative, has agreed in writing to carry out the responsibility imposed on employers under this chapter. (2) The person has control and discretion over the means and manner of performance of the work, in that the result of the work, rather than the means or manner by which the work is performed, is the primary element bargained for by the employer. (3) The person has control over the time when the work is performed, and the time of performance is not dictated by the employer, although the employer may still prescribe a completion schedule, range of work hours and maximum number of work hours to be provided by the person. (4) The person hires and pays the person's assistants, if any, and to the extent such assistants are employees, supervises the details of the assistants' work. (5) The person holds himself or herself out to be in business for himself or herself or is registered with the state as a business and the person has continuing or recurring business liabilities or obligations. (6) The person is responsible for satisfactory completion of work and may be held contractually responsible for failure to complete the work. (7) The person is not required to work exclusively for the employer. <p>N.H. REV. STAT. ANN. § 281-A:2 (2017).</p>

NJ	Yes	N.J. STAT. ANN. § 43:21-19 (2010)	<p>Under New Jersey’s unemployment law, services provided for remuneration shall be deemed to be under an employment relationship unless it is shown that:</p> <ol style="list-style-type: none"> (1) An individual has been and will continue to be free from control or direction over the performance of such service, both under his contract of service and in fact. (2) Such service is either outside the usual course of the business for which such service is performed, or that such service is performed outside of all the places of business of the enterprise for which such service is performed. (3) Such individual is customarily engaged in an independently established trade, occupation, profession or business. <p>The New Jersey Supreme Court in <i>Hargrove v. Sleepy’s, LLC</i>, 106 A.3d 449 (2015) adopted the above test for worker’s compensation purposes and stated that for determining whether an individual is an employee or an independent contractor, the courts must consider twelve factors:</p> <ol style="list-style-type: none"> (1) The employer’s right to control the means and manner of the worker’s performance. (2) The kind of occupation and whether the work is supervised or unsupervised. (3) The amount of skill involved. (4) Who furnishes the equipment and workplace. (5) The length of time in which the individual has worked. (6) The method of payment. (7) The manner of termination of the work relationship. (8) Whether there is annual leave. (9) Whether the work is an integral part of the business of the employer. (10) Whether the worker accrues retirement benefits. (11) Whether the employer pays social security taxes. (12) The intention of the parties. <p>N.J. STAT. ANN. § 43:21-19 (2010), <i>Hargrove v. Sleepy’s, LLC</i>, 106 A.3d 449 (N.J. 2015).</p>
NM	Yes	No provision	<p>New Mexico courts will first employ a “right-to-control” test to determine whether a worker is an employee or independent contractor. If the right-to-control test points to independence, the court will then apply a “relative-nature of the work” test.</p> <p>Factors that may be considered in determining existence of employment relationship include:</p> <ol style="list-style-type: none"> (1) Direct evidence of exercise of control. (2) The right to terminate employment relationship at will by either party without liability (3) The right to delegate work or to hire and fire assistants. (4) The method of payment whether by time or by job. (5) Whether the party employed engages in distinct operation or business. (6) Whether the work is part of employer’s regular business. (7) Skill required in particular occupation. (8) Whether the employer supplies instrumentalities, tools or place of work. (9) Duration of person’s employment. (10) Whether the person works full-time or part-time or control by one and submission to control by the other. <p>N.M. STAT. ANN. § 52-1-22 (1978); <i>Romero v. Shumate Constructors, Inc.</i>, 888 P.2d 940 (N.M. 1994); <i>Harger v. Structural Services, Inc.</i>, 916 P.2d 1234 (N.M. 1996).</p>
NY	Yes	<p>Presumption for employment for construction workers unless the worker is a “separate business entity”</p> <p>§ 861-c; N.Y. WORKER’S</p>	<p>An independent contractor is one who is:</p> <ol style="list-style-type: none"> (1) Free from control and direction in performing the job, both under his contract and in fact. (2) The service is performed outside the usual course of business for which the service is performed. (3) The individual is customarily engaged in an independently established trade, occupation, profession or business that is similar to the service at issue. <p>When making a determination of whether an employer-employee relationship exists, the New York courts will consider factors such as the right to control the</p>

		COMPENSATION LAW § 21	work, the method of payment, the right to discharge, the furnishing of equipment and supplies, and the relative nature of the work. No single factor is dispositive. N.Y. WORKER'S COMPENSATION LAW §§ 2, 21 (2017); Sang Hwan Park v. Lee, 53 A.D.3d 936 (2008).
NC	Yes	§ 97-5.1 (2013) Presumption that taxicab drivers are independent contractors	North Carolina courts define "independent contractor" as one who exercises an independent employment and contracts to do certain work according to his own judgment and method, without being subject to his employer except as to the result of his work. The determinative factor in North Carolina courts as to whether a person is an employee or independent contractor for purposes of workers' compensation is control. North Carolina courts will use the "right to control" when determining whether a person is an employee or an independent contractor for purposes of the Workers' Compensation Act. Generally, where an employer has the right to control over the means and the methods of an employee's work, there will be an employer-employee relationship. The requirement of control is sufficiently met where its extent is commensurate with that degree of supervision that is necessary and appropriate considering the type of work to be done and the capabilities of the person doing it. The North Carolina courts will also look at eight factors which indicate classification as independent contractor, including if: <ol style="list-style-type: none"> (1) The worker is engaged in independent business, calling, or occupation. (2) The worker has independent use of his or her special skill, knowledge, or training in execution of work. (3) The worker is doing specified piece of work at fixed price or for lump sum or upon quantitative basis. (4) The worker is not subject to discharge because he adopts one method of doing work rather than another. (5) The worker is not in regular employ of other contracting party. (6) The worker is free to use such assistants as he or she may think proper. (7) The worker has full control over such assistants. (8) The worker is able to select his or her own time. N.C. GEN. STAT. § 97-2 (2000); Youngblood v. North State Ford Truck Sales, 364 S.E.2d 433 (N.C. 1988); Alford v. Victory Cab Co., Inc., 228 S.E.2d 43 (N.C. 1976); McCown v. Hines, 537 S.E.2d 242 (N.C. 2000).
ND	Yes	N.D. CENT. CODE § 65-01-03	N.D. ADMIN CODE § 92-01-02-49 (2012) states that 20 factors are to be considered when determining whether a worker is an independent contractor or an employee: <ol style="list-style-type: none"> (1) The amount of instructions given to the employee by the employer. (2) The amount of training given to the employee. (3) The amount of integration of a person's services into the business operations. (4) Services rendered personally. If the services must be rendered personally, the person whom the services are performed for are interested in the methods used, which goes towards employee-employer relationship. (5) The ability to hire, supervise, and pay assistants. (6) The continuing relationship between the person and person(s) for whom the services are performed. (7) Set hours of work. (8) Whether full-time is required. An independent contractor is one who is free to work when and for whom he or she chooses. Full-time required suggests an employer-employee relationship. (9) Where the work is performed. (10) The order or sequence set the work must be performed. (11) Whether there is a requirement for regular oral or written reports. (12) How the worker is paid. (13) Whether there is payment of business or traveling expenses, or both. (14) Who is responsible for furnishing of tools and materials. (15) Whether there is significant investment in facilities used by the workman. (16) Realization of profit or loss: A person who may realize a profit or suffer a loss as a result of the person's services (in addition to the profit or loss ordinarily realized by employees) is generally an independent contractor, but the person who cannot is an employee.

			<p>(17) Whether the worker provides services for more than one employer at a time.</p> <p>(18) Whether the worker’s services are available to the general public.</p> <p>(19) Whether the right of the employer to terminate/discharge exists.</p> <p>(20) The right to dismissal.</p> <p>There is no certain number of the 20 factors of the common-law test that must be met to qualify as an independent contractor, and the degree of each factor varies depending on the occupation and the factual context in which the services are performed.</p> <p>N.D. CENT. CODE. § 65-01-02 (2017); Myers-Weigel Funeral Home v. Job Ins. Div. of Job Serv. N.D., 578 N.W.2d 125 (N.D. 1998).</p>
OH	No provision	OHIO REV. CODE ANN. § 4123.01 (2015) Industry Exceptions	<p>OHIO REV. CODE ANN. § 4123.01 (2015) states that a person who meets at least 10 of the following criteria are excluded from the definition of employee:</p> <ol style="list-style-type: none"> (1) The worker is required to comply with instructions from the other contracting party regarding the manner or methods of performing services. (2) The person is required by the other contracting party to have particular training. (3) The person’s services are integrated into the regular functioning of the other contracting party. (4) The person is required to perform the work personally. (5) The person is hired, supervised, or paid by the other contracting party. (6) A continuing relationship exists between the person and the other contracting party that contemplates continuing or recurring work even if the work is not full time. (7) The person’s hours of work are established by the other contracting party. (8) The person is required to devote full time to the business of the other contracting party. (9) The person is required to perform the work on the premises of the other contracting party. (10) The person is required to follow the order of work set by the other contracting party. (11) The person is required to make oral or written reports of progress to the other contracting party. (12) The person is paid for services on a regular basis such as hourly, weekly, or monthly. (13) The person’s expenses are paid for by the other contracting party. (14) The person’s tools and materials are furnished by the other contracting party. (15) The person is provided with the facilities used to perform services. (16) The person does not realize a profit or suffer a loss as a result of the services provided. (17) The person is not performing services for a number of employers at the same time. (18) The person does not make the same services available to the general public. (19) The other contracting party has a right to discharge the person. (20) The person has the right to end the relationship with the other contracting party without incurring liability pursuant to an employment contract or agreement. <p>The general test for determining independent contractor status considers the following factors: who has the right to direct what shall be done and when and how it shall be done; the existence of a contract for the performance by a person of a certain piece or kind of work at a fixed price; the independent nature of the worker’s business; the worker’s employment of assistants with the right to supervise their activities; his or her obligation to furnish the necessary tools, supplies, and materials; his or her right to control the progress of the work except as to final results; the time for which the workman is employed; the method of payment, whether by time or by job; and whether the work is part of the regular business of the employer.</p> <p>Gillum v. Ind. Com’n, 141 Ohio St. 373 (1943).</p>

OK	No provision	<p>OKLA. ADMIN. CODE § 380:30-1-2 (2012)</p> <p>Department of Labor excludes business owners, volunteers, co-partners, and joint venturers from the definition of “employee”</p>	<p>Oklahoma’s case law and the DOL set out several factors to be considered when determining whether an employee/employer relationship exists, including:</p> <ol style="list-style-type: none"> (1) The nature of the contract between the parties. (2) The degree of control the employer may exercise on the details of the of the work. (3) Whether the one employed is engaged in a distinct occupation or business for others. (4) The kind of occupation with reference to whether in the locality the work is usually done under the direction of the employer. (5) The skill required in the particular occupation. (6) Whether the employer or the workman supplies the instrumentalities, tools and the place of work for the person doing the work. (7) The length of time for which the person is employed. (8) The method of payment. (9) Whether the work is part of the regular business of the employer. (10) Whether the parties believe they are creating the relationship of master and servant. (11) The right of either to terminate the relationship without liability. <p>No one factor is controlling, and the court will look into the set of particular facts of each case.</p> <p>Carbajal v. Precision Builders, Inc., 333 P.3d 258 (OK 2014); OKLA. ADMIN. CODE § 380:30-1-2 (2012).</p>
OR	No provision	<p>OR. REV. STAT. § 656.027 (2010)</p> <p>Certain holders of professional licenses</p>	<p>OR. REV. STAT. § 670.600 (2005) defines an independent contractor as a person who provides services for remuneration and who is:</p> <ol style="list-style-type: none"> (1) Free from direction and control over the means and manner of providing the services, subject only to the right of the person for whom the services are provided to specify the desired results. (2) Except as provided in subsection (4) of this section, is customarily engaged in an independently established business. (3) Is licensed under Oregon Revised Statutes Chp. 671 or 701 if the person provides services for which a license is required under those chapters. (4) Is responsible for obtaining other licenses or certificates necessary to provide services. <p>This definition of independent contractor has been adopted into the worker’s compensation statute. OR. REV. STAT. § 656.005 (2017)</p> <p>Oregon case law states that in determining whether a person is an independent contractor, the right to control is decisive. The principal factors in determining independent contractor status are:</p> <ol style="list-style-type: none"> (1) The evidence of the right to or actual exercise of control. (2) The method of payment. (3) The furnishing of equipment. (4) The right to fire. <p>See McQuiggin v. Burr, 119 Or. App. 202 (1993); Soderback v. Townsend, 57 Or.App. 366 (1982).</p>

PA	Yes	<p>Domestic Service, Real Estate, Construction Workers</p> <p>77 P.S. § 676; 43 P.S. § 933.3</p>	<p>In determining employee or independent contractor status, the following factors should be considered, but all do not need to be present:</p> <ol style="list-style-type: none"> (1) Control of the manner in which work is to be done. (2) Responsibility for result only. (3) Terms of agreement between the parties. (4) Nature of the work or occupation. (5) Skill required for performance. (6) Whether one employed is engaged in distinct occupation or business. (7) Who supplies the party tools. (8) Whether payment is by time or by job. (9) Whether work is part of regular business or alleged employer. (10) Whether alleged employer had right to terminate employment at any time. <p>Control over the work to be completed and the manner in which it is to be performed are the primary factors in determining employee status for purposes of the worker's compensation act.</p> <p>77 P.S. § 22; <i>Hammermill Paper Company v. Rust Engineering Company</i>, 243 A.2d 389 (Pa. 1968); <i>Johnson v. W.C.A.B. (Dubois Courier Exp.)</i>, 631 A.2d 693 (Pa. 1993).</p>
RI	No provision	<p>28 R.I. GEN. LAWS. ANN. §§ 28-29-2; 28-29-7 to 28-29-7.2; 28-29-15</p> <p>Certain industries have special status or are exempted</p>	<p>Under Rhode Island's workers' compensation law, an independent contractor is a person who has filed a notice of designation as independent contractor with the director pursuant to or as otherwise found by the workers' compensation court.</p> <p>In determining whether a worker is an employee or independent contractor, the status depends on the employer's right or power to exercise control over methods and means of performing the work and not the exercise of actual control. Whether an injured worker is an employee or independent contractor must be decided by the employment contract in the particular case and the surrounding particular circumstances.</p> <p>28 R.I. GEN. LAWS. ANN. §§ 28-29-2; 28-29-17.1 (1956) <i>Pasetti v. Brusa</i>, 98 A.2d 833 (1953); <i>Henry v. Mondillo</i>, 142 A. 230 (1928).</p>
SC	Yes	<p>S.C. CODE ANN. § 42-1-360 (2007)</p> <p>Exemption of casual employees and certain other employments from worker's compensation law</p>	<p>Case law establishes the criteria for distinguishing between employee and independent contractor under South Carolina's worker's compensation law.</p> <p>Determination of whether a worker's compensation claimant is an employee or independent contractor focuses on the issue of control.</p> <p>In determining whether an employer had a right to control a workers' compensation claimant in performance of his or her work, there are four factors the court will look at:</p> <ol style="list-style-type: none"> (1) Direct evidence of the right or exercise of control. (2) Furnishing of equipment. (3) Method of payment. (4) Right to fire. <p>It is not actual control exercised, but whether there exists a right and authority to control and direct the particular work or undertake as to the manner or means of its accomplishment.</p> <p>S.C. CODE ANN. § 42-1-130 (1976); <i>Nelson v. Yellow Cab Co.</i>, 343 S.C. 102, 538 S.E.2d 276 (S.C.App. 2000); <i>Shatto v. McLeod Regional Medical Center</i>, 406 S.C. 470 (2013).</p>
SD	No provision	<p>S.D. CODIFIED LAWS §§ 62-1-4 to 62-1-5.1</p> <p>Certain industry exceptions</p>	<p>There are three primary factors South Dakota courts look at to determine whether one is employee or independent contractor include:</p> <ol style="list-style-type: none"> (1) Whether individual has been and will continue to be free from control or direction over performance of services. (2) Both under contract of service and in fact. (3) Whether the individual is customarily engaged in independent established trade, occupation, profession or business. <p>Specifically, courts will employ a "right of control" test is used to determine independent contractor status, which includes consideration of the following factors:</p> <ol style="list-style-type: none"> (1) Direct evidence of rate of control. (2) Method of payment.

			<p>(3) Furnishing of major items of equipment. (4) Right to terminate employment relationship at will and without liability.</p> <p>S.D. CODIFIED LAWS §§ 62-1-2 (1994); 62-1-3 (2008) Egemo v. Flores, 470 N.W.2d 817 (S.D. 1991); Davis v. Frizzell 504 N.W.2d 330 (S.D. 1993).</p>
TN	Yes	<p>Construction workers are exempt from the statutory classification test if requirements of TENN. CODE ANN. § 50-6-102(10) are met</p>	<p>Tennessee’s workers’ compensation law states that to determine whether an individual is an employee or independent contractor, the following factors will be considered:</p> <ol style="list-style-type: none"> (1) The right to control the conduct of the work. (2) The right of termination. (3) The method of payment. (4) The freedom to select and hire helpers. (5) The furnishing of tools and equipment. (6) Self-scheduling of working hours. (7) The freedom to offer services to other entities. <p>For purposes of determining whether employee’s relationship is employee or independent contractor, courts consider whether work being performed by contractor is same type of work usually performed by the company that hired the contractor and whether the company has right to control employees of contractor.</p> <p>TENN. CODE ANN. § 50-6-102 (2017); Barber v. Ralston Purina, 825 S.W.2d 96 (1991).</p>
TX	No provision	<p>TEX. INS. CODE ANN. §§ 406.091 to 406.098; 406.141 to 406.146; 406.161 to 406.165</p> <p>Special coverage to members of certain industries, construction workers and farm and ranch employees</p>	<p>Texas’ workers’ compensation act defines an independent contractor as a person who contracts to perform work or provide a service for the benefit of another and who ordinarily:</p> <ol style="list-style-type: none"> (1) Acts as the employer of any employee of the contractor by paying wages, directing activities, and performing other similar functions characteristic of an employer-employee relationship; (2) Is free to determine the manner in which the work or service is performed, including the hours of labor of or method of payment to any employee; (3) Is required to furnish or to have employees, if any, furnish necessary tools, supplies, or materials to perform the work or service. (4) Possesses the skills required for the specific work or service. <p>The Texas courts will also consider the following factors when considering whether one is an independent contractor: the independent nature of the worker’s business; the worker’s obligation to furnish necessary tools, supplies and material to perform the job; the worker’s right to control progress of work, except as to final results; the time for which (s)he is employed; and method of payment, whether by time or by job.</p> <p>TEX. INS. CODE ANN. § 406.121 (1993); Industrial Indem. Exchange v. Southard, 138 Tex. 531 (1942); INA of Texas v. Torres, 808 S.W.2d 291. (1991).</p>
UT	Yes	<p>UTAH CODE ANN. § 34A-2-104 (2017)</p> <p>Excludes certain industries from the definition of “employee” for purposes of the statute</p>	<p>Utah’s workers’ compensation law defines an independent contractor as any person engaged in the performance of any work for another who, while so engaged, is:</p> <ol style="list-style-type: none"> (1) Independent of the employer in all that pertains to the execution of the work. (2) Not subject to the routine rule or control of the employer. (3) Engaged only in the performance of a definite job or piece of work. (4) Subordinate to the employer only in effecting a result in accordance with the employer’s design. <p>The Utah court will consider whatever agreements exist concerning the right of control, as well as the actual dealings between the parties and the control that was in fact asserted. Determination of status of individual as an employee or an independent contractor is based on various factors, and of primary concern is the control, direction, supervision, or the right to control, direct or supervise on behalf of the employer.</p> <p>UTAH CODE ANN. § 34A-2-103 (2017); Utah Home Fire Ins. Co. V. Manning, 985 P.2d 243 (1999); Ruster Lodge v. Industrial Commission, 562 P.2d 227 (1977).</p>

VT	No provision	Vt. Stat. Ann. tit. 21, §§ 601; 706 Certain industry exceptions	<p>Vermont’s case law establishes the test for determining whether a worker is an employee or independent contractor and will utilize the “right to control” test.</p> <p>Factors that are taken into account when employing the “right to control” test include the location of the work, whether the employee chose their own hours, whether the employee used their own tools for the job, how the employee was paid and whether the type of work being carried out by a worker is the type of work that could have been carried out by the owner’s employees as part of the regular course of business.</p> <p>Vt. STAT. ANN. tit. 21, § 601; Crawford v. Lumbermen’s Mut. Cas. Co., 220 A.2d 480 (1966); Klinker v. Furdiga, 22 F.Supp.3d 366 (2014).</p>
VA	Yes	VA CODE ANN. §§ 65.2-101- to 65.2-104	<p>Virginia case law defines an independent contractor as one who contracts to produce a specific result for a fixed price without outside control concerning the method use.</p> <p>The status of a worker as an employee or as an independent contractor is not governed by Virginia’s workers’ compensation act, but instead is governed by common law.</p> <p>The test applied in determining whether an employee of an independent contractor will be considered statutory employee of owner of project is whether the worker is “performing an indispensable activity normally carried on through employees, rather than independent contractors.”</p> <p>The ordinary test to determine whether one is an “employee” or an “independent contractor” is to ascertain who can control and direct servants in performance of their work. Factors that are considered in determination of a worker’s status include what the parties to an employment contract call their relationship.</p> <p>VA CODE ANN. § 65.2-101 (2015); Phillips v. Brinkley, 72 S.E.2d 339 (Va. 1952); Ramsburg v. Target Stores, Inc., 982 F.Supp. 1194 (Va. 1997); Nolde Bros. v. Chalkley, 1945, 35 S.E.2d 827, 184 Va. 553.</p>
WA	No provision	WASH. REV. CODE ANN. §§ 51.12.010 to 51.12.185 (1996) Industry Exception	<p>Under Washington’s workers’ compensation law, there are three elements that must be satisfied to be considered an independent contractor:</p> <ol style="list-style-type: none"> (1) The individual has been and will be free from control over performance of services, both under the contract and in fact. (2) The service is either outside the course of business or performed outside the place of business. (3) The individual is customarily engaged in an independently established trade of the same nature as that being performed. <p>In determining whether the worker is an employee or an independent contractor, the court will look to the employment contract, the work, the parties’ situation, and other concomitant circumstances.</p> <p>WASH. REV. CODE ANN. §§ 51.08.180; 51.08.181; 51.08.195 (West 2008); Department of Labor and Industries of State v. Lyons Enterprises, Inc., 347 P.3d 464 (Wash.App. 2015); Henry Industries, Inc. v. Department of Labor and Industries, 381 P.3d 172 (Wash.App. 2016).</p>

WV	Yes	W. VA. CODE R. § 85-8-6 (2008)	<p>Under West Virginia’s worker’s compensation law, the burden of proving that an individual is an independent contractor is on the party asserting independent contractor status. The following factors are dispositive of whether a worker is an independent contractor:</p> <ol style="list-style-type: none"> (1) Whether the individual holds himself or herself out to be in business for himself for herself, including whether he or she possesses a license, permit or other certification required to engage in the type of work the worker is performing; whether the individual enters into verbal or written contracts with the persons and/or entities for whom the work is being performed; and whether the individual has the right to regularly solicit business from different persons or entities to perform for compensation the type of work that is being performed. (2) Whether the individual has control over the time when the work is being performed. (3) The individual has control and discretion over the means and manner of the work being performed and in achieving the result of the work. (4) Unless expressly required by law, the individual is not required to work exclusively for the person or entity for whom the work is being performed. (5) If the use of equipment is required to perform the work, the individual provides most significant equipment required to perform the job. <p>The West Virginia courts will look at the following factors to determine if a worker is an employee or independent contractor: the right or lack of right to supervise work, the method of payment, who owns substantial equipment to be used on the job, who determines what hours are worked, and the nature and terms of the employment contract.</p> <p>W. VA. CODE ANN. § 23-2-1a (1999); W. VA. CODE R. § 85-8-6 (2008); Smith v. Donald Coal Co., 115 S.E. 477 (W.Va. 1922); Null v. State Compensation Com’r, 35 S.E.25 359 (W.Va. 1945); Myers v. Workmen’s Compensation Com’r, 148 S.E.2d 664 (W.Va. 1966).</p>
WI	Yes	No provision	<p>Wisconsin’s worker’s compensation law lists nine criteria, all of which must be met to be considered an independent contractor:</p> <ol style="list-style-type: none"> (1) Maintains a separate business with his or her own office, equipment, materials and other facilities. (2) Holds or has applied for a federal employer identification number with the IRS or has filed business or self-employment income tax returns with the IRS based on that work or service in the previous year. (3) Operates under contracts to perform specific services or work for specific amounts of money and under which the independent contractor controls the means of performing the services or work. (4) Incurs the main expenses related to the service or work that he or she performs under contract. (5) Is responsible for the satisfactory completion of work or services that he or she contracts to perform and is liable for a failure to complete the work or service. (6) Receives compensation for work or service performed under a contract on a commission or per job or competitive-bid basis and not on any other basis. (7) May realize a profit or suffer a loss under contracts to perform work or service. (8) Has continuing or recurring business liabilities or obligations. (9) The success or failure of the independent contractor’s business depends on the relationship of business receipts to expenditures. <p>The presumption that a person injured while performing service for another is an employee rather than an independent contractor is rebuttable and ceases to have force or effect when evidence to the contrary is adduced.</p> <p>Wis. STAT. ANN. § 102.07 (2016); J. Romberger Co. v. Industrial Commission, 234 Wis. 226, 229 (Wis. 1940).</p>

WY	No	No provision	<p>Wyoming’s workers’ compensation law defines independent contractor as “an individual who performs services for another individual or entity” and:</p> <ol style="list-style-type: none"> (1) Is free from control or direction over the details of the performance of services by contract and by fact. (2) Represents his services to the public as a self-employed individual or an independent contractor. (3) May substitute another person to perform his services. <p>The Wyoming Supreme Court has defined an independent contractor as “one who, exercising an independent employment, contracts to do a piece of work according to his or her own methods and without being subject to the control of his or her employer except as to the result of the work.” An express contract between the parties is not conclusive on whether a worker is an independent contractor. However, it is an important factor in defining the relationship between the employer and the worker. The Wyoming Supreme Court stated other factors that are important to the determination, including:</p> <ol style="list-style-type: none"> (1) The method of payment. (2) The right to determine the relationship without incurring liability. (3) The furnishing of tools and equipment. (4) The scope of the work. (5) The control of the premises where the work is to be done; and whether the worker devotes all of his or her efforts to the position or if he or she also performs work for others. <p>WYO. STAT. ANN. § 27-14-102 (2017); Diamond B Services Inc. v. Rohde, 120 P.3d 1031 (Wyo. 2005); Stratman v. Admiral Beverage Corp., 760 P.2d 974, 980 (Wyo. 1988); Cline v. State, Dep’t of Family Services, 927 P.2d 261, 263 (Wyo. 1996).</p>
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*Adopted by Executive (EX) Committee and Plenary, Dec. 9, 2020
Adopted by Property and Casualty (C) Committee, Aug. 12, 2020*

[Agency Name]

INSURANCE DISASTER RESPONSE PLAN

[Date]

Table of Contents

Introduction.....	1
What this document provides	1
The purpose of the disaster response plan	1
Information the disaster response plan provides	2
NAIC Disaster Assistance Program.....	2
Ways a jurisdiction can prepare to receive NAIC assistance	2
NAIC services set-up time after approval of assistance.....	3
Additional information.....	3
Disaster relief call center.....	3
DRC insurance regulator staff	4
NAIC-hosted insurance department website	4
NAIC-coordinated data call	4
Preparation.....	5
The steps to preparation	5
Important planning considerations.....	5
Available training.....	5
Insurance contact information that a DOI should regularly collect	6
Insurance company contacts:.....	6
Requirements of insurance company contacts.....	6
Other necessary contacts.....	6
Types of information that should be ready for dissemination in the event of a disaster.....	7
Types of data a DOI should collect regarding disasters.....	7
Data collection tools the NAIC can provide	7
The NAIC coordinated data call.....	7
Types of information a DOI, in coordination with Public Affairs, should maintain, update, post on the state’s website, and distribute via social media	8
Resources required for emergency response.....	8
Brief description of the Major Incident Management Functions (See org chart template - Appendix 1)	9
Disaster Response/Incident Management Team	10
Incident Commander (IC) – (may be the Agency Head or their designee).....	10
Public Information Officer (PIO).....	11
Safety Officer (SO).....	12
Legal Counsel (LC)	12
Emergency Liaison Officer (ELO).....	12
Roles and Responsibilities.....	13
Financial & Administration Section Chief.....	13

Finance and Administration Section Team Leads	14
Logistics Section Chief.....	14
Operations Section Chief	15
Operation Section Team Leads.....	15
Planning Section Chief.....	15
Deputy	16
Statistics Operational Network Task Group.....	16
Consumer Operational Team Lead	17
Communications Operations Task Group.....	17
Logistics Task Group	19
Branch Office(s).....	19

Introduction

In the event of a disaster that requires an extraordinary response, the [state insurance regulatory entity] has adopted the following disaster response plan.

What this document provides

Following a disaster, this document provides a template for departments of insurance (DOIs) to use when assisting consumers. In advance of a disaster, this document also provides guidance to insurers and other licensees.

This document details how a DOI can work with other agencies to assist consumers, including:

- Federal agencies
- State or local agencies
- The NAIC
- Other state DOIs

This document does not provide information regarding a Continuity of Operations Plan (COOP). Check to see if your department has a COOP that provides detailed information regarding how it is to be implemented.

The purpose of the disaster response plan

The purpose of the disaster response plan is to:

- Provide states with information regarding quick and effective responses to meet the insurance information needs of its citizens.
- Provide information regarding the coordination of resources with other state agencies to mitigate the effects of a disaster.

The disaster response plan will be activated by the commissioner, director or superintendent. It will be implemented by the disaster or incident management team.

Information the disaster response plan provides

This disaster response plan template provides information to assist state insurance departments in responding to disasters. This disaster response plan is scalable to respond to disasters affecting:

- Limited areas within the state.
- Several locations throughout the state.
- The entire state.

NAIC Disaster Assistance Program

The NAIC Disaster Assistance Program is a series of services provided by the NAIC to any member jurisdiction experiencing the aftermath of a disaster where additional support is needed.

The NAIC can provide the following services following a disaster:

- Disaster Relief Call Center
- Disaster Recovery Center (DRC) Insurance Regulator Staff
- Communications Services
- NAIC Coordinated Data Call

Services are provided once a formal request is made by an NAIC member (a jurisdiction's appointed/elected insurance commissioner) to the NAIC officers, asking them to direct NAIC senior management to allocate budgeted funds and resources toward their need for disaster relief assistance. The day-to-day project is then overseen by the NAIC Director of Member Services who coordinates a variety of NAIC department staff overseeing operations and volunteers throughout the length of services needed.

Ways a jurisdiction can prepare to receive NAIC assistance

Jurisdictions can prepare information that will better facilitate NAIC assistance after a catastrophic event. These items may be incorporated as part of your jurisdiction's Business Continuity Plan. Jurisdictions need to consider how they want calls and complaints tracked by NAIC volunteers and provide templates, if appropriate.

The following are some high-level action items to do prior to contacting the NAIC:

- Identify your critical staff and who will be coordinating with the NAIC.
- Assess the level of impact to your staff. This level of impact may determine the support you need from the NAIC.
- Assess the functionality of your systems and facilities—i.e., phone, internet, other communications and office—after the event.
- Assess access to power and your critical infrastructure.
- Assess business impact analysis; i.e., the minimum you need to function.
- If possible, consider the type of assistance you may need: call center overflow, onsite regulatory staff support, website, or remote office. However, the NAIC is also prepared to consider new services to meet your unique needs.
- Document how a trusted third party may access your communications systems: phone and internet.

- Prepare and provide talking points for the NAIC, frequently asked questions (FAQ), jurisdiction guidelines—i.e., emergency adjuster licensing rules—which can be shared with call center staff and onsite DRC volunteers.
- Share jurisdiction-issued bulletins and how we are to handle them.

NAIC services set-up time after approval of assistance

The NAIC is ready to help at any time after a member has requested assistance.

- Call center: within 24–48 hours after contact.
- DRC volunteers may be available within 48–72 hours after contact.
- Communications services are available within 24–48 hours after contact and member approval of information.
- NAIC Coordinated Data Call within 24–48 hours after contact.

Additional information

Where possible, the NAIC may reach out to a member jurisdiction prior to an imminent disaster to offer information about our program or answer any questions they may have about systems that may be affected in the event of a disaster.

NAIC Research and Government Relations departments are able to participate in briefings with the Financial and Banking Information Infrastructure Committee (FBII), the Federal Emergency Management Agency (FEMA), and Homeland Security to share information from, and to, NAIC jurisdictions.

The National Insurance Producer Registry (NIPR) and/or the Interstate Insurance Product Regulation Commission (Compact) are able to assist affected jurisdictions who may need emergency adjuster licenses and/or help processing product filings.

Disaster relief call center

The NAIC works with your department's technical team to connect a 1-800 NAIC telephone line and/or computer system—State Based Systems (SBS)—with your jurisdiction's consumer phone line and/or complaint tracking system.

- Call center is staffed with experienced insurance department regulator volunteers capable of answering consumer concerns.
- Call center is flexible enough to handle your entire call volume, allowing your staff to assist people in the field.
- Call center may also be set to roll-over to state insurance regulator volunteers whenever you experience call overflow.

Cost:

- There is no cost to your jurisdiction for this service.
- The NAIC covers the cost for the 1-800 phone line; call center equipment, facilities and coordination; and the travel/lodging reservations and expense for state insurance regulator volunteers.
- Your fellow members/commissioners provide their state insurance regulator staff as volunteers.

DRC insurance regulator staff

The NAIC facilitates and coordinates insurance department regulator volunteers to staff your designated DRC location(s).

- Volunteers cover one to two week shift rotations to man the daily operation of the DRC.
- The NAIC will arrange travel and lodging for the assigned state insurance regulator volunteers.
- If needed, the NAIC can help provide loaner laptops or cell phones for state insurance regulator volunteer use at a DRC location.

Cost:

- There is no cost to your jurisdiction for this service.
- The NAIC covers the cost of the loaner equipment and travel/lodging expenses for the state insurance regulator volunteers.
- Your fellow members/commissioners proffer their state insurance regulator staff as volunteers.

To deploy this service, an insurance department staff/disaster coordinator contacts Trish Schoettger, NAIC Director of Member Services at tschoettger@naic.org or 816.783.8506. She will coordinate a call with the member/commissioner, NAIC President, and NAIC Chief Executive Officer (CEO) or Chief Operating Officer (COO) to utilize these services.

NAIC-hosted insurance department website

In the case where the affected jurisdiction has lost the use of its facility or their website becomes inoperable, the NAIC can act as an interim host for the jurisdiction's insurance department website. If needed, the NAIC can also serve as a resource to communicate your updated status to other jurisdictions and/or agencies or change information.

Cost:

- There is no cost to your jurisdiction for this service.
- The NAIC covers the cost of hosting the site.

NAIC-coordinated data call

The NAIC assists states with data calls related to the collection of claims data following disasters. Data calls are typically conducted weekly immediately after a disaster and then biweekly or monthly as a higher percentage of claims close.

Preparation

The steps to preparation

A DOI needs to promptly and efficiently respond to a disaster. Effective response to a disaster requires preparation and planning, including:

- Identifying appropriate staff to perform necessary activities.
- Training appropriate staff.
- Identifying available resources.
- Identifying any resource shortfalls and how these might be addressed.

Important planning considerations

Preparedness for disasters requires identifying resources and expertise in advance and planning how these can be used in a disaster. Planning considerations include:

- Putting procedures in place for internal tracking and reimbursement costs expended by the DOI in response to a disaster.
- Designating a team of individuals and assigning responsibilities to ensure that everyone on the team understands their roles and responsibilities during a disaster situation.
- Updating plans and procedures based upon post-mortem evaluation of the DOI's performance in prior disaster response efforts.

Available training

As a part of efforts to prepare for response to disasters, state DOIs and agencies participate with local jurisdictions and private entities in exercises and training.

Staff should be periodically trained on how to assist consumers during a disaster.

Training regarding information on FEMA assistance programs and the National Flood Insurance Program (NFIP) is recommended.

FEMA has free courses available to emergency management teams. These courses can be found by using the following link: <https://training.fema.gov/is/>.

The NFIP has developed a reference guide on flood-related issues for state insurance regulators and other officials. This document can be found using the following link: https://www.fema.gov/media-library-data/1525272377818-3cb0cf795a73c135c8543d2459e12c80/NFIPDeskReferencev18_508_V4.1.pdf.

Insurance contact information that a DOI should regularly collect

It is important for a DOI to maintain current insurance company contacts for insurers licensed to do business in the state, including non-admitted surplus lines insurers. Some states may maintain contact information in SBS, another database, or through a Microsoft Outlook contact list obtained by an annual request.

Partnerships with private volunteer organizations can also be useful in coordinating response after a disaster. [State Insurance Department] should identify consumer or non-profit organizations that would be open to a partnership.

Insurance company contacts:

Following a disaster, a DOI will likely need to contact insurers. The contact information should include:

- Insurers doing business in a state.
- A primary contact and a secondary contact (both would likely be a member of the insurer's disaster response team).
- High-level senior management to respond to questions or issues promptly.

Requirements of insurance company contacts

After a disaster, state insurance regulators will need to be able to contact insurers for information. Contacts should:

- Be able to provide coverage data and loss statistics, by county or region, according to a standardized format developed by the DOI.
- Be knowledgeable regarding their internal information systems and sources and authorized to access such systems so that applicable and timely information can be provided upon the request of the DOI.
- Be able to respond to requests for information from legislators, the governor's office, FEMA officials, or press inquiries.

Other necessary contacts

DOIs will need contacts for local, state and federal officials (these should be maintained and updated).

Contacts will report other disaster information to the DOI, including lists of company claim offices and phone numbers, adjuster information, and company toll-free numbers, etc.

Types of information that should be ready for dissemination in the event of a disaster

Following a disaster, a DOI will be responsible for helping consumers regarding claims. Some of the items a DOI will want to have on hand to provide to consumers include:

- Consumer brochures.
- Consumer alerts.
- Insurer contacts for consumers.
- Other forms of information relating to preparation and response to all types of disasters (this information should be updated prior to a disaster).

The NAIC's Transparency and Readability of Consumer Information (C) Working Group created a document to help guide consumers through a claim following a disaster. This document can be passed out following a disaster: <https://content.naic.org/sites/default/files/inline-files/Claim%20Disaster%20Guide%20-%20Generic%20FINAL%207%2023%202019.pdf>.

Types of data a DOI should collect regarding disasters

A DOI should define the appropriate area in their department responsible for creating and maintaining a database that holds coverage data and loss statistics collected from insurers. If a DOI does not have the resources to maintain a database, the NAIC can provide this service.

Information to be collected (generally collected by ZIP code) includes such items as the:

- Number of claims reported
- Number of claims closed with and without payment
- Paid losses
- Incurred losses

Data collection tools the NAIC can provide

The NAIC can provide the data template adopted by the NAIC Property and Casualty (C) Committee and Executive (EX) Committee and Plenary if the DOI does not have its own data call template. This template can be found on the Catastrophe Insurance (C) Working Group's webpage under the Related Documents tab. The link to the webpage is: https://www.naic.org/cmte_c_catastrophe.htm.

The NAIC coordinated data call

The NAIC assists states with data calls related to the collection of claims data following disasters. Data calls are typically conducted weekly immediately after a disaster and then biweekly or monthly as a higher percentage of claims close. The length of time that data is collected is usually dependent upon the severity of the event. For example, a minor hurricane, like Irma, will not necessitate weekly reporting, even in the beginning. Having the NAIC assist with a data call could require a confidentiality agreement if the state does not already have one that would encompass the data call.

Types of information a DOI, in coordination with Public Affairs, should maintain, update, post on the state's website, and distribute via social media

- https://www.insureuonline.org/disaster_prep_flood.pdf
- https://www.insureuonline.org/disaster_prep_tornado.pdf
- https://www.insureuonline.org/disaster_prep_hurricanes.pdf
- https://www.insureuonline.org/disaster_prep_wildfires.pdf
- https://www.insureuonline.org/disaster_prep_earthquakes.pdf
- https://www.insureuonline.org/home_inventory_checklist.pdf
- https://www.naic.org/documents/consumer_alert_wake_of_the_storm.htm
- https://www.naic.org/documents/consumer_alert_flood_insurance_understanding_risk.htm

Resources required for emergency response

The availability and capability of resources needs to be determined and includes the following:

- People
- Facilities
- Materials and supplies
- Funding
- Information regarding threats or hazards

Periodically review resources dedicated to the Disaster Response Team to make certain that there are enough cell phones, laptops, and other equipment and materials available for staff.

Disaster Recovery Team Personnel within the DOI should be identified to act as first responders if the DOI is required to respond to an emergency.

DOI employees are divided into those who will work outside of the office and those who will work at the DOI in an onsite or offsite call center.

Contact information for members of the team should be maintained.

Employees should receive periodic training and updates on procedures for assisting consumers in the event of a disaster.

The DOI shall maintain Disaster Recovery supplies and information for use by the Team.

Brief description of the Major Incident Management Functions (See org chart template - Appendix 1)

COMMAND

Sets the incident objectives, strategies and priorities. Has overall responsibility for the incident.

OPERATIONS

Conducts operations to reach the incident objectives. Establishes tactics and directs all operational resources.

PLANNING

Supports the incident action planning process by tracking resources, collecting/analyzing information, and maintaining documentation.

LOGISTICS

Arranges for resources and needed services to support achievement of the incident objectives.

FINANCE AND ADMINISTRATION

Monitors costs related to the incident. Provides accounting, procurement, time recording and cost analysis.

Keep in mind, larger states may have more resources available than smaller states. See important note to DOIs.

Disaster Response/Incident Management Team

Response Leadership Team (Your State Emergency Management Agency would call this the Command Support Staff)

The purpose of this team is to:

- Provide direction before, during and after a disaster.
- Ensure periodic review and assessment of the State Disaster Response Plan and hold the incident management team accountable for implementation.
- Test and update the plan on a regular and consistent basis.

Location

This team is located at the [Home office] unless an alternative location is needed.

Duties:

Upon notification of a significant disaster, the commissioner, superintendent or director will notify this team to begin implementation of the Disaster Response Plan.

Identify which other disaster response units should be activated.

Members:

The response leadership team should include the following:

- Incident Commander (IC) (commissioner, director, superintendent, chief deputy or their designee).
- Public Information Officer (PIO) (the person that handles media and communication requests).
- Safety Officer (SO) (this person is the human resources (HR) chief manager).
- Finance /Administration Section Chief.
- Legal Counsel (LC).
- Emergency Operations Center (EOC) Liaison Officer (ELO) (this could be your lead consumer affairs staff member).
- Any other positions, as required, who report directly to the IC (they may have an assistant or assistants, as needed).

Incident Commander (IC) – (may be the Agency Head or their designee)

The IC is responsible for all incident action plans (IAPs) and activities to sustain critical functions and services. These tasks include:

- Developing strategies and tactics before the execution of action plans in the event of a disaster.
- Ordering and releasing resources.
- Conducting incident operations.

The IC is responsible for:

- Managing all incident operations.
- Ensuring overall incident safety.

- Assessing the situation and notifying internal teams and departments.
- Appointing others.
- Carrying out all ICS management functions until they delegate a function.
- Providing information services to internal and external stakeholders.
- Managing all operations at the disaster site.

It is possible for the IC to accomplish all management functions during the aftermath of a small event.

The IC only creates the sections that are needed. If a section is not staffed, the IC will personally manage those functions.

Public Information Officer (PIO)

The PIO is responsible for interfacing with the public, industry, media, and/or other agencies with incident-related information requirements.

The PIO is responsible for:

- Drafting and issuing all public announcements.
- Making all press releases.
- Establishing an event-specific webpage (if needed).
- Sending event-specific updates out via social media and posting them online.
- Giving all interviews with the communications media relative to the incident and the Agency's action plan to address the situation. The PIO establishes communications with PIOs in other State Agencies and the Governor's Media Office to convey situation status, progress toward resolving the incident, and any actions needed in support of or to address the situation.

The PIO works directly with the IC and Agency Head on all sensitive communications and may seek advice and counsel from other members of the Command Support Staff on legal or personnel matters and from the Section Chiefs on background relating to the situation and the actions the Agency are taking.

Safety Officer (SO)

The SO monitors incident operations and advises the IC on all matters relating to operational safety, including the health and safety of agency personnel.

The SO is responsible for:

- Monitoring conditions and developing measures for assuring safety of personnel.
- Advising the IC about incident safety issues.
- Conducting risk analyses.
- Implementing safety measures.
- Monitoring building accessibility.
- Communicating with the IC and staff.

Legal Counsel (LC)

The LC is the member of the Incident Command Support Team who provides legal counsel to the IC.

Examples of support would include:

- Providing advice relative to Agency jurisdiction and contractual obligations.
- Completing other tasks as assigned by the IC.

The LC may also be asked to:

- Review any public statements to be issued by the PIO.
- Provide opinion and guidance on employee relations-based issues.
- Provide opinion and guidance on issues that relate to the Agency mission and the public.

Emergency Liaison Officer (ELO)

The ELO is the point of contact for representatives of other governmental agencies, nongovernmental organizations, and the private sector.

The ELO provides a liaison between the DOI and the state's Department of Emergency Management and Homeland Security (DEMHS), especially when the DEMHS has elected to activate its EOC.

A close working relationship between the Agency and the EOC is required for timely communication and action appropriate to directives received. The ELO will represent the Agency at the EOC and establish ongoing communications and scheduled status reviews with the Agency Incident Command.

Roles and Responsibilities

Financial & Administration Section Chief

The Financial and Administration Section Chief is a member of the Incident Command General Staff. This person is also the leader of the Administration Section. In the context of the COOP, the Financial and Administration Section Chief is responsible for the internal processes within the Agency, including financial and human resource functions, which are necessary to enable the critical functions being addressed by the Operations Section.

The Administration Section Chief sustains or recovers processes to maintain the fiscal integrity of the Agency and ensure that essential human resource processes are sustained. The Administration Section Chief works closely with the Operations and Logistics Sections to identify requirements and assess available options.

The Finance/Administration Section Chief is responsible for:

- Analyzing all financial, administrative and cost aspects of an incident.
- Maintaining daily contact with agency administrative headquarters on finance and administration matters.
- Meeting with assisting and cooperating agency representatives.
- Advising the IC on financial and administrative matters.
- Developing the operating plan for the Finance/Administrative Section.
- Coordinating finances at the local level.
- Establishing or transitioning into an existing Finance/Administrative Section.
- Supervising and configuring section with units to support, as necessary.
- Negotiating and monitoring contracts.
- Timekeeping.
- Analyzing cost.
- Compensating for injury or damage to property.
- Documenting reimbursement (e.g., under mutual aid agreements and assistance agreements).

The Finance/Administration Section is set up for any incident that requires incident-specific financial management.

The Time, Compensation/Claims, Cost and Procurement Units may be established within this section.

Finance and Administration Section Team Leads

The Finance and Administration Section Team Leads should be a qualified member of the Incident Command General Staff. This person reports to the Administration Section Chief.

Finance and Administration Section Team Leads are responsible for:

- The coordination of the initial action plan execution and recovery efforts for one of the Administration Section Teams.
- Business continuity interruption preparedness.
- Response coordination.
- Post-interruption corrective action based on lessons learned for the functions that are part of the normal operational responsibilities of the work group.

In the National Incident Management System (NIMS) these Team Leads often head branches or divisions.

Section Chiefs will determine the organization appropriate under respective sections.

Logistics Section Chief

This Logistics Section Chief is a member of the Incident Command General Staff and the leader of the Logistics Section.

The Logistics Section Chief is responsible for:

- Overseeing the resources and processes needed to sustain or recreate the work environment for Operations and Administration Section functions (in the context of the COOP), including facility, technology, equipment and supplies.
- Addressing plant, tool, technology and information security (including the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) requirements for the Incident Command.
- Working closely with the Operations and Administration Sections to identify requirements and assess available options.

The Logistics Section is responsible for all services and support needs, including:

- Ordering, obtaining, maintaining and accounting for essential personnel, equipment and supplies.
- Providing communication planning and resources.
- Setting up food services for responders.
- Setting up and maintaining incident facilities.
- Providing support transportation.
- Providing medical services to incident personnel.

Operations Section Chief

Typically, the Operations Section Chief is the person with the greatest tactical expertise in dealing with the problem at hand. The Operations Section Chief is a member of the Incident Command General Staff and the leader of the Operations Section. This person is responsible for the sustenance or recovery of the functions within the agency that serve the citizens of the state. The Operations Section Chief may have one or more Deputies who are qualified to fill this position.

The Operations Section Chief is responsible for:

- Directly managing all incident tactical activities.
- Implementing the IAP.
- Developing and implementing strategies and tactics to carry out the incident objectives.
- Organizing, assigning and supervising the tactical response resources.
- Having one or more Deputies who are qualified to assume these responsibilities. (This is recommended where multiple shifts are needed, as well as for succession planning).

Operation Section Team Leads

An Operation Section Team Lead is a qualified member of the Incident Command General Staff who reports to the Operation Section Chief. This individual is responsible for the coordination of the initial action plan and recovery effort of the Operation Section Teams.

Operation Section Team Leads are responsible for:

- Pre-incident preparedness.
- IAP coordination.
- Post-incident corrective action based on lessons learned for the functions that are part of the normal operational responsibilities of the work group.

Planning Section Chief

The Planning Section Chief is a member of the Incident Command General Staff and leader of the Planning Section. This individual is responsible for the development of the Business Continuity Plan and COOP document and works closely with the IC, General Staff (other Section Chiefs), and Command Support Staff to ensure that critical functions and their resource requirements are identified and that preparatory actions are taken. The Planning Section Chief ensures that communications information needed to execute the COOP has been captured.

In the continuity plan action period, the Planning Section Chief is responsible for:

- Serving as a coach to Incident Command.
- Ensuring that regular crisis action plan review sessions are held.
- Ensuring that outstanding issues are identified.
- Ensuring that appropriate alternatives are considered.
- Ensuring that action assignments are clearly distributed.

The Planning Section Chief may have one or more Deputies who are qualified to assume these responsibilities. This is recommended where multiple shifts are needed, as well as for succession planning.

The major activities of the Planning Section may include:

- Collecting, evaluating and displaying incident intelligence and information.
- Preparing and documenting IAPs.
- Tracking resources assigned to the incident.
- Maintaining incident documentation.
- Developing plans for demobilization.

Deputy

The Deputy is a fully qualified individual who, in the absence of a superior, can be delegated the authority to manage a functional operation or perform a specific task. In some cases, the Deputy acts as relief for a superior; therefore, the Deputy must be fully qualified in the position.

Deputies can be assigned to the IC, Command Support Staff, and the Section Chief positions.

Statistics Operational Network Task Group

The purpose of this group is to facilitate an analysis of a catastrophe with insurance companies and the [agency name] whenever a catastrophic event occurs.

The Statistics Operational Network Task Group will be located [insert location of home office or other designated location] unless otherwise chosen due to necessity.

The Statistics Operational Network Task Group is charged with the responsibility of creating a “contact list” of insurance community liaisons. This contact list will allow for prompt contact of people within the insurance industry who should be able to provide coverage data and loss statistics, by region, according to any standardized format developed by [agency].

The Team Lead should be knowledgeable of company internal information systems and sources authorized to access such systems so that applicable and timely information can be provided to [agency] or emergency response agencies upon request.

Members of this Task Group should include divisions that perform data collection/analysis, market conduct, and financial regulation.

Consumer Operational Team Lead

The Consumer Operational Team Lead works with the PIO to provide consumers with the information needed to contact their insurance companies and the fundamentals to file a claim and convey necessary information to the Emergency Response Team.

A Consumer Information Task Group will be located [insert location of home office or other designated location] unless otherwise selected by the Disaster Executive Committee due to necessity.

If a disaster is declared, a consumer hotline should be immediately activated, but consideration may be needed to relocate it. The hotline:

- Should be able to ramp up to provide a 24-hour service.¹
- Should operate utilizing four six-hour shifts.

Branch offices might initially be made operational through the use of cell phones until other landlines are established.

Hotline staff should:

- Have a list of 800 numbers of the major property/casualty (P/C) insurers in the state.
- Have the list of Emergency Response Task Group key personnel.
- Have other emergency agency numbers to be used in the event of a disaster.
- Be provided with a communications kit, which will be used to tell consumers about claim procedures.

Members should include:

- Consumer services unit senior management.
- Internal resource senior management.

Communications Operations Task Group

The purpose of this group is to work with the PIO to create a central source for media information relevant to disaster insurance and the disaster plan response activities.

This Group:

- Prepares news releases about the steps to take before, during and after a disaster.
- Produces brochures about preparedness.
- Dispatches speakers to various locations, as needed.
- Maintains contact with all media.

¹ It may not be necessary to operate 24 hours a day, but it is likely that the hotline may need to be open for hours longer than the agency is typically open. The agency will need to be prepared for these circumstances.

The Communications Team will be [insert location of home office or other designated location] unless otherwise chosen by the Disaster Executive Committee due to necessity.

The Communications Operations Task Group is responsible for:

- Developing a consistent message to be communicated to consumers.
- Distributing advisories and brochures to units of government throughout the state so that they may reproduce them for local residents. (The NAIC may be contacted for assistance in bulk reproduction).

The Communications Task Group should:

- Be in constant contact with the [State Emergency Management Agency's Communications Team] to coordinate media announcements.
- Contact news organizations throughout the state with a Media Advisory.
- Notify news agencies that [agency name] is the primary source for obtaining and forwarding information relative to insurance and a disaster.
- Be in constant touch with the Emergency Response Task Group and branch offices to coordinate the information flow.

Much of the information will be obtained from the designated liaison persons of the Emergency Response Task Group.

This system ensures that information being supplied to the media is consistent, accurate, and up-to-the-minute.

The Communications Task Group is:

- Responsible for ensuring that messaging is consistent.
- Responsible for developing an Outreach Team to operate quickly and efficiently in affected areas to answer questions in town meetings and other informational gatherings.
- Responsible for supplement information provided through the media and other sources about how to quickly and effectively prepare insurance claims information.

Members include:

- Senior media or communications staff.
- Legislative personnel.
- Key agency staff with public speaking experience.

Logistics Task Group

The purpose of this Task Group is:

- To consult with other task groups regarding the DOI's logistical and technical capabilities, and requirements, to enable the efficient execution of the DOI's State Disaster Response Plan.
- To coordinate with the Emergency Response Task Group regarding logistical and technical capabilities for Emergency Response Task Group and/or field or temporary offices.
- To coordinate with other areas regarding logistical and technical capabilities for hotline and other consumer communication needs.

The Logistics Task Group will be [insert location of home office or other designated location] unless otherwise chosen by the Disaster Executive Committee due to necessity.

The duties of the Logistics Task Group are:

- To identify resource needs of the other task groups regarding the DOI's logistical and technical capabilities and requirements to enable the insurance department to respond better and faster to disasters and include these in the implementation plan.
- To coordinate technical requirements for an alternate designated facility to ensure its immediate activation in case the DOI's home or central office is damaged/destroyed in a disaster and include these in the implementation plan.

Members include:

- Senior staff from internal resource or budget.
- Senior staff from the information technology (IT) unit.
- Senior staff from any branch office locations.

Branch Office(s)

Branch offices will be responsible for addressing and solving problems where possible and overseeing operations in their responsibility area.

While the composition and basic duties will be the same as those of the Emergency Response Task Group, the branch office(s) will deal with the local problems and handle them from a closer vantage point.

Branch offices will be established at the existing location of the branch offices, unless the Emergency Response Task Group indicates a more appropriate location.

The branch office will be responsible for:

- Channeling information within the zone for which the branch office is responsible.
- Forwarding requests for speakers and press contacts to the Communications Task Group.
- Obtaining general insurance information and all written material explaining how to prepare claims from the Consumer Services Task Group.

- Routinely reporting to the Emergency Response Task Group about daily activities.
- Sending all problems that cannot be worked out locally to the Emergency Response Task Group for review.
- Obtaining DOI brochures.

Members include senior staff from branch office location(s).

Where serious disputes or problems arise, the branch office will forward these back to the Emergency Response Task Group; otherwise, the branch office will manage its own operation and report only.

It is imperative that senior staff remain at the Branch Office Operations center for command purposes.

These centers fall under the direction of the Emergency Response Task Group.

Appendix 1

Business Continuity Org Chart

Appendix 2

Response Levels and Definitions

**RESPONSE LEVELS
AND
DEFINITIONS**

	Disaster Level 1	Disaster Level 2	Disaster Level 3	Disaster Level 4
Typical Damage	Exterior Damage to Private Property	Exterior Damage, Possibly Some Interior Damage, and Possibly Some Structural Damage to Private and Commercial Property. Infrastructure Damage to Telephone and Power Lines.	Exterior Damage, Interior Damage, and Structural Damage to Private and Commercial Property. Infrastructure Damage to Telephone and Power Lines. Temporary Interruption of Normal Public Services.	Significant to Massive Exterior, Interior and Structural Damage to Private and Commercial Property. Infrastructure Damage to Telephone and Power Lines and Possibly Cell Towers. Communications, Public Services Lost for Extended Time.
Insured Losses	Less than \$100 Million	Between \$100 Million and \$1 Billion	Between \$1 Billion and \$10 Billion	Greater than \$10 Billion
Types of Events	Rural Tornadoes Rural Hailstorms Rural Windstorms Local Flash Floods	Town-leveling tornadoes Suburban Hail and/or windstorms Area-wide ice storms Area-wide flash floods Rural & Residential Forest/Wildfires	Region-wide Region-wide ice storms Urban Tornadoes Major outbreak multiple tornadoes Urban Floods Urban/Suburban Fires Significant Blizzards Moderate earthquakes	Significant Earthquakes A major New Madrid EQ Significant record-breaking floods Major influenza outbreak
Geographical Extent	Localized	Localized to disbursed	Localized to widespread	Disbursed to widespread
Affected Population	Small	Small to Moderate	Small to Large	Moderate to Large
Examples	Hoisington, Kansas F4 Tornado (April 21, 2001) \$43 Billion in Damages	La Plata, Maryland F4 Tornado (April 28, 2002) \$100M in Damage	Nashville Flood (May 1, 2010) \$1.5 Billion in Damages	Great Flood of 1993 (Missouri & Mississippi Rivers) \$15–20 Billion in Damages
		Haysville/Wichita, Kansas F4 Tornado (May 3, 1999) \$150 Million in Damage	Oakland/Berkeley Firestorm (October 19, 1991) \$1.54 Billion in Damages	Northridge Earthquake (January 17, 1994) (Mag. 6.7 Mom. Mag.) \$15 Billion in Damages
		Greensburg, Kansas EF5 Tornado (May 4, 2007) \$153 million in Damage (Approx. 2,000 claims)	Tornado Outbreak in KC, Okla. City (May 2005) F3s & F4s \$3.2 Billion	FEMA Estimate for a Mag. 7.7 Earthquake in Missouri: \$30+ Billion in Damages

**DIRECTOR'S CONTACTS
TOP 20 P/C INDUSTRY CONTACT
LIST**

Carrier Name	Director's Contact Name	Director's Contact Title	Director's Contact Address	Director's Contact E-mail	Director's Contact Cell Phone #	Director's Contact Fax #

**DIRECTOR'S CONTACTS
TOP 20 COMMERCIAL/ALLIED
LINES CONTACT LIST**

Carrier Name	Director's Contact Name	Director's Contact Title	Director's Contact Address	Director's Contact E-mail	Director's Contact Cell Phone #	Director's Contact Fax #

Appendix 3

Sample Contact Lists

INSURANCE TRADE ASSOCIATION and KEY INDUSTRY GROUPS CONTACT LIST

STATE INSURANCE TRADE ASSOCIATION (SITA)

Address 1

Address 2

Executive Director:

Phone:

Fax:

E-mail Address:

Internet Address:

STATE INSURANCE AGENT ASSOCIATION

Address 1

Address 2

Executive Director:

Phone:

Fax:

E-mail Address:

Internet Address: _

NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES (NAMIC)

3601 Vincennes Rd

Indianapolis, IN 46268

Key Executive: Charles Chamness, CFO

Phone: 317-875-5250

Fax: 317-879-8408

E-mail Address: lforrester@namic.org or cchamness@namic.org

Internet Address: www.namic.org

INSURANCE SERVICES OFFICE (ISO)

2828 E. Trinity Mills Road, Suite 315

Carrollton, TX 75006

Assistant Regional Manager:

Phone

Fax:

E-mail Address:

Internet Address: www.iso.com

AMERICAN PROPERTY CASUALTY INSURANCE ASSOCIATION (APCIA)

Address:

City, State, Zip:

Contact:

Phone:

Fax:

E-mail Address:

Internet Address: www.pciaa.net

INSURANCE INFORMATION INSTITUTE (III)

110 William Street

New York, NY 10038

Key Executive:

Phone:

Fax:

E-mail Address

Internet Address: www.iii.org

STATE INSURANCE GUARANTY ASSOCIATIONS

Address1

Address 2

Contact:

Phone:

Fax:

E-mail Address:

Internet Address:

NATIONAL ASSOCIATION OF INSURANCE AND FINANCIAL ADVISORS (NAIFA)

Address 1

Address 2

Contact:

Phone:

Fax:

E-mail Address:

Internet Address:

NATIONAL COUNCIL ON COMPENSATION INSURANCE (NCCI)

Address 1

Address 2

Contact:

Phone:

Mobile:

Fax:

E-mail Address:

Internet Address: _

STATE PROPERTY RESIDUAL MARKET OR FAIR PLAN

Address 1

Address 2

Manager:

Phone:

Fax:

E-mail Address:

Internet Address:

MEDIA CONTACTS (EXAMPLE FROM MISSOURI Department of Insurance)

Newspapers		
Blue Springs Examiner	dbrendel @examiner.net	(816) 229-9161
Boonville Daily News, The	news@boonvillenews.com	(660) 882-5335
Branson Daily News, The	bdn@tri-lakes.ent	(417) 334-3161
Carthage Press, The	carpress@ipa.net	(417) 358-2191
Broadcast		
Associated Press	pstevens@ap.org	
Television Stations		
KCTV	kctv@kctv.com	913-677-5555
KETC	letters@ketc.pbs.org	800-729-9966
Radio Stations		
KAAN	rodneyh@netins.net	660-425-7575
KAHR	kool967@semo.net	866-917-9797
KALM -	mail@kkountry.com	417-264-7211
KAOL	KMZU@carolnet.com	660-542-0404
KBDZ	news@suntimesnews.com	573-547-2980

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Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 8, 2020

Draft: 12/2/20

**Property & Casualty Market Conduct Annual Statement
Private Passenger Auto and Homeowners
Definitions of “Lawsuit” and “Lawsuits Closed During the Period with Consideration for the Consumer”**

Lawsuit – A court proceeding to recover a right to a claim, including lawsuits for arbitration cases.

Exclude:

- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, and declaratory judgment actions filed by an insurer.

Calculation Clarification:

- Lawsuits should be reported on the same basis as claims. One lawsuit should be reported for each claimant / coverage combination, regardless of the number of actual lawsuits filed.
- One lawsuit with two claimants would be reported as two lawsuits as any awards/payments made would be made to the claimants individually.
- One lawsuit filed seeking damages for multiple coverages should be reported as one lawsuit for each applicable coverage. If the lawsuit is seeking damages for bodily injury and property damage, one lawsuit should be reported for each of the two coverages.
- Lawsuits should be reported in the state in which the claim is reported on this statement.
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

~~Lawsuit—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.~~

~~For purposes of reporting lawsuits for Private Passenger Auto products:~~

- ~~Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;~~
- ~~Include all lawsuits, whether or not a hearing or proceeding before the court occurred;~~
- ~~Do not include arbitrations of any sort;~~
- ~~If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;~~
- ~~If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;~~
- ~~Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;~~
- ~~Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.~~
- ~~Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.~~

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the ~~applicant, policyholder, or beneficiary~~ claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC's Executive Committee is required. The NAIC's Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: New Model Law or Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

Group Capital Calculation (E) Working Group

2. NAIC staff support contact information:

Dan Daveline
ddaveline@naic.org
(816) 783-8134

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

- *Insurance Holding Company System Regulatory Act* (#440)
- *Insurance Holding Company System Regulation with Reporting Forms and Instructions* (#450)

In 2015, the NAIC adopted the following charge to the Financial Condition (E) Committee who subsequently formed the Group Capital Calculation (E) Working Group to carry out such a change.

“Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the Comframe Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation.”

The Group Capital Calculation (E) Working Group has been developing the group capital calculation (GCC) since receiving its charge and in May, with the assistance of 33 insurance groups and 15 lead states, began testing the current construction. The lead states are currently reviewing the completed templates and take aways from the testing are expected to be summarized and discussed at the Fall National Meeting in Austin. Upon completion of the field-testing, state regulators will use the results to further improve the construction of the calculation and at this junction, the Working Group is striving to adopt the calculation sometime in 2020. In order to allow states to be able to adopt the GCC, the Working Group is seeking approval to modify the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Regulation with Reporting Forms and Instructions* (#450). While the Working Group has not concluded the exact construct of such changes, the Working Group expects Section 4 of #440 will need to be revised to require a new filing and #450 will need to be revised to add the new filing and a related new section (Form G).

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

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

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

If yes, please explain why:

State insurance regulators currently perform group analysis on all U.S. insurance groups, including assessing the risks and financial position of the insurance holding company system based on currently available information. However, state regulators currently do not have the benefit of a consolidated statutory accounting system and financial statements to assist them in these efforts. The GCC is expected to fill this void since it requires an aggregation and display of the individual company's available capital and operating figures. More specifically, the GCC and related reporting will provide more transparency to insurance regulators regarding the insurance group and make risks more identifiable and more easily quantified. In this regard, the tool will assist regulators in holistically understanding the financial condition of non-insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies may be subsidizing the operations of non-insurance entities, potentially undermining the insurance company's financial condition and/or placing upward pressure on premiums to the detriment of insurance policyholders. It is envisioned that this calculation will provide an additional early warning signal to regulators so they can begin working with a company to resolve any concerns in a manner that will ensure that policyholders will be protected. Importantly, the GCC will complement existing group supervisory tools already available to state insurance regulators, such as the *Form F Enterprise Risk Report*¹, the *Own Risk and Solvency Assessment Summary Report*² and the *Form B Holding Company Filings*³. As such, we would expect it to be a national standard

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

Yes or No (Check one)

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

As previously noted, the Working Group is striving to adopt the calculation sometime in 2020 and it is expected that revisions to the model be adopted by the NAIC within that same time period so that states can begin to implement through changes to state law.

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: See previous discussion.

¹ *Insurance Holding Company System Model Act* (#440) and supporting *Insurance Holding Company System Model Regulation* (#450) require the annual filing of an Enterprise Risk Report (Form F) which requires the disclosure on material risks within the insurance holding company system that could pose enterprise risk to the insurer

² *Risk Management and Own Risk and Solvency Assessment (ORSA) Model Act* (#505) require the annual filing of an ORSA Summary report that includes 1) Description of the Insurer's Risk Management Framework; 2) Insurer's Assessment of Risk Exposure; and 3) Group Assessment of Risk Capital and Prospective Solvency Assessment

³ *Insurance Holding Company System Model Act* (#440) and supporting *Insurance Holding Company System Model Regulation* (#450) require the annual filing of an Registration Statement (Form B) which includes, among other items, the annual financial statements of the ultimate controlling person in the insurance holding company system and all of its affiliates and subsidiaries

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

At this juncture, the changes to the NAIC models are expected to 1) require the filing of the GCC with the state; 2) provide important confidentiality protections; 3) provide exemptions for who is not expected to file the GCC. As such, variations by states related to these elements are not expected.

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

The Group Capital Calculation (E) Working Group has not discussed whether the GCC should be an accreditation standard. However, because the GCC is expected to be required of the largest and most complex U.S. insurance group who operate in all states, a national standard is appropriate.

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

Yes. Under Title V of the Dodd-Frank Act, the U.S. Department of the Treasury and the Office of the U.S. Trade Representative are authorized to jointly negotiate covered agreements, defined under the Dodd-Frank Act as written bilateral or multilateral agreements between the United States and one or more foreign governments, authorities or regulators regarding prudential measures with respect to insurance or reinsurance, on the condition that the prudential measures subject to a covered agreement achieve a level of protection for insurance or reinsurance consumers that is “substantially equivalent” to the level of protection achieved under U.S. state insurance laws. On Sept. 22, 2017, the U.S. Department of the Treasury and the Office of the U.S. Trade Representative signed the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement). On December 18, 2018, a separate Covered Agreement was signed between the U.S. and the United Kingdom, which mirrors the language from the agreement with the EU, and has the same timing requirements for implementation.

The Covered Agreement includes requirements on reinsurance collateral, group supervision and group capital. Specifically, Article 4(h) provides that the host supervisor (i.e., a supervisory authority from the territory in which an insurance group has operations but which is not the territory where the worldwide parent is domiciled or headquartered) may not impose a group capital assessment or requirement at the level of the worldwide parent, but only if the insurance group is subject to a group capital assessment imposed by the home supervisor. The group capital assessment of the home supervisor must include a worldwide group capital calculation capturing risk at the level of the entire group, and the home supervisor must have the authority to impose preventive, corrective or otherwise responsive measures on the basis of the assessment, including the authority to impose capital measures where appropriate.

Under Article 10(e) of the Covered Agreement, supervisory authorities in the European Union shall not impose a group capital requirement at the level of the worldwide parent undertaking of the insurance or reinsurance group, with regard to a U.S. insurance or reinsurance group with operations in the European Union, for 60 months after the date of provisional application of the Covered Agreement; i.e., Nov. 7, 2022. The NAIC is developing a group capital calculation intended to serve as an analytical tool for evaluating an insurer’s capital position at the group level, but which is not intended to be applied as a group-level capital requirement or standard. The *Statement of the United States on the Covered Agreement with the European Union* provides further clarification with respect to this group capital assessment:

The Agreement limits the worldwide application of EU prudential group insurance measures on U.S. insurers operating in the EU. The Agreement provides that U.S. insurers and reinsurers can operate in the EU without the U.S. parent being subject to the group level governance, solvency and capital, and reporting requirements of Solvency II, and reinforces that the EU system of prudential insurance supervision is not the system in the United States. The Agreement does not require development of a group capital standard or group capital requirement in the United States. Article 4(h) contemplates that the states will develop a group-wide capital assessment. Through the National

Association of Insurance Commissioners (NAIC), the states are in the process of developing a group capital calculation which is intended to serve as an analytical tool for evaluating a firm's capital position at the group level. **The United States expects that the NAIC's group capital calculation will satisfy the "group capital assessment" condition of Article 4(h)**, provided that the work is completed and implemented within five years of the date on which the Agreement is signed. [Emphasis added].

Any state with U.S. groups operating in either the European Union or the United Kingdom will need to adopt these legislative changes by Nov. 7, 2022 in order to effectuate compliance with the Covered Agreement.

Adopted by the Financial Condition (E) Committee November 19, 2020

INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

Table of Contents

Section 1.	Definitions
Section 2.	Subsidiaries of Insurers
Section 3.	Acquisitions of Control of or Merger With Domestic Insurer
Section 3.1	Acquisitions Involving Insurers Not Otherwise Covered
Section 4.	Registration of Insurers
Section 5.	Standards and Management of an Insurer Within an Insurance Holding Company System
Section 6.	Examination
Section 7.	Supervisory Colleges
Section 7.1	Group-wide Supervision of Internationally Active Insurance Groups
Section 8.	Confidential Treatment
Section 9.	Rules and Regulations
Section 10.	Injunctions, Prohibitions against Voting Securities, Sequestration of Voting Securities
Section 11.	Sanctions
Section 12.	Receivership
Section 13.	Recovery
Section 14.	Revocation, Suspension, or Nonrenewal of Insurer's License
Section 15.	Judicial Review, Mandamus
Section 16.	Conflict with Other Laws
Section 17.	Separability of Provisions
Section 18.	Effective Date
Appendix.	Alternate Provisions

Section 1. Definitions note

As used in this Act, the following terms shall have these meanings unless the context shall otherwise require:

- A. "Affiliate." An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.
- B. "Commissioner." The term "commissioner" shall mean the insurance commissioner, the commissioner's deputies, or the Insurance Department, as appropriate.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the word "commissioner" appears.

- C. "Control." The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by Section 4K that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.
- D. "Group-wide supervisor." The regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner under Section 7.1 to have sufficient significant contacts with the internationally active insurance group.

- E. "Group Capital Calculation instructions" means the group capital calculation instructions as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.
- F. "Insurance Holding Company System." An "insurance holding company system" consists of two (2) or more affiliated persons, one or more of which is an insurer.
- GF. "Insurer." The term "insurer" shall have the same meaning as set forth in Section [insert applicable section] of this Chapter, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

Drafting Note: References in this model act to "Chapter" are references to the entire state insurance code.

Drafting Note: States should consider applicability of this model act to fraternal societies and captives.

- HG. "Internationally active insurance group." An insurance holding company system that (1) includes an insurer registered under Section 4; and (2) meets the following criteria: (a) premiums written in at least three countries, (b) the percentage of gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system's total gross written premiums, and (c) based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars (\$50,000,000,000) or the total gross written premiums of the insurance holding company system are at least ten billion dollars (\$10,000,000,000).
- IH. "Enterprise Risk." "Enterprise risk" shall mean any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's Risk-Based Capital to fall into company action level as set forth in [insert cross reference to appropriate section of Risk-Based Capital (RBC) Model Act] or would cause the insurer to be in hazardous financial condition [insert cross reference to appropriate section of Model Regulation to define standards and commissioner's authority over companies deemed to be in hazardous financial condition].
- J. "NAIC" means the National Association of Insurance Commissioners.
- K. "NAIC Liquidity Stress Test Framework." The "NAIC Liquidity Stress Test Framework" is a separate NAIC publication which includes a history of the NAIC's development of regulatory liquidity stress testing, the Scope Criteria applicable for a specific data year, and the Liquidity Stress Test instructions and reporting templates for a specific data year, such Scope Criteria, instructions and reporting template being as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.
- L. "Person." A "person" is an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.
- M. "Scope Criteria." The "Scope Ceriteria," as detailed in the NAIC Liquidity Stress Test Framework, are the designated exposure bases along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC Liquidity Stress Test Framework for that data year.
- M-N. "Securityholder." A "securityholder" of a specified person is one who owns any security of such person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.
- NK-O. "Subsidiary." A "subsidiary" of a specified person is an affiliate controlled by such person directly or indirectly through one or more intermediaries.

~~OLP.~~ “Voting Security.” The term “voting security” shall include any security convertible into or evidencing a right to acquire a voting security.

Section 2. Subsidiaries of Insurers

A. Authorization. A domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. The subsidiaries may conduct any kind of business or businesses and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

Drafting Note: This bill neither expressly authorizes noninsurance subsidiaries nor restricts subsidiaries to insurance related activities. It is believed that this is a policy decision which should be made by each individual state. Attached as an appendix are alternative provisions which would authorize the formation or acquisition of subsidiaries to engage in diversified business activity.

B. Additional Investment Authority. In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under all other sections of this Chapter, a domestic insurer may also:

- (1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of ten percent (10%) of the insurer’s assets or fifty percent (50%) of the insurer’s surplus as regards policyholders, provided that after such investments, the insurer’s surplus as regards policyholders will be reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included:
 - (a) Total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities, and
 - (b) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities; and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation;

Drafting Note: When considering whether to amend its Holding Company Act to exempt health maintenance organizations and other similar entities from certain investment limitations, a state should consider whether the solvency and general operations of the entities are regulated by the insurance department. In addition to, or in place of, the term “health maintenance organizations” in Paragraph (1) above, a state may include any other entity which provides or arranges for the financing or provision of health care services or coverage over which the commissioner possesses financial solvency and regulatory oversight authority.

- (2) Invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer provided that each subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in Paragraph (1) or in Sections [insert applicable section] through [insert applicable section] of this Chapter applicable to the insurer. For the purpose of this paragraph, “the total investment of the insurer” shall include:
 - (a) Any direct investment by the insurer in an asset, and
 - (b) The insurer’s proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary’s investment by the percentage of the ownership of the subsidiary;

- (3) With the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries; provided that after the investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.
- C. Exemption from Investment Restrictions. Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to Subsection B shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in this Chapter applicable to such investments of insurers [except the following:].

Drafting Note: The last phrase is optional in those states having certain special qualitative limitations, such as prohibitions on investments in stock of mining companies, which the state may wish to retain as a matter of public policy.

- D. Qualification of Investment; When Determined. Whether any investment made pursuant to Subsection B meets the applicable requirements of that subsection is to be determined before the investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.
- E. Cessation of Control. If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three (3) years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after the investment shall have been made, the investment shall have met the requirements for investment under any other section of this Chapter, and the insurer has so notified the commissioner.

Section 3. Acquisition of Control of or Merger with Domestic Insurer

- A. Filing Requirements.
 - (1) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time the offer, request or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, such person has filed with the commissioner and has sent to the insurer, a statement containing the information required by this section and the offer, request, invitation, agreement or acquisition has been approved by the commissioner in the manner prescribed in this Act.
 - (2) For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days prior to the cessation of control. The commissioner shall determine those instances in which the party(ies) seeking to divest or to acquire a controlling interest in an insurer, will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in his or her discretion determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in Paragraph (1) is otherwise filed, this paragraph shall not apply.
 - (3) With respect to a transaction subject to this section, the acquiring person must also file a pre-acquisition notification with the commissioner, which shall contain the information set forth in Section 3.1C(1). A failure to file the notification may be subject to penalties specified in Section 3.1E(3).

- (4) For purposes of this section a domestic insurer shall include any person controlling a domestic insurer unless the person, as determined by the commissioner, is either directly or through its affiliates primarily engaged in business other than the business of insurance. For the purposes of this section, "person" shall not include any securities broker holding, in the usual and customary broker's function, less than twenty percent (20%) of the voting securities of an insurance company or of any person which controls an insurance company.
- B. Content of Statement. The statement to be filed with the commissioner shall be made under oath or affirmation and shall contain the following:
- (1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in Subsection A is to be effected (hereinafter called the "acquiring party"), and
 - (a) If the person is an individual, his or her principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years;
 - (b) If the person is not an individual, a report of the nature of its business operations during the past five (5) years or for the lesser period as the person and any predecessors shall have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to such positions. The list shall include for each individual the information required by Subparagraph (a) of this paragraph;
 - (2) The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose (including any pledge of the insurer's stock, or the stock of any of its subsidiaries or controlling affiliates), and the identity of persons furnishing consideration; provided, however, that where a source of consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing the statement so requests;
 - (3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each acquiring party (or for such lesser period as the acquiring party and any predecessors shall have been in existence), and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement;
 - (4) Any plans or proposals which each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;
 - (5) The number of shares of any security referred to in Subsection A which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in Subsection A, and a statement as to the method by which the fairness of the proposal was arrived at;
 - (6) The amount of each class of any security referred to in Subsection A which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;
 - (7) A full description of any contracts, arrangements or understandings with respect to any security referred to in Subsection A in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements or understandings have been entered into;

- (8) A description of the purchase of any security referred to in Subsection A during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid;
- (9) A description of any recommendations to purchase any security referred to in Subsection A made during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, or by anyone based upon interviews or at the suggestion of the acquiring party;
- (10) Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in Subsection A, and (if distributed) of additional soliciting material relating to them;
- (11) The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in Subsection A for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto;

Drafting Note: An insurer required to file information pursuant to sub-sections 3B(12) and 3B(13) may satisfy the requirement by providing the commissioner with the most recently filed parent corporation reports that have been filed with the SEC, if appropriate.

- (12) An agreement by the person required to file the statement referred to in Subsection A that it will provide the annual report, specified in Section 4L(1), for so long as control exists;
- (13) An acknowledgement by the person required to file the statement referred to in Subsection A that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer; and
- (14) Such additional information as the commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in Subsection A is a partnership, limited partnership, syndicate or other group, the commissioner may require that the information called for by Paragraphs (1) through (14) shall be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member or person is a corporation or the person required to file the statement referred to in Subsection A is a corporation, the commissioner may require that the information called for by Paragraphs (1) through (14) shall be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of the corporation.

If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within two (2) business days after the person learns of the change.

C. Alternative Filing Materials.

If any offer, request, invitation, agreement or acquisition referred to in Subsection A is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in Subsection A may utilize the documents in furnishing the information called for by that statement.

D. Approval by Commissioner: Hearings.

- (1) The commissioner shall approve any merger or other acquisition of control referred to in Subsection A unless, after a public hearing, the commissioner finds that:
 - (a) After the change of control, the domestic insurer referred to in Subsection A would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;
 - (b) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly. In applying the competitive standard in this subparagraph:
 - (i) The informational requirements of Section 3.1C(1) and the standards of Section 3.1D(2) shall apply;
 - (ii) The merger or other acquisition shall not be disapproved if the commissioner finds that any of the situations meeting the criteria provided by Section 3.1D(3) exist; and
 - (iii) The commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;
 - (c) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;
 - (d) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;
 - (e) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or
 - (f) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.
- (2) The public hearing referred to in Paragraph (1) shall be held within thirty (30) days after the statement required by Subsection A is filed, and at least twenty (20) days notice shall be given by the commissioner to the person filing the statement. Not less than seven (7) days notice of the public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the commissioner. The commissioner shall make a determination within the sixty (60) day period preceding the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the [insert title] Court of this state. All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing.
- (3) If the proposed acquisition of control will require the approval of more than one commissioner, the public hearing referred to in Paragraph (2) may be held on a consolidated basis upon request of the person filing the statement referred to in Subsection A. Such person shall file the statement referred to in Subsection A with the National Association of Insurance Commissioners (NAIC) within five (5) days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten (10) days of the receipt of the statement referred to in Subsection A. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A

commissioner may attend such hearing, in person or by telecommunication.

- (4) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to Section 3A(1) of this Act.
- (5) The commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

E. Exemptions. The provisions of this section shall not apply to:

- (1) [Any transaction which is subject to the provisions of Sections [insert applicable section] and [insert applicable section] of the laws of this state, dealing with the merger or consolidation of two or more insurers].

Drafting Note: Optional for use in those states where existing law adequately governs standards and procedures for the merger or consolidation of two or more insurers.

- (2) Any offer, request, invitation, agreement or acquisition which the commissioner by order shall exempt as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or as otherwise not comprehended within the purposes of this section.

F. Violations. The following shall be violations of this section:

- (1) The failure to file any statement, amendment or other material required to be filed pursuant to Subsection A or B; or
- (2) The effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with, a domestic insurer unless the commissioner has given approval.

G. Jurisdiction, Consent to Service of Process. The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this state who files a statement with the commissioner under this section, and overall actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by the person of the commissioner to be his true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to the person at his last known address.

Section 3.1 Acquisitions Involving Insurers Not Otherwise Covered

A. Definitions. The following definitions shall apply for the purposes of this section only:

- (1) "Acquisition" means any agreement, arrangement or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers.
- (2) An "involved insurer" includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

B. Scope

- (1) Except as exempted in Paragraph (2) of this subsection, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state.

- (2) This section shall not apply to the following:
- (a) A purchase of securities solely for investment purposes so long as the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under Section 1C, it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of this state;
 - (b) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if pre-acquisition notification is filed with the commissioner in accordance with Section 3.1C(1) thirty (30) days prior to the proposed effective date of the acquisition. However, such pre-acquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other subparagraph of Section 3.1B(2);
 - (c) The acquisition of already affiliated persons;
 - (d) An acquisition if, as an immediate result of the acquisition,
 - (i) In no market would the combined market share of the involved insurers exceed five percent (5%) of the total market,
 - (ii) There would be no increase in any market share, or
 - (iii) In no market would
 - (I) The combined market share of the involved insurers exceeds twelve percent (12%) of the total market, and
 - (II) The market share increase by more than two percent (2%) of the total market.

For the purpose of this Paragraph (2)(d), a market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;
 - (e) An acquisition for which a pre-acquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business;
 - (f) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary commissioner to the commissioner of this state.

C. Pre-acquisition Notification; Waiting Period. An acquisition covered by Section 3.1B may be subject to an order pursuant to Section 3.1E unless the acquiring person files a pre-acquisition notification and the waiting period has expired. The acquired person may file a pre-acquisition notification. The commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in Section 8 of this Act.

- (1) The pre-acquisition notification shall be in such form and contain such information as prescribed by the National Association of Insurance Commissioners (NAIC) relating to those markets which, under Section 3.1B(2)(d), cause the acquisition not to be exempted from the provisions of this

section. The commissioner may require such additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of Section 3.1D. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating his or her ability to render an informed opinion.

- (2) The waiting period required shall begin on the date of receipt of the commissioner of a pre-acquisition notification and shall end on the earlier of the thirtieth day after the date of receipt, or termination of the waiting period by the commissioner. Prior to the end of the waiting period, the commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of the additional information by the commissioner or termination of the waiting period by the commissioner.

D. Competitive Standard

- (1) The commissioner may enter an order under Section 3.1E(1) with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly or if the insurer fails to file adequate information in compliance with Section 3.1C.
- (2) In determining whether a proposed acquisition would violate the competitive standard of Paragraph (1) of this subsection, the commissioner shall consider the following:

- (a) Any acquisition covered under Section 3.1B involving two (2) or more insurers competing in the same market is *prima facie* evidence of violation of the competitive standards.

- (i) If the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more

- (ii) Or, if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

A highly concentrated market is one in which the share of the four (4) largest insurers is seventy-five percent (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two (2) insurers are involved, exceeding the total of the two columns in the table is *prima facie* evidence of violation of the competitive standard in Paragraph (1) of this subsection. For the purpose of this item, the insurer with the largest share of the market shall be deemed to be Insurer A.

- (b) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two (2) largest to the eight (8) largest, has increased by seven percent (7%) or more of the market over a period

of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under Section 3.1B involving two (2) or more insurers competing in the same market is *prima facie* evidence of violation of the competitive standard in Paragraph (1) of this subsection if:

- (i) There is a significant trend toward increased concentration in the market;
 - (ii) One of the insurers involved is one of the insurers in a grouping of large insurers showing the requisite increase in the market share; and
 - (iii) Another involved insurer's market is two percent (2%) or more.
- (c) For the purposes of Section 3.1D(2):
- (i) The term "insurer" includes any company or group of companies under common management, ownership or control;
 - (ii) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be this state;
 - (iii) The burden of showing *prima facie* evidence of violation of the competitive standard rests upon the commissioner.
- (d) Even though an acquisition is not *prima facie* violative of the competitive standard under Paragraphs (2)(a) and (2)(b) of this subsection, the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is *prima facie* violative of the competitive standard under Paragraphs (2)(a) and (2)(b) of this subsection, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subparagraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.
- (3) An order may not be entered under Section 3.1E(1) if:
- (a) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or
 - (b) The acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition.

E. Orders and Penalties

- (1) (a) If an acquisition violates the standards of this section, the commissioner may enter an order:
 - (i) Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation; or

- (ii) Denying the application of an acquired or acquiring insurer for a license to do business in this state.
- (b) Such an order shall not be entered unless:
 - (i) There is a hearing;
 - (ii) Notice of the hearing is issued prior to the end of the waiting period and not less than fifteen (15) days prior to the hearing; and
 - (iii) The hearing is concluded and the order is issued no later than sixty (60) days after the date of the filing of the pre-acquisition notification with the commissioner.

Every order shall be accompanied by a written decision of the commissioner setting forth findings of fact and conclusions of law.

- (c) An order pursuant to this paragraph shall not apply if the acquisition is not consummated.
- (2) Any person who violates a cease and desist order of the commissioner under Paragraph (1) and while the order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or more of the following:
 - (a) A monetary penalty of not more than \$10,000 for every day of violation; or
 - (b) Suspension or revocation of the person's license.
- (3) Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good faith effort to comply with any filing requirement, shall be subject to a fine of not more than \$50,000.

F. Inapplicable Provisions. Sections 10B, 10C, and 12 do not apply to acquisitions covered under Section 3.1B.

Section 4. Registration of Insurers

- A. Registration. Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in:
 - (1) Section 4;
 - (2) Section 5A(1), 5B, 5D; and
 - (3) Either Section 5A(2) or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each change or addition.

Any insurer which is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by [insert date] of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any insurer authorized to do business in the state which is a member of an insurance holding company system, and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in Section 4C or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

- B. Information and Form Required. Every insurer subject to registration shall file the registration statement with the commissioner on a form and in a format prescribed by the NAIC, which shall contain the following current information:
- (1) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;
 - (2) The identity and relationship of every member of the insurance holding company system;
 - (3) The following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:
 - (a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;
 - (b) Purchases, sales or exchange of assets;
 - (c) Transactions not in the ordinary course of business;
 - (d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;
 - (e) All management agreements, service contracts and all cost-sharing arrangements;
 - (f) Reinsurance agreements;
 - (g) Dividends and other distributions to shareholders; and
 - (h) Consolidated tax allocation agreements;
 - (4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;
 - (5) If requested by the commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the U.S. Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;
 - (6) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner;

Drafting Note: Neither option below is intended to modify applicable state insurance and/or corporate law requirements.

- (7) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

Alternative Section 4B(7):

- (7) Statements that the insurer's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and
- (8) Any other information required by the commissioner by rule or regulation.

- C. Summary of Changes to Registration Statement. All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.
- D. Materiality. No information need be disclosed on the registration statement filed pursuant to Subsection B if the information is not material for the purposes of this section. Unless the commissioner by rule, regulation or order provides otherwise; sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent (.5%) or less of an insurer's admitted assets as of the 31st day of December next preceding shall not be deemed material for purposes of this section. The definition of materiality provided in this subsection shall not apply for purposes of the Group Capital Calculation or the Liquidity Stress Test Framework.
- E. Reporting of Dividends to Shareholders. Subject to Section 5B, each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof.
- F. Information of Insurers. Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this Act.
- G. Termination of Registration. The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.
- H. Consolidated Filing. The commissioner may require or allow two (2) or more affiliated insurers subject to registration to file a consolidated registration statement.
- I. Alternative Registration. The commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under Subsection A and to file all information and material required to be filed under this section.
- J. Exemptions. The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the commissioner by rule, regulation or order shall exempt the same from the provisions of this section.
- K. Disclaimer. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved.

L. Enterprise Risk Filings.

(1) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners;

(2) Group Capital Calculation. Except as provided below, the ultimate controlling person of every insurer subject to registration shall concurrently file with the registration an annual group capital calculation as directed by the lead state commissioner. The report shall be completed in accordance with the NAIC Group Capital Calculation Instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file

the group capital calculation. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the commissioner in accordance with the procedures within the Financial Analysis Handbook adopted by the NAIC. Insurance holding company systems described below are exempt from filing the group capital calculation:

- (a) An insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state, and assumes no business from any other insurer;
- (b) An insurance holding company system that is required to perform a group capital calculation specified by the United States Federal Reserve Board. The lead state commissioner shall request the calculation from the Federal Reserve Board under the terms of information sharing agreements in effect. If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the group capital calculation filing;
- (c) An insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction as described in [insert cross-reference to appropriate section of Credit for Reinsurance Law] that recognizes the U.S. state regulatory approach to group supervision and group capital;

Drafting Note: On September 22, 2017, the United States and the European Union (EU) entered into the “*Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance.*” A similar agreement with the United Kingdom (UK) was signed on December 18, 2018. Both agreements are considered to be a “covered agreement” entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that addresses the U.S. state regulatory approach to group supervision and group capital, and provides that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the commissioner or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group. Under the revised Credit for Reinsurance Models, not only are jurisdictions that are subject to the EU and UK Covered Agreements treated as Reciprocal Jurisdictions, but any other Qualified Jurisdiction can also qualify as Reciprocal Jurisdiction if they provide written confirmation that they recognize and accept the U.S. state regulatory approach to group supervision and group capital.

- (d) An insurance holding company system:
 - (i) That provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook, and
 - (ii) Whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts, as specified by the commissioner in regulation, the group capital calculation as the world-wide group capital assessment for U.S. insurance groups who operate in that jurisdiction.

Drafting Note: The phrase “Recognizes and accepts” does not require the non-U.S. group-wide supervisor to require the U.S. insurance groups to actually file the group capital calculation with the non-U.S. supervisor but rather does not apply its own version of a group capital filing to U.S. insurance groups.

- (e) Notwithstanding the provisions of Sections 4L(2)(c) and 4L(2)(d), a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

- (f) Notwithstanding the exemptions from filing the group capital calculation stated in Section 4L(2)(a) through Section 4L(2)(d), the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation or to accept a limited group capital filing or report in accordance with criteria as specified by the commissioner in regulation.
- (g) If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this section, the insurance holding company system shall file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.
- (3) Liquidity Stress Test. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year's Liquidity Stress Test. The filing shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners:
- (a) The NAIC Liquidity Stress Test Framework includes Scope Criteria applicable to a specific data year. These Scope Criteria are reviewed at least annually by the Financial Stability Task Force or its successor. Any change to the NAIC Liquidity Stress Test Framework or to the data year for which the Scope Criteria are to be measured shall be effective on January 1 of the year following the calendar year when such changes are adopted. Insurers meeting at least one threshold of the Scope Criteria are considered scoped into the NAIC Liquidity Stress Test Framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year. Similarly, insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year.
- (i) Regulators wish to avoid having insurers scoped in and out of the NAIC Liquidity Stress Test Framework on a frequent basis. The lead state insurance commissioner, in consultation with the Financial Stability Task Force or its successor, will assess this concern as part of the determination for an insurer.
- (b) The performance of, and filing of the results from, a specific year's Liquidity Stress Test shall comply with the NAIC Liquidity Stress Test Framework's instructions and reporting templates for that year and any lead state insurance commissioner determinations, in conjunction with the Financial Stability Task Force or its successor, provided within the Framework.

Drafting Note: The delay included in the change to the NAIC Liquidity Stress Test Framework or to the data year for which the Scope Criteria are to be measured being effective on January 1 of the year following the calendar year when such changes are adopted is present to: 1) allow sufficient time for states needing to adopt by rule the NAIC Liquidity Stress Test Framework for a given data year and 2) to ensure scoped in insurers have adequate time to comply with the requirements for a given data year .

L.M. Violations. The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for filing shall be a violation of this section.

Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System

A. Transactions Within an Insurance Holding Company System

- (1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:
 - (a) The terms shall be fair and reasonable;
 - (b) Agreements for cost sharing services and management shall include such provisions as required by rule and regulation issued by the commissioner;
 - (c) Charges or fees for services performed shall be reasonable;
 - (d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;
 - (e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and
 - (f) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs.

- (2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subparagraphs (a) through (g), may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty (30) days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any.
 - (a) Sales, purchases, exchanges, loans, extensions of credit, or investments, provided the transactions are equal to or exceed:
 - (i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;
 - (ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of the 31st day of December next preceding;
 - (b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions are equal to or exceed:
 - (i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

- (ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of the 31st day of December next preceding;
- (c) Reinsurance agreements or modifications thereto, including:
 - (i) All reinsurance pooling agreements;
 - (ii) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;
- (d) All management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements;
- (e) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer's admitted assets or ten percent (10%) of surplus as regards policyholders as of the 31st day of December next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph;
- (f) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 2 of this Act (or authorized under any other section of this Chapter), or in non-subsidiary insurance affiliates that are subject to the provisions of this Act, are exempt from this requirement; and

Drafting Note: When reviewing the notification required to be submitted pursuant to Section 5A(2)(f), the commissioner should examine prior and existing investments of this type to establish that these investments separately or together with other transactions, are not being made to contravene the dividend limitations set forth in Section 5B. However, an investment in a controlling person or in an affiliate shall not be considered a dividend or distribution to shareholders when applying Section 5B of this Act.

- (g) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing in this paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

- (3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise his or her authority under Section 11.
- (4) The commissioner, in reviewing transactions pursuant to Subsection A(2), shall consider whether the transactions comply with the standards set forth in Subsection A(1) and whether they may adversely affect the interests of policyholders.

- (5) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.

B. Dividends and other Distributions

No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the commissioner has received notice of the declaration thereof and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period.

For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

- (1) Ten percent (10%) of the insurer's surplus as regards policyholders as of the 31st day of December next preceding; or
- (2) The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the 31st day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval, and the declaration shall confer no rights upon shareholders until (1) the commissioner has approved the payment of the dividend or distribution or (2) the commissioner has not disapproved payment within the thirty-day period referred to above.

Drafting Note: The following Subsection C entitled "Management of Domestic Insurers Subject to Registration" is optional and is to be adopted according to the needs of the individual jurisdiction.

C. Management of Domestic Insurers Subject To Registration.

- (1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this Act.
- (2) Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of Section 5A(1).
- (3) Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

- (4) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.
 - (5) The provisions of Paragraphs (3) and (4) shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of Paragraphs (3) and (4) with respect to such controlling entity.
 - (6) An insurer may make application to the commissioner for a waiver from the requirements of this subsection, if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than \$300,000,000. An insurer may also make application to the commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.
- D. Adequacy of Surplus. For purposes of this Act, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:
- (1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;
 - (2) The extent to which the insurer's business is diversified among several lines of insurance;
 - (3) The number and size of risks insured in each line of business;
 - (4) The extent of the geographical dispersion of the insurer's insured risks;
 - (5) The nature and extent of the insurer's reinsurance program;
 - (6) The quality, diversification and liquidity of the insurer's investment portfolio;
 - (7) The recent past and projected future trend in the size of the insurer's investment portfolio;
 - (8) The surplus as regards policyholders maintained by other comparable insurers;
 - (9) The adequacy of the insurer's reserves; and
 - (10) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.

Section 6. Examination

- A. Power of Commissioner. Subject to the limitation contained in this section and in addition to the powers which the commissioner has under Sections [insert applicable sections] relating to the examination of insurers, the commissioner shall have the power to examine any insurer registered under Section 4 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

- B. Access to Books and Records.
- (1) The commissioner may order any insurer registered under Section 4 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this Chapter.
 - (2) To determine compliance with this Chapter, the commissioner may order any insurer registered under Section 4 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the commissioner, the insurer shall provide the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the commissioner that the detailed explanation is without merit, the commissioner may require, after notice and hearing, the insurer to pay a penalty of \$[insert amount] for each day's delay, or may suspend or revoke the insurer's license.
- C. Use of Consultants. The commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as shall be reasonably necessary to assist in the conduct of the examination under Subsection A above. Any persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.
- D. Expenses. Each registered insurer producing for examination records, books and papers pursuant to Subsection A above shall be liable for and shall pay the expense of examination in accordance with Section [insert applicable section].
- E. Compelling Production. In the event the insurer fails to comply with an order, the commissioner shall have the power to examine the affiliates to obtain the information. The commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in [insert appropriate statutory reference to trial-level court in that state], which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

Section 7. Supervisory Colleges

- A. Power of Commissioner. With respect to any insurer registered under Section 4, and in accordance with Subsection C below, the commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this Chapter. The powers of the commissioner with respect to supervisory colleges include, but are not limited to, the following:
- (1) Initiating the establishment of a supervisory college;
 - (2) Clarifying the membership and participation of other supervisors in the supervisory college;
 - (3) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;
 - (4) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and
 - (5) Establishing a crisis management plan.

- B. Expenses. Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in a supervisory college in accordance with Subsection C below, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the commissioner may establish a regular assessment to the insurer for the payment of these expenses.
- C. Supervisory College. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with Section 6, the commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The commissioner may enter into agreements in accordance with Section 8C providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

Section 7.1. Group-wide Supervision of Internationally Active Insurance Groups

- A. The commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section.. However, the commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:
 - (1) Does not have substantial insurance operations in the United States;
 - (2) Has substantial insurance operations in the United States, but not in this state; or
 - (3) Has substantial insurance operations in the United States and this state, but the commissioner has determined pursuant to the factors set forth in Subsections B and F that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

- B. In cooperation with other state, federal and international regulatory agencies, the commissioner will identify a single group-wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The commissioner shall consider the following factors when making a determination or acknowledgment under this subsection:
 - (1) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets or liabilities;
 - (2) The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;
 - (3) The location of the executive offices or largest operational offices of the internationally active insurance group;
 - (4) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:
 - (a) Substantially similar to the system of regulation provided under the laws of this state, or otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

- (5) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

However, a commissioner identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in Paragraphs (1) through (5) above, and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

- C. Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, in the event of a material change in the internationally active insurance group that results in:
- (1) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets or liabilities; or
 - (2) This state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group, the commissioner shall make a determination or acknowledgment as to the appropriate group-wide supervisor for such an internationally active insurance group pursuant to Subsection B.
- D. Pursuant to Section 6, the commissioner is authorized to collect from any insurer registered pursuant to Section 4 all information necessary to determine whether the commissioner may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to Section 4 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than thirty (30) days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the [insert name of state administrative record] and on its Internet website the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.
- E. If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner is authorized to engage in any of the following group-wide supervision activities:
- (1) Assess the enterprise risks within the internationally active insurance group to ensure that:
 - (a) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management, and
 - (b) Reasonable and effective mitigation measures are in place;
 - (2) Request, from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:
 - (a) Governance, risk assessment and management,
 - (b) Capital adequacy, and
 - (c) Material intercompany transactions;

- (3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;
 - (4) Communicate with other state, federal and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of Section 8, through supervisory colleges as set forth in Section 7 or otherwise;
 - (5) Enter into agreements with or obtain documentation from any insurer registered under Section 4, any member of the internationally active insurance group, and any other state, federal and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and
 - (6) Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the commissioner.
- F. If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:
- (1) The commissioner's cooperation is in compliance with the laws of this state; and
 - (2) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the commissioner is authorized to refuse recognition and cooperation.
- G. The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under Section 4, any affiliate of the insurer, and other state, federal and international regulatory agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.
- H. The commissioner may promulgate regulations necessary for the administration of this section.
- I. A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

Section 8. Confidential Treatment

- A. Documents, materials or other information in the possession or control of the Department of Insurance that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to Section 6 and all information reported or provided to the Department of Insurance pursuant to Section 3B(12) and (13), Section 4, Section 5 and Section 7.1 are recognized by this state as being proprietary and to contain trade secrets, and shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer

and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

- (1) For purposes of the information reported and provided to the Department of Insurance pursuant to Section 4L(2), the commissioner shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any group capital information received from an insurance holding company supervised by the Federal Reserve Board or any U.S. group wide supervisor.
- (2) For purposes of the information reported and provided to the [Department of Insurance] pursuant to Section 4L(3), the commissioner shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company supervised by the Federal Reserve Board and non-U.S. group wide supervisors.

Drafting note: This group capital calculation and group capital ratio includes confidential information and filings received from insurance holding companies supervised by the Federal Reserve Board. Similarly, the liquidity stress test may include confidential information and filings received from insurance holding companies supervised by the Federal Reserve Board. The confidential treatment afforded to group capital calculation filings includes any Federal Reserve Board group capital filings and information.

- B. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this Act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Subsection A.
- C. In order to assist in the performance of the commissioner's duties, the commissioner:
 - (1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, including proprietary and trade secret documents and materials with other state, federal and international regulatory agencies, with the NAIC ~~and its affiliates and subsidiaries~~, and with any third-party consultants designated by the commissioner. with state, federal, and international law enforcement authorities, including members of any supervisory college described in Section 7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality.
 - (2) Notwithstanding paragraph (1) above, the commissioner may only share confidential and privileged documents, material, or information reported pursuant to Section 4L(1) with commissioners of states having statutes or regulations substantially similar to Subsection A and who have agreed in writing not to disclose such information.
 - (3) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, including propriety and trade-secret information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and
 - (4) Shall enter into written agreements with the NAIC and any third-party consultant designated by the commissioner governing sharing and use of information provided pursuant to this Act consistent with this subsection that shall:
 - (a) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC ~~and its affiliates and subsidiaries or a third-party consultant designated by the commissioner~~ pursuant to this Act, including procedures and protocols for sharing by the NAIC with other state, federal or international regulators.

The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials or other information and has verified in writing the legal authority to maintain such confidentiality;

(b) Specify that ownership of information shared with the NAIC or a third party consultant and its affiliates and subsidiaries pursuant to this Act remains with the commissioner and the NAIC's or a third-party consultant's, as designated by the commissioner, use of the information is subject to the direction of the commissioner;

~~(c) Excluding documents, material or information reported pursuant to Section 4L(3), prohibit the NAIC or third-party consultant designated by the commissioner from storing the information shared pursuant to this Act in a permanent database after the underlying analysis is completed;~~

~~(e)(d) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant designated by the commissioner pursuant to this Act is subject to a request or subpoena to the NAIC or a third-party consultant designated by the commissioner for disclosure or production; and~~

(e) Require the NAIC or a third-party consultant designated by the commissioner and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant designated by the commissioner and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant designated by the commissioner and its affiliates and subsidiaries pursuant to this Act.

(f) For documents, material or information reporting pursuant to Section 4L(3), ~~in the case of an agreement involving a third-party consultant designated by the commissioner,~~ provide for notification of the identity of the consultant to the applicable insurer~~the insurer's written consent.~~

D. The sharing of information by the commissioner pursuant to this Act shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this Act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection C.

~~F. Documents, materials or other information in the possession or control of the NAIC or a third-party consultant designated by the commissioner pursuant to this Act shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.~~

~~G. The group capital calculation and resulting group capital ratio required under Section 4L(2) and the liquidity stress test along with its results and supporting disclosures required under Section 4L(3) are regulatory tools for assessing group risks and capital adequacy and group liquidity risks, respectively, and are not intended as a means to rank insurers or insurance holding company systems generally. Therefore, except as otherwise may be required under the provisions of this Act, the making, publishing, disseminating, circulating or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with~~

respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer's or insurance group's group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer's or insurance group's liquidity stress test result or supporting disclosures is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

Drafting Note: In Section 8-C(4) above, the exclusions in sub-items (ii), (iii) and (vi) are the result of the Liquidity Stress Test primary purpose, which is to be used as a tool for assessing macroprudential risks by the NAIC Financial Stability Task Force assisted by NAIC staff, including trend analysis over time. Provisions against the NAIC owning the information, databasing the results and disclosures, and obtaining written consent from the insurer when a consultant is involved were deemed inappropriate.

Section 9. Rules and Regulations

The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations and orders as shall be necessary to carry out the provisions of this Act.

Section 10. Injunctions, Prohibitions Against Voting Securities, Sequestration of Voting Securities

- A. Injunctions. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of this Act or of any rule, regulation or order issued by the commissioner hereunder, the commissioner may apply to the [insert title] Court for the county in which the principal officer of the insurer is located or if the insurer has no office in this state then to the [insert title] Court for [insert county] County for an order enjoining the insurer or director, officer, employee or agent thereof from violating or continuing to violate this Act or any rule, regulation or order, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors and shareholders or the public may require.
- B. Voting of Securities; When Prohibited. No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this Act or of any rule, regulation or order issued by the commissioner hereunder may be voted at any shareholder's meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of the securities, unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this Act or of any rule, regulation or order issued by the commissioner hereunder; the insurer or the commissioner may apply to the [insert title] Court for the county in which the insurer has its principle place of business to enjoin any offer, request, invitation, agreement or acquisition made in contravention of Section 3 or any rule, regulation or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditor and shareholders or the public may require.
- C. Sequestration of Voting Securities. In any case where a person has acquired or is proposing to acquire any voting securities in violation of this Act or any rule, regulation or order issued by the commissioner hereunder, the [insert title] Court for [insert county] County or the [insert title] Court for the county in which the insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner, seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue such order as may be appropriate to effectuate the provisions of this Act.

Notwithstanding any other provisions of law, for the purposes of this Act the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

Section 11. Sanctions

- A. Any insurer failing, without just cause, to file any registration statement as required in this Act shall be required, after notice and hearing, to pay a penalty of \$[insert amount] for each day's delay, to be recovered by the commissioner of Insurance and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is \$[insert amount]. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.
- B. Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly shall permit any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or submitted pursuant to Section 4A, 5A(2), or 5B, or which violate this Act, shall pay, in their individual capacity, a civil forfeiture of not more than \$[insert amount] per violation, after notice and hearing before the commissioner. In determining the amount of the civil forfeiture, the commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.
- C. Whenever it appears to the commissioner that any insurer subject to this Act or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract which is subject to Section 5 of this Act and which would not have been approved had the approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the commissioner may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of the policyholders, creditors or the public.
- D. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed a willful violation of this Act, the commissioner may cause criminal proceedings to be instituted by the [insert title] Court for the county in which the principal office of the insurer is located or if the insurer has no office in this state, then by the [insert county] Court for [insert title] County against the insurer or the responsible director, officer, employee or agent thereof. Any insurer which willfully violates this Act may be fined not more than \$[insert amount]. Any individual who willfully violates this Act may be fined in his or her individual capacity not more than \$[insert amount] or be imprisoned for not more than one to three (3) years or both.
- E. Any officer, director or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the commissioner in the performance of his or her duties under this Act, upon conviction shall be imprisoned for not more than [insert amount] years or fined \$[insert amount] or both. Any fines imposed shall be paid by the officer, director or employee in his or her individual capacity.
- F. Whenever it appears to the commissioner that any person has committed a violation of Section 3 of this Act and which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with [insert appropriate statutory reference related to orders of supervision].

Section 12. Receivership

Whenever it appears to the commissioner that any person has committed a violation of this Act which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders or the public, then the commissioner may proceed as provided in Section [insert applicable section] of this Chapter to take possessions of the property of the domestic insurer and to conduct its business.

Section 13. Recovery

- A. If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, (i) from any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock, or (ii) any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer or employee, where the distribution or payment pursuant to (i) or (ii) is made at any time during the one year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of Subsections B, C, and D of this section.
- B. No distribution shall be recoverable if the parent or affiliate shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.
- C. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments under Subsection A which the person received. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.
- D. The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.
- E. To the extent that any person liable under Subsection C of this section is insolvent or otherwise fails to pay claims due from it, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it.

Section 14. Revocation, Suspension, or Nonrenewal of Insurer's License

Whenever it appears to the commissioner that any person has committed a violation of this Act which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, suspend, revoke or refuse to renew the insurer's license or authority to do business in this state for such period as the commissioner finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

Section 15. Judicial Review, Mandamus

- A. Any person aggrieved by any act, determination, rule, regulation or order or any other action of the commissioner pursuant to this Act may appeal to the [insert title] Court for [insert county] County. The court shall conduct its review without a jury and by trial *de novo*, except that if all parties, including the commissioner, so stipulate, the review shall be confined to the record. Portions of the record may be introduced by stipulation into evidence in a trial *de novo* as to those parties so stipulating.
- B. The filing of an appeal pursuant to this section shall stay the application of any rule, regulation, order or other action of the commissioner to the appealing party unless the court, after giving the party notice and an opportunity to be heard, determines that a stay would be detrimental to the interest of policyholders, shareholders, creditors or the public.
- C. Any person aggrieved by any failure of the commissioner to act or make a determination required by this Act may petition the [insert title] Court for [insert county] County for a writ in the nature of a mandamus or a preemptory mandamus directing the commissioner to act or make a determination.

Section 16. Conflict with Other Laws

All laws and parts of laws of this state inconsistent with this Act are hereby superseded with respect to matters covered by this Act.

Section 17. Separability of Provisions

If any provision of this Act or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or application, and for this purpose the provisions of this Act are separable.

Section 18. Effective Date

This Act shall take effect thirty (30) days from its passage.

**APPENDIX
ALTERNATE PROVISIONS**

Alternative Section 1. Findings

- A. It is hereby found and declared that it may not be inconsistent with the public interest and the interest of policyholders and shareholders to permit insurers to:
- (1) Engage in activities which would enable them to make better use of management skills and facilities;
 - (2) Diversify into new lines of business through acquisition or organization of subsidiaries;
 - (3) Have free access to capital markets which could provide funds for insurers to use in diversification programs;
 - (4) Implement sound tax planning conclusions; and
 - (5) Serve the changing needs of the public and adapt to changing conditions of the social, economic and political environment, so that insurers are able to compete effectively and to meet the growing public demand for institutions capable of providing a comprehensive range of financial services.
- B. It is further found and declared that the public interest and the interests of policyholders and shareholders are or may be adversely affected when:
- (1) Control of an insurer is sought by persons who would utilize such control adversely to the interests of policyholders or shareholders;
 - (2) Acquisition of control of an insurer would substantially lessen competition or create a monopoly in the insurance business in this state;
 - (3) An insurer which is part of an insurance holding company system is caused to enter into transactions or relationships with affiliated companies on terms which are not fair and reasonable;
or
 - (4) An insurer pays dividends to shareholders which jeopardize the financial condition of such insurers.
- C. It is hereby declared that the policies and purposes of this Act are to promote the public interest by:
- (1) Facilitating the achievement of the objectives enumerated in Subsection A;
 - (2) Requiring disclosure of pertinent information relating to changes in control of an insurer;
 - (3) Requiring disclosure by an insurer of material transactions and relationships between the insurer and its affiliates, including certain dividends to shareholders paid by the insurer; and
 - (4) Providing standards governing material transactions between the insurer and its affiliates.
- D. It is further declared that it is desirable to prevent unnecessary multiple and conflicting regulation of insurers. Therefore, this state shall exercise regulatory authority over domestic insurers and unless otherwise provided in this Act, not over nondomestic insurers, with respect to the matters contained herein.

Alternative Section 2. Subsidiaries of Insurers

- A. Authorization. Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries engaged in the following kinds of business:
- (1) Any kind of insurance business authorized by the jurisdiction in which it is incorporated;
 - (2) Acting as an insurance broker or as an insurance agent for its parent or for any of its parent's insurer subsidiaries;
 - (3) Investing, reinvesting or trading in securities for its own account, that of its parent, a subsidiary of its parent, or an affiliate or subsidiary;
 - (4) Management of an investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services;
 - (5) Acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended;
 - (6) Rendering investment advice to governments, government agencies, corporations or other organizations or groups;
 - (7) Rendering other services related to the operations of an insurance business, such as actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal and collection services;
 - (8) Ownership and management of assets which the parent corporation could itself own or manage;

Drafting Note: The aggregate investment by the insurer and its subsidiaries acquired or organized pursuant to this paragraph should not exceed the limitations applicable to such investments by the insurer.

- (9) Acting as administrative agent for a governmental instrumentality that is performing an insurance function;
- (10) Financing of insurance premiums, agents and other forms of consumer financing;
- (11) Any other business activity determined by the commissioner to be reasonably ancillary to an insurance business; and
- (12) Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1969 Proc. II 736, 737, 738-751, 756 (adopted).
1972 Proc. I 14, 16, 443, 449 (corrected).
1980 Proc. II 22, 26, 29, 42-46 (amended, added Section 3.1).
1983 Proc. I 6, 37, 96, 99 (amended).
1985 Proc. I 19, 37, 178, 183-200 (amended and reprinted).
1985 Proc. II 11, 24-25, 74, 75-92 (amended and reprinted).
1986 Proc. I 10, 25, 72 (amended).
1986 Proc. II 12, 19-20, 93-94, 94-109 (amended and reprinted).
1993 Proc. 4th Quarter 16, 31, 57, 61-62 (amended).
1995 Proc. 4th Quarter 11, 33, 307, 310, 312-328 (amended and reprinted).
1996 Proc. 1st Quarter 124, 270, 272-275 (amendments adopted later printed here).
1997 Proc. 4th Quarter 11 (amendments adopted).
1999 Proc. 4th Quarter 15, 364, 369, 379-380 (amended).
2001 Proc. 2nd Quarter 11, 14, 319, 339, 342-348 (amended).

2011 Proc. 1st Quarter I 3-11 (amended).
2014 Proc. 3rd Quarter, Vol. I 122, 136, 140, 183, 243-266 (amended).

Draft: 11/20/20

PROJECT HISTORY

REVISIONS TO INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)

LIQUIDITY STRESS TESTING

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

In April 2017, the Executive (EX) Committee adopted a new charge for the Financial Stability (EX) Task Force at the Spring National Meeting. The charge is still active and reads as follows:

“Analyze existing post-financial crisis regulatory reforms for their application in identifying macroeconomic trends, including identifying possible areas of improvement or gaps, and propose to the Financial Condition (E) Committee or other relevant committee enhancements and/or additions to further improve the ability of state insurance regulators and the industry to address macroprudential impacts; consult with such committees on implementation, as needed.”

Prior to, and prompting the need for, the adoption of this charge, the Financial Stability (EX) Task Force performed a review of other jurisdictions’ activities in the macroprudential space. Common themes noted in this review included a focus on: stress testing; liquidity assessments, both within specific sectors and cross-sector exposures; enhancing resolution planning and disclosures; and charts and discussions on various domestic economic/regional trends impacting the insurance sector.

After considering these common macroprudential activities against the U.S. system of insurance regulation, the Financial Stability (EX) Task Force adopted a Macroprudential Initiative (MPI) Framework during the 2017 Summer National Meeting. The MPI Framework contained four focused areas for potential enhancements: 1) liquidity; 2) recovery and resolution; 3) capital stress testing; and 4) exposure concentrations. During this meeting, liquidity risk was identified as a top priority for MPI, and the Liquidity Risk Assessment (EX) Subgroup was appointed to address this work and assigned the following charges:

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

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

The Liquidity Assessment (EX) Subgroup of the Financial Stability (EX) Task Force drafted the initial revisions to Model #440. The 2020 members of the Subgroup were: Nebraska (Chair); Connecticut; District of Columbia; Florida; Illinois; Iowa; Minnesota; Missouri; and Texas.

The Financial Stability (EX) Task Force finalized the liquidity stress test (LST) revisions to Model #440. The 2020 members of the Task Force were: New Jersey (Chair); Maine (Vice Chair); Arkansas; California; Connecticut; District of Columbia; Florida; Illinois; Iowa; Massachusetts; Missouri; Nebraska; New York; Oregon; Pennsylvania; and Texas.

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

As described in paragraph 1 above, the initial charge prompting a review of the U.S. system of insurance regulation to assess its ability to address macroprudential monitoring was assigned to the Financial Stability (EX) Task Force during the 2017 Spring National Meeting. However, the specific charge to create an LST framework—which includes the need to address regulatory authority for requiring the filing of LST reports and confidentiality protection of those filings—was assigned to the Liquidity Assessment (EX) Subgroup during the 2017 Summer National Meeting and reads as follows:

“Construct a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee, including the proposed universe of companies to which the framework will apply (e.g., large life insurers).”

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

In late 2017, the Liquidity Assessment (EX) Subgroup began its work to address its first charge related to liquidity data gaps, resulting in two blanks proposals to add more product breakout data in the life statutory financial statement or blank. Once the blanks proposals were submitted to the Blanks (E) Working Group, the Subgroup began work on the LST Framework in early 2018. The Subgroup first addressed the scope criteria to determine which life insurers should be subject to an LST requirement, which was adopted by the Financial Stability (EX) Task Force during the 2019 Spring National Meeting.

To construct the actual LST proposal, the Subgroup utilized an unofficial study group, with members consisting of Nebraska (lead), Connecticut, Iowa, Minnesota, Missouri, New Jersey and Texas. Also, the study group included industry participants from some of the insurers triggering the initial scope criteria; specifically, John Hancock, Manulife, MassMutual, MetLife, New York Life, Principal and Prudential. At times, the lead states of, and industry participants from, all 23 insurers triggering the initial scope criteria were included in study group calls.

Work on the LST Framework proposal continued until the COVID-19 pandemic prompted the Financial Stability (EX) Task Force to place the LST Framework development on hold effective April 17, 2020. Importantly, this pause did not include any work related to addressing regulatory authority for the LST and confidentiality of the LST reports, which, pursuant to a Feb. 26, 2020 call of the Financial Stability (EX) Task Force, was to initially consider using revisions to Model #440. Instead, the Subgroup and study group were directed to obtain data from the 23 insurers to assess how liquidity stress was impacted by the pandemic and subsequent economic stresses. In November 2020, the study group expressed its intent to resume the work to develop the LST proposal.

For the actual proposed revisions to Model #440 required for LST needs, NAIC staff worked with Justin Schrader (NE), chair of the Liquidity Assessment (EX) Subgroup, to draft the initial exposure document. The current version of edits exposed by the Group Capital Calculation (E) Working Group were used as the baseline for Model #440 and were edited for LST needs.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

On June 23, 2020, Justin Schrader (NE), chair of the Liquidity Assessment (EX) Subgroup, exposed proposed revisions to Model #440 for a public comment period ending July 29, 2020. Comments were received from the Texas Department of Insurance (TDI) and the American Council of Life Insurers (ACLI). The TDI comments were suggestions for how to organize the revisions within Model #440, consistent with similar comments made with respect to the Group Capital Calculation (E) Working Group's exposed revisions, and were all acceptable to the Liquidity Assessment (EX) Subgroup members. All but one of the ACLI comments, most with respect to governance and timing issues, were acceptable to the Liquidity Assessment (EX) Subgroup members.

On Aug. 31, 2020, an updated draft of proposed revisions to Model #440 was posted as materials for the Sept. 1, 2020, meeting of the Liquidity Assessment (EX) Subgroup. Because there were so few comments received during the initial comment period and all comments were accepted except one ACLI comment, a second exposure period was not deemed necessary for the Liquidity Assessment (EX) Subgroup. Rather, the Liquidity Assessment (EX) Subgroup voted to forward the proposed revisions to Model #440—as modified during its Sept. 1, 2020, conference call to partially address the outstanding ACLI comment—to the Financial Stability (EX) Task Force for a final exposure period.

On Sept. 3, 2020, Commissioner Marlene Caride (NJ), chair of the Financial Stability (EX) Task Force, exposed for a public comment period ending Oct. 5, 2020, the Liquidity Assessment (EX) Subgroup's modified proposed revisions to Model #440. One comment letter was received, from the ACLI, requesting several editorial changes that were made for the proposed revisions to Model #440 included as materials for the meeting of the Financial Stability (EX) Task Force held Oct. 13, 2020.

Several items were raised as concerns with respect to the proposed revisions during the Financial Stability (EX) Task Force's Oct. 13, 2020, conference call, but all were resolved with recommended changes that satisfied the members. As such, on the Oct. 13, 2020, conference call of the Financial Stability (EX) Task Force, the members voted to adopt the modified proposed revisions to Model #440 and forward them to the Financial Condition (E) Committee for its consideration.

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

There were no issues of real significance raised during the exposure periods. However, these are the items discussed during the final consideration by the Financial Stability (EX) Task Force:

- a. The ACLI request to limit the use of the LST data to macroprudential purposes only was rejected by state insurance regulators, given that microprudential oversight of legal entity insurers and groups will benefit from this data also.
- b. Confirmed the need to change “assets and liabilities” to “exposure bases” in the scope criteria definition as recommended by the ACLI.
- c. Agreed with the TDI request to specify that the LST data is still owned by the lead state when a consultant is used.
- d. Changed “in conjunction with” to “in consultation with” to clarify that the lead state makes the final decision in terms of when an insurer is added to or removed from the list of insurers required to perform the LST for a specific year.

7. List the key provisions of the model (sections considered most essential to state adoption).

The changes to Section 4L(3) of Model #440 are the most important provisions in the proposed changes, as they require the ultimate controlling person of every insurer subject to registration and meeting the scope criteria to file the results of a specific year’s LST to the lead state insurance commissioner. The filing shall be made in accordance with the procedures housed within the *Financial Analysis Handbook*.

Immediately following this provision in Section 4L(3)(a) of Model #440 is the information regarding the scope criteria and indication that the lead state commissioner, in consultation with the Financial Stability (EX) Task Force or its successor, will make the final determination regarding the insurers that will be scoped in and out of a specific data year’s LST.

Section 4L(3)(b) of Model #440 indicates the performance of, and filing of the results from, a specific year’s LST shall comply with the NAIC LST framework’s instructions and reporting templates for that year, along with any lead state insurance commissioner determinations (in consultation with the Financial Stability (EX) Task Force or its successor).

Finally, Section 8(A)(2) of Model #440 provides key statutory authority to hold the LST confidential.

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

It is considered extremely important that lead states of insurance companies that are considered to be internationally active insurance groups (IAIGs) under Model #440 enact these LST revisions. However, it is also important to make the LST revisions to Model #440 an accreditation standard applicable to all states in order to develop a macroprudential surveillance program for the U.S. state-based insurance regulatory system. Each state has primarily microprudential goals in order to regulate individual insurers’ solvency, which extend to insurance groups, as well. But all commissioners do have macroprudential goals with respect to having competitive markets in their respective states. However, no state has a complete purview of the entire U.S. insurance industry, or even the entire U.S. life insurance segment. Federal regulators and the U.S. insurance industry have strongly encouraged the creation of a macroprudential framework throughout the states, and this LST should become a baseline element in the overall financial solvency regulation of insurance.

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC's Executive Committee is required. The NAIC's Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: New Model Law or Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

Financial Stability (EX) Task Force

2. NAIC staff support contact information:

Todd Sells
tsells@naic.org
816-783-8403

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

- *Insurance Holding Company System Regulatory Act (#440)*
- *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)*

Background & Description

One of the key deliverables of the Financial Stability (EX) Task Force is to implement the Macroprudential Initiative (MPI) domestically, which includes enhancements to the U.S. regulatory toolkit as part of the *State Ahead* initiative. The most significant of the deliverables from the MPI includes the development of a liquidity stress test for the largest life insurers.

Scope of the Proposed Revisions to Model #440 and Model #450

The scope of the request is limited to addressing the issue of establishing regulatory authority to require stress testing and disclosures related to liquidity risk and establish, in statute, the confidentiality of those disclosures as appropriate. The Financial Stability (EX) Task Force would complete the review and recommend proposed draft revisions to Model #440 and Model #450. It is anticipated that these revisions will need to reference liquidity stress testing framework documents that will need to be able to be modified annually without opening up the models themselves (e.g., directions regarding the liquidity stress test, reporting templates, and specific requirements of the stress scenarios). Revisions may be necessary to the following sections of Model #440 and Model #450, including, but not limited to:

Model #440 Section 1. Definitions
Model #440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
Model #440 Section 8. Confidential Treatment
Model #450: Consistency with any revisions to Model #440

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

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

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

If yes, please explain why:

While this change is being made in connection with the NAIC's MPI, most important is that such changes are needed for confidentiality protections for those who would be filing this stress test, which includes the largest life insurers that are operating in all of the states.

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

Yes or No (Check one)

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple; the Task Force believes that such changes will be widely supported.

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

The Model #440 is an accreditation standard, but the Task Force has not yet considered whether this should become part of the required elements of that specific standard.

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

No.

Amendments adopted by the Financial Condition (E) Committee on 11/19/2020

**INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION
WITH REPORTING FORMS AND INSTRUCTIONS**

Table of Contents

Section 1.	Authority
Section 2.	Purpose
Section 3.	Severability Clause
Section 4.	Forms - General Requirements
Section 5.	Forms - Incorporation by Reference, Summaries and Omissions
Section 6.	Forms - Information Unknown or Unavailable and Extension of Time to Furnish
Section 7.	Forms - Additional Information and Exhibits
Section 8.	Definitions
Section 9.	Subsidiaries of Domestic Insurers
Section 10.	Acquisition of Control - Statement Filing (Form A)
Section 11.	Amendments to Form A
Section 12.	Acquisition of Section 3A(4) Insurers
Section 13.	Pre-Acquisition Notification (Form E)
Section 14.	Annual Registration of Insurers -Statement Filing (Form B)
Section 15.	Summary of Changes to Registration - Statement Filing (Form C)
Section 16.	Amendments to Form B
Section 17.	Alternative and Consolidated Registration
Section 18.	Disclaimers and Termination of Registration
Section 19.	Transactions Subject to Prior Notice - Notice Filing (Form D)
Section 20.	Enterprise Risk Report
<u>Section 21.</u>	<u>Group Capital Calculation</u>
Section 24 2 .	Extraordinary Dividends and Other Distributions
Section 22 3 .	Adequacy of Surplus
Form A	Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer
Form B	Insurance Holding Company System Annual Registration Statement
Form C	Summary of Changes to Registration Statement
Form D	Prior Notice of a Transaction
Form E	Pre-Acquisition Notification Form
Form F	Enterprise Risk Report

Section 20. Enterprise Risk Report

The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to Section 4L(1) of the Act shall furnish the required information on Form F, hereby made a part of these regulations.

Section 21. Group Capital Calculation

A. Where an insurance holding company system has previously filed the annual group capital calculation at least once, the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation if the lead state commissioner makes a determination based upon that filing that the insurance holding company system meets all of the following criteria:

- (1) Has annual direct written and unaffiliated assumed premium (including international direct and assumed premium), but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than \$1,000,000,000;
- (2) Has no insurers within its holding company structure that are domiciled outside of the United States or one of its territories;

- (3) Has no banking, depository or other financial entity that is subject to an identified regulatory capital framework within its holding company structure;
- (4) The holding company system attests that there are no material changes in the transactions between insurers and non-insurers in the group that have occurred since the last filing of the annual group capital; and
- (5) The non-insurers within the holding company system do not pose a material financial risk to the insurer's ability to honor policyholder obligations.

B. Where an insurance holding company system has previously filed the annual group capital calculation at least once, the lead state commissioner has the discretion to accept in lieu of the group capital calculation a limited group capital filing if:

- (1) The insurance holding company system has annual direct written and unaffiliated assumed premium (including international direct and assumed premium), but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than \$1,000,000,000; and all of the following additional criteria are met:
 - (a) Has no insurers within its holding company structure that are domiciled outside of the United States or one of its territories;
 - (b) Does not include a banking, depository or other financial entity that is subject to an identified regulatory capital framework; and
 - (c) The holding company system attests that there are no material changes in transactions between insurers and non-insurers in the group that have occurred since the last filing of the report to the lead state commissioner and the non-insurers within the holding company system do not pose a material financial risk to the insurers ability to honor policyholder obligations.

C. For an insurance holding company that has previously met an exemption with respect to the group capital calculation pursuant Section 21A or 21B of this regulation, the lead state commissioner may require at any time the ultimate controlling person to file an annual group capital calculation, completed in accordance with the NAIC Group Capital Calculation Instructions, if any of the following criteria are met:

- (1) Any insurer within the insurance holding company system is in a Risk-Based Capital action level event as set forth in [insert cross-reference to appropriate section of Risk-Based Capital (RBC) Model Act] or a similar standard for a non-U.S. insurer; or
- (2) Any insurer within the insurance holding company system meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in [insert cross-reference to appropriate section of Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition]; or
- (3) Any insurer within the insurance holding company system otherwise exhibits qualities of a troubled insurer as determined by the lead state commissioner based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

D. A non-U.S. jurisdiction is considered to "recognize and accept" the group capital calculation if it satisfies the following criteria:

- (1) With respect to the [insert cross-reference to Section 4L(2)(d) of the Model Act]
 - (a) The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital, by providing confirmation by a competent regulatory authority, in such jurisdiction, that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to

worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction; or

(b) Where no U.S. insurance groups operate in the non-U.S. jurisdiction, that non-U.S. jurisdiction indicates formally in writing to the lead state with a copy to the International Association of Insurance Supervisors that the group capital calculation is an acceptable international capital standard. This will serve as the documentation otherwise required in Section 21D(1)(a).

(2) The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force.

E. A list of non-U.S. jurisdictions that “recognize and accept” the group capital calculation will be published through the NAIC Committee Process:

(1) A list of jurisdictions that “recognize and accept” the group capital calculation pursuant to [insert cross-reference to Sections 4L(2)(d)], is published through the NAIC Committee Process to assist the lead state commissioner in determining which insurers shall file an annual group capital calculation. The list will clarify those situations in which a jurisdiction is exempted from filing under [insert cross-reference to Sections 4L(2)(d)]. To assist with a determination under 4L(2)(e), the list will also identify whether a jurisdiction that is exempted under either [insert cross-reference to Sections 4L(2)(c) and 4L(2)(d)] requires a group capital filing for any U.S. based insurance group’s operations in that non-U.S. jurisdiction.

(2) For a non-U.S. jurisdiction where no U.S. insurance groups operate, the confirmation provided to meet the requirement of Section 21D(1)(b) will serve as support for recommendation to be published as a jurisdiction that “recognizes and accepts” the group capital calculation through the NAIC Committee Process.

(3) If the lead state commissioner makes a determination pursuant to Section 4L(2)(d) that differs from the NAIC List, the lead state commissioner shall provide thoroughly documented justification to the NAIC and other states.

(4) Upon determination by the lead state commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to “recognize and accept” the group capital calculation, the lead state commissioner may provide a recommendation to the NAIC that the non-U.S. jurisdiction be removed from the list of jurisdictions that “recognize and accepts” the group capital calculation.

Section 242. Extraordinary Dividends and Other Distributions

A. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

- (1) The amount of the proposed dividend;
- (2) The date established for payment of the dividend;
- (3) A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation;

- (4) A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:
 - (a) The amounts, dates and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of twelve (12) consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;
 - (b) Surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding;
 - (c) If the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;
 - (d) If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-month periods; and
 - (e) If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer's own securities in the preceding two (2) calendar years;
 - (5) A balance sheet and statement of income for the period intervening from the last annual statement filed with the Commissioner and the end of the month preceding the month in which the request for dividend approval is submitted; and
 - (6) A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.
- B. Subject to Section 5B of the Act, each registered insurer shall report to the Commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof, including the same information required by Subsection A(4).

Section 223. Adequacy of Surplus

The factors set forth in Section 5D of the Act are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus no single factor is necessarily controlling. The Commissioner instead will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Commissioner will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the Commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

*1970 Proc. IIB 1055-1066 (printed).
1971 Proc. I 54, 58, 134, 149 (adopted).
1986 Proc. II 12, 19-20, 93-94, 109-123 (amended).
1993 Proc. 1st Quarter 3, 33, 362, 364-370 (amended).
2011 Proc. 1st Quarter I 3-11 (amended).
2013 3rd Quarter (editorial revision).*

Draft: 11/20/20

PROJECT HISTORY

REVISIONS TO INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440) AND INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450) GROUP CAPITAL CALCULATION (GCC)

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

In 2015, the NAIC Plenary adopted a charge to the Financial Condition (E) with respect to the construction of a group capital calculation (GCC). The Financial Condition (E) Committee subsequently formed the Group Capital Calculation (E) Working Group to carry out the following charge:

“Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation.”

The charge was developed primarily as a result of discussions that revealed that developing a GCC was a natural extension of work that state insurance regulators had already begun on group supervision as a result of the lessons learned from the 2008 financial crisis. While state insurance regulators currently have the authority to obtain information regarding the capital positions of non-insurance affiliates, they do not have a consistent analytical framework for evaluating such information. The GCC is designed to address this shortcoming and will serve as an additional financial metric that will assist state insurance regulators in identifying risks that may emanate from a holding company system. More specifically, the GCC and related reporting provides more transparency to state insurance regulators regarding insurance groups and make risks more identifiable and more easily quantified.

It is important to understand that the GCC utilizes an aggregation approach to group capital where existing legal entity capital requirements [e.g., risk-based capital (RBC)] and existing valuation for capital (e.g., statutory accounting) are utilized. In selecting this approach, it was recognized as satisfying state regulatory needs while at the same time having the advantages of being less burdensome and costly to regulators and the industry, in addition to respecting other jurisdictions' existing capital regimes. To capture the risks associated with the entire insurance group, including the insurance holding company, calculations were developed in those instances where no RBC calculations currently exist (i.e., non-regulated entities) and are part of the GCC. The methods selected were tested in 2019 by more than 30 insurance groups representing 15 lead states. These methods have since been modified to consider the lessons learned from the testing and subsequent comments from the industry and state insurance regulators. The more significant items are discussed in paragraph 6 below.

Also important in finalizing the GCC was the scope of groups that would be required to complete it. Specifically, Model #440 exempts single-state companies, insurers located in reciprocal jurisdictions that have already recognized the U.S. approach to group supervision and group capital, as well as other jurisdictions that agree to recognize the U.S. approach to group capital. Model #450 also provides commissioners with additional discretion to exempt groups that have less than \$1 billion in premium, provided the group has no non-U.S. insurers, has no banks or similar financial institutions, and has non-risky non-regulated entities within the group.

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

The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee drafted the revisions to Model #440 and Model #450. The 2020 members of the Working Group were: Florida (Chair); Connecticut (Vice Chair); California; District of Columbia; Illinois; Indiana; Iowa; Massachusetts; Michigan; Minnesota; Missouri; Nebraska; New Jersey; New York; North Carolina; Ohio; Oregon; Pennsylvania; Tennessee; Texas; Virginia; and Wisconsin.

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

At the 2015 Fall National Meeting, the Financial Condition (E) Committee received the following charge:

“Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation.”

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The Group Capital Calculation (E) Working Group began its work on the GCC in 2016 and spent the next two-and-one-half years constructing the calculation. Over the course of that time, the Working Group conducted numerous public conference calls to discuss the proposed construction on a topic-by-topic basis. In 2019, the Working Group set up a voluntary process under which the GCC was tested by more than 30 insurance groups represented by 15 lead states. This testing was completed in early 2020, at which time the Working Group began to make changes to the GCC to reflect the learnings from the testing. Simultaneously with this testing, at the 2019 Fall National Meeting, the Executive (EX) Committee approved the Working Group’s request to open Model #440 and Model #450 to develop the legal authority under which the GCC would be implemented. In addition to requiring the filing of the GCC with the lead state commissioner, the models would also provide information on the types of insurance groups that would be exempt from filing the GCC, as well as provide the necessary language to protect the confidentiality of the tool.

In January 2020, the Working Group exposed for public comment a draft memorandum that set forth possible exemptions, as well as the basic construct for the confidentiality protections, based on previous public comments made by Working Group members. The first draft of amendments to Model #440 and Model #450 were drafted based on decisions made by Working Group members, with previous input from the industry considered by the Working Group members. This continued to be the case with respect to future versions of the model(s), although the Sept. 18 version was drafted with specific input from a small drafting group consisting of California, Nebraska, Missouri, Texas and Wisconsin.

NAIC staff met via conference call with representatives of the U.S. Department of the Treasury (Treasury Department) and the Office of the U.S. Trade Representative (USTR) on Sept. 10 and Oct. 14 to discuss their concerns regarding the consistency of the draft revisions to a covered agreement with the European Union (EU). (Please refer to discussion in paragraph 8.)

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

At the 2019 Fall National Meeting, the Executive (EX) Committee approved the Working Group’s request to open Model #440 and Model #450 to develop the legal authority under which the GCC would be implemented. In January 2020, the Working Group exposed for public comment a draft memorandum that set forth possible exemptions, as well as the basic construct for the confidentiality protections. Comments were received Feb. 17, 2020, but due to the COVID-19 pandemic, the first discussion of proposed changes to Model #440 and Model #450 did not occur until June 2, 2020.

During its June 2, 2020, call, the Working Group made several key decisions related to the comments on exemptions and subsequently released its first version of proposed changes to Model #440. Comments were received July 15, 2020, with numerous edits proposed by interested parties that were incorporated into a modified version for discussion by the Working Group on its July 21, 2020, call, including comments on subgroup reporting. Discussion on the subgroup reporting issue was deferred by the Working Group until decisions were made on all other comments, and the Working Group exposed for public comment proposed changes to Model #440, along with proposed changes to Model #450, on July 23, 2020. Comments on this exposure, which were largely focused on subgroup reporting, were discussed by the Working Group on its Sept. 18, 2020, call. The next version of Model #440 and Model #450 were exposed for a public comment period ending Oct. 5, 2020, with most of the changes from the July 23, 2020, version representing proposed revised wording from various interested parties intended to streamline both models. New versions of the models were produced and exposed following the Working Group’s Oct. 20, 2020, call based on comments received Oct. 5, 2020, and discussed by the Working Group on its Oct. 20, 2020, call. The final versions of Model #440 and Model #450 were exposed Oct. 21, 2020, for a public comment period, and subsequently adopted by the Working Group on its Nov. 17, 2020, call.

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

Significant issues which were ultimately addressed include:

1. Ability to exclude immaterial risky affiliates from the calculation.
2. Excluding recasting of XXX/AXXX transactions in the GCC.¹
3. Allowing a proxy level of senior debt to be added to capital that represents the subordinated capital controlled by the commissioner's authority over approving extraordinary dividends.
4. Inclusion of the concept of scalars to recognize U.S. reserve requirements are often much higher than other jurisdictions.
5. The level at which the GCC is calibrated with RBC (200%).
6. A subgroup capital calculation under which a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system if it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. This particular aspect of Model #440 was the most controversial topic and was debated extensively, while other potential options failed to receive a majority vote.

7. List the key provisions of the model (sections considered most essential to state adoption).

The changes to Section 4L(2) of Model #440 are the most important provisions in the proposed changes, as they require the ultimate controlling person of every insurer subject to registration to concurrently file an annual GCC as directed by the lead state commissioner with the registration statement. Immediately following this provision in Section 4L(2)(a) through Section 4L(2)(d) are four types of holding company systems that are exempt from filing, which are also important to many parties. As previously discussed, Section 4L(2)(e) would permit, under certain circumstances, a subgroup capital calculation. Section 4L(2)(f) is also important, as it provides the commissioner the discretion to exempt other groups from filing that meet the criteria in Model #450. Finally, Section 8(A)(1) of Model #440 provides key statutory authority to hold the GCC confidential and actually prevents the group itself from sharing the GCC publicly. Model #450 provides more detailed aspects of the exemptions, including additional discretionary authority for exempting certain groups, as well as additional details of the NAIC process for maintaining a list of jurisdictions whose groups recognize and accept the GCC and are, therefore, exempt from filing the GCC.

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

a. Covered Agreement

Under Title V of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), the Treasury Department and the USTR are authorized to jointly negotiate covered agreements, defined under the Dodd-Frank Act as written bilateral or multilateral agreements between the U.S. and one or more foreign governments, authorities or regulators regarding prudential measures with respect to insurance or reinsurance, on the condition that the prudential measures subject to a covered agreement achieve a level of protection for insurance or reinsurance consumers that is "substantially equivalent" to the level of protection achieved under U.S. state insurance laws. On Sept. 22, 2017, the Treasury Department and the USTR signed the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (Covered Agreement). On Dec. 18, 2018, a separate covered agreement was signed between the U.S. and the United Kingdom, which mirrors the language from the agreement with the EU and has the same timing requirements for implementation.

The Covered Agreement includes requirements on reinsurance collateral, group supervision and group capital. Specifically, Article 4(h) provides that the host supervisor (i.e., a supervisory authority from the territory in which an insurance group has operations but which is not the territory where the worldwide parent is domiciled or headquartered) may not impose a group capital assessment or requirement at the level of the worldwide parent, but only if the insurance group is subject to a group capital assessment imposed by the home supervisor. The group capital assessment of the home supervisor must include a worldwide group capital calculation capturing risk at the level of the entire group, and the home supervisor must have the authority to impose preventive, corrective or otherwise responsive measures on the basis of the assessment, including the authority to impose capital measures where appropriate.

¹ "XXX/AXXX transactions" are those transactions required to be valued under Section 6 or Section 7 of the *Valuation of Life Insurance Policies Model Regulation* (#830).

Under Article 10(e) of the Covered Agreement, supervisory authorities in the EU shall not impose a group capital requirement at the level of the worldwide parent undertaking of the insurance or reinsurance group, with regard to a U.S. insurance or reinsurance group with operations in the EU, for 60 months after the date of provisional application of the Covered Agreement; i.e., Nov. 7, 2022. The GCC is intended to serve as an analytical tool for evaluating an insurer's capital position at the group level, but is not intended to be applied as a group-level capital requirement or standard. The *Statement of the United States on the Covered Agreement with the European Union* provides further clarification with respect to this group capital assessment.

The Covered Agreement limits the worldwide application of EU prudential group insurance measures on U.S. insurers operating in the EU. The Covered Agreement also provides that U.S. insurers and reinsurers can operate in the EU without the U.S. parent being subject to the group-level governance, solvency and capital, and reporting requirements of Solvency II, and reinforces that the EU system of prudential insurance supervision is not the system in the U.S. The Covered Agreement does not require development of a group capital standard or group capital requirement in the U.S. Article 4(h) contemplates that the states will develop a group-wide capital assessment. Through the NAIC, the states are in the process of developing a group capital calculation which is intended to serve as an analytical tool for evaluating a firm's capital position at the group level. **The U.S. expects that the NAIC's GCC will satisfy the "group capital assessment" condition of Article 4(h), provided that the work is completed and implemented within five years of the date on which the Agreement is signed.** [Emphasis added].

Any state with U.S. groups operating in either the European Union or the United Kingdom will need to adopt these legislative changes by Nov. 7, 2022, to effectuate compliance with the Covered Agreement.

b. Liquidity Stress Testing

In coordination with the work on the GCC, the Liquidity Assessment (EX) Subgroup of the Financial Stability (EX) Task Force drafted revisions to Model #440 to incorporate a liquidity stress test (LST) and to provide confidentiality requirements with respect to the LST. These revisions to Model #440, while not directly related to the GCC, are also intended to be considered for adoption by the NAIC membership simultaneously with the GCC-related revisions to Model #440. A separate Project History has been prepared with respect to the LST.

c. Accreditation

The Group Capital Calculation (E) Working Group has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. However, it is expected that these revisions will be incorporated into the accreditation standard in order to encourage the states to effectuate compliance with the Covered Agreement.

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Date: 11/10/2020

State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Adoption of the new *Insurance Data Security Model Law (#668)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2017 Fall National Meeting. 11 states have enacted this model.

Life Insurance and Annuities (A) Committee

- Amendments to the *Suitability in Annuity Transactions Model Regulation (#275)*—These revisions were adopted by the Executive (EX) Committee and Plenary during the February 13, 2020 conference call. Two states have enacted these revisions to the model.

Health Insurance and Managed Care (B) Committee

- Amendments to the *Health Carrier Prescription Drug Benefit Management Model Act (#22)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2018 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.
- Amendments to the *Accident and Sickness Insurance Minimum Standards Model Act (#170)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.
- Adoption of the *Limited Long-Term Care Insurance Model Act (#642)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.
- Adoption of the *Limited Long-Term Care Insurance Model Regulation (#643)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

Property and Casualty Insurance (C) Committee

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

Financial Condition (E) Committee

- Amendments to the *Life and Health Insurance Guaranty Association Model Act (#520)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Fall National Meeting. 33 states have enacted these revisions to the model.
- Amendments to the *Credit for Reinsurance Model Law (#785)*—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019 conference call. 16 states have enacted this model.
- Amendments to the *Credit for Reinsurance Model Regulation (#786)*—These revisions were adopted by the Executive (EX) Committee and Plenary during its June 26, 2019 conference call. Three states have enacted this model.

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