Draft: 6/5/09

Casualty Actuarial and Statistical (C) Task Force
Conference Call
May 12, 2009

The Casualty Actuarial and Statistical (C) Task Force met via conference call May 12, 2009. The following Task Force members participated: Thomas R. Sullivan, Chair, represented by John Purple and Richard Marcks (CT); Mary Jo Hudson, Vice Chair, represented by Mary Miller, Tom Hess and Brad Schroer (OH); Linda Hall represented by Sarah McNair-Grove (AK); Jim L. Ridling represented by Charles Angell (AL); Michael McRaith represented by Sarah Fore (IL); Scott J. Kipper represented by Janice Moskowitz (NV); Steven M. Goldman represented by Boris Privman (NJ); Eric Dinallo represented by Anne Kelly, Shrinivas (Jay) Havaldar, Gloria Huberman, Sak Man Luk, Deborah Rosenberg, Hau Michael Ying and Alice Wang (NY); Teresa Miller represented by Rae Taylor and David Dahl (OR); Joel Ario represented by Melissa Greiner and Stephanie Ohnmacht (PA); Mike Kreidler represented by Lee Barclay (WA); and Jane L. Cline represented by Aaron Baughman (WV). Also participating were Karen Adams (AZ); Robin Coombs (KY); Nicole Elliott (TX) and Kevin Gaffney (VT).

1. Premium Deficiency Reserves

Mr. Purple said the Task Force exposed a proposal to modify the Statement of Actuarial Opinion instructions to require the premium deficiency reserves (PDR) to be within the scope of the opinion. Comments were received by the American Academy of Actuaries (AAA), Pinnacle Actuarial Resources, Inc., and Kenneth Quintilian (XX-A, XX-B, XX-C). Mr. Purple suggested that the Task Force discuss the proposal but not consider adoption, during this call.

Mr. Privman said that in New Jersey 90% of companies do not use actuaries to assess the need for PDR and not a single company booked a PDR. Mr. Marcks said that in Connecticut more than a handful of actuaries said they were involved in the evaluation and assessment of PDR. Of the couple of companies in Connecticut that carry a PDR, actuaries were not involved.

Mr. Quintilian said he encourages the Task Force to increase the visibility and transparency of the statutory accounting requirement already in place. He said that based on current accounting standards there should not be offsets by line of business. He disagreed with having a materiality standard below which the actuary would not have to review the reserves. He suggested that the actuarial opinion requirements should overlay the accounting standards, with the actuarial profession developing guidance rather than regulators adding or modifying accounting standards.

Marc Oberholtzer (PricewaterhouseCoopers) said that when there is no PDR established by the company, it would not be worth the trouble for actuaries to include a PDR opinion. As an audit-firm actuary, he said the accounting does not defer acquisition costs; broad groupings are allowed under general and broad characterizations, and it is rare to have a premium deficiency for short-duration contracts. He said he could see value for a PDR opinion on mortgage and financial guaranty business. He recommended modification to require disclosure within the opinion, rather than inclusion of the PDR within the scope. He asked what the impetus was that resulted in this proposal. Mr. Purple said the issue was first considered years ago, so there is no one event that triggered the proposal other than good public policy and to have as much transparency as possible. Mr. Marcks said he has reviewed numerous articles over the past few years that discussed increased competition on pricing, particularly on commercial lines.

Shawna Ackerman (Pinnacle Actuarial Resources, Inc.) was unable to present her comments because of technical difficulties. Mr. Purple said there are some good questions in her letter about calculating PDR.

Mr. Barclay said that some financial analysts and examiners in Washington support this type of proposal and they encourage the Task Force to go in this direction. Regarding comment letters, while the actuarial standards of practice and methods might not be complete, he said the Task Force's proposal should not wait for those to develop. As this proposal advances, those will catch up and regulators could also encourage development in that area. Just because there is no PDR, he said, that does not mean there should not be one. If 90% of companies do not have actuaries involved in PDR analysis in New Jersey, then that distinction between zero and non-zero is not a distinction upon which he wants to rely.

Ms. Elliot said that there might be a place for an actuary to opine, but that this crosses actuarial disciplines from the reserving actuary to the pricing actuary. Ms. Fore agreed and, in consideration of the time needed to do the analysis and the due date,

she suggested consideration of having a separate opinion due July 1. She said there should also be consideration about whether the PDR opinion could be completed by a different actuary.

Ms. Miller asked whether there should be a safe haven, or limitation, to the requirement. She said that if a company consistently has underwriting gains with minimal losses and generally adequate reserves, then a PDR opinion would not be needed, and the added expense would not necessarily add value. Bill Boyd (National Association of Mutual Insurance Companies—NAMIC) believes there should be some indicator to decide whether the additional time, effort and cost would be appropriate. Mr. Quintilian said the safe haven question is similar to frameworks of materiality. He said he does not believe it is necessary, because the PDR analysis should be done line-by-line. If underwriting gains are used to evaluate whether a company should opine on PDR, then one line of business could overwhelm the others; plus, these metrics would be hard to measure. If the companies are already doing the level of price monitoring that is necessary to adequately monitor the profitability of their products, he said it would not be difficult to determine PDR and the expense would not be major. That is, the actuary could say PDR is immaterial and the justification would be documented in the Actuarial Report. The insurance department could request the report if desired.

Mr. Purple asked why actuaries are often not consulted to determine PDR, given that actuaries are more closely involved in determining price adequacy. Mr. Oberholtzer said his experience is that PDR determination tends to be a joint effort, with accountants receiving inputs from the actuary, but with accountants in control. The accounting department might utilize the most recent accident-year loss estimates. He agreed that a PDR opinion would not necessarily need to require a lot of work, but an actuary might choose to be more thorough in documentation than what might be needed.

Mr. Oberholtzer said that, from an accounting standpoint, the broad groupings in PDR analysis results from a company's judgment call on how to measure profitability. Companies tend to look at this broadly and even allow business in one state to be offset by business in another state. Groupings could be as broad as property/casualty as a whole, personal lines vs. commercial lines or reporting segment. Ms. Miller said that when this topic was first discussed years ago, the AAA assessed PDR amounts held by companies. They found that the more inclusive the grouping, the less likely a company was to have a PDR. The more granular the grouping, the more opportunity for a particular line to have a PDR. Companies use judgment and sometimes make the determination that their company markets and services business as a whole, so they use the whole company as their grouping. As such, Ms. Elliott said the grouping would need to be addressed — and guidance would need to proceed or be in tandem with enforcing such a requirement. Ms. Miller said smaller companies do not always have actuaries involved in pricing or they might employ consultants on an occasional basis. So, even though they might have less-sophisticated price monitoring, if they tend to be profitable year-in and year-out, it would be difficult to justify that they need to have this actuarial opinion performed. Mr. Oberholtzer said that large companies are less likely to have a PDR. Mr. Quintilian said that the PDR is granulated to a finer detail and that he finds it difficult to conclude that personal lines vs. commercial lines would be the level of detail that defines how policies are marketed and serviced. Ms. Elliot said managing general agents (MGAs) might group their analysis by program, even if the programs are the same line of business. She said the accounting guidance is broad and open to interpretation.

Mr. Purple's concern is that there are companies with inadequate rates that should be carrying a PDR. He requested that additional comments be submitted in writing to Kris DeFrain (NAIC) by June 5. A subgroup of Connecticut, Illinois, Ohio, Texas and any other volunteers will revise the proposal.

2. Statement of Actuarial Opinion Data Collection

The electronic data filing for Statement of Actuarial Opinion data has not been successful. There is missing data and incorrect data submission. It also appears that the annual statement vendors are populating some of the numbers directly from the annual statement, rather than the insurer inputting the numbers from the Statement of Actuarial Opinion. The Task Force decided to draft a letter to annual statement contacts to provide instructions to companies about how to populate the data. Mr. Marcks will draft a letter for consideration by the Task Force.

3. Statement of Actuarial Opinion Regulatory Discussion

The Task Force decided to hold a regulator-to-regulator conference call June 9 to discuss individual company Statement of Actuarial Opinions. As in prior years, actuaries were asked to collect data and items for discussion.

4. Catastrophe Modeling Subgroup

Mr. Purple said the Catastrophe Modeling Subgroup had calls April 2 and 27 to revise the *Catastrophe Modeling Handbook* questions. They scheduled another call May 14 to revise the remainder of the questions.

Mr. Purple and Arthur Schwartz (NC) are working with three modeling companies and other modeling experts to develop webinars for regulators about how models function. There will likely be a series of four to five webinars hosted by the NAIC and presented by these experts. An agenda should be available by the Summer National Meeting.

5. Property/Casualty Line of Business Definitions Subgroup

Ms. Miller said the Property/Casualty Line of Business Subgroup received responses from its survey about property/casualty financial statement line of business definitions. NAIC staff is compiling the input received.

6. Statistical Issues Subgroup

Mr. Barclay said the Statistical Issues Subgroup held calls March 31 and April 21 to continue discussion of comments on Part A of the guidelines for implementing the Medical Professional Liability Closed Claim Reporting Model Law. There is significant discussion about economic and non-economic damages, and especially about which particular components of economic damages should be estimated and reported. The Subgroup expects to require estimates of a portion of indemnity payments related to economic damages, but the question is the level of detail. They will have another call May 18 to finish discussion of Part A and will then present a draft of that part to the Task Force prior to proceeding. Optimally, they will distribute the draft at the Summer National Meeting, although they do not plan to have discussion at that meeting.

Another project for the Subgroup is to produce an NAIC Personal Lines Competition Database Report, similar to the NAIC's Commercial Lines Competition Database Report. Aaron Brandenburg (NAIC) will soon have a draft report with 2007 data. For a 2008 report, the profitability numbers are needed. The Subgroup will review the report on a regulator-to-regulator call. He said this is a key time to have as many members of this Task Force involved as possible to get a careful review of a first edition. The Task Force will be notified when that call is scheduled.

7. Workers' Compensation Large Deductible Subgroup

Ms. McNair-Grove said the Workers' Compensation Large Deductible Subgroup is hoping to finalize its project at the Summer National Meeting. Rita Nowak (Property Casualty Insurers Association of America—PCI) said they submitted a letter to the Subgroup asking that this work be discontinued. PCI will work with the American Insurance Association (AIA) to see if they can coordinate a joint letter and be ready for the Summer National Meeting. She expects that the PCI and AIA are in agreement.

8. Solvency Modernization Initiative

The Solvency Modernization Initiative (EX) Task Force met April 16. They adopted the working groups' charges, discussed the process to review and comment on international papers, and discussed the development of a U.S. framework/principles document.

The International Solvency and Accounting (EX) Working Group will have a call May 14 to discuss the International Association of Insurance Supervisors (IAIS) standard and guidance papers on capital resources, the IAIS actuary/auditor paper and the NAIC document outlining the non-accounting issues for the Solvency Modernization Initiative.

9. Catastrophe Reserve (C) Working Group

Mr. Purple said the Task Force should expect a referral from the Catastrophe Reserve (C) Working Group prior to the Summer National Meeting. The Working Group is discussing whether there should be a pre-event catastrophe reserve, regardless of whether there is an IRS tax discount. The Task Force might need to evaluate whether there would be a negative impact on insurance availability if companies are forced to hold reserves for future catastrophes.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
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Agenda
Meeting of the Casualty Actuarial and Statistical (C) Task Force
June 14, 2009

Roll Call

Commissioner	Primary Rep.	Alternate Reps.	State
Thomas R. Sullivan, Chair	John Purple	Richard Marcks	Connecticut
Mary Jo Hudson, Vice Chair	Mary Miller	Tom Hess/Maureen Motter/Brad Schroer	Ohio
Jim L. Ridling	Charles Angell		Alabama
Linda S. Hall	Sarah McNair-Grove		Alaska
Steve Poizner	Ron Dahlquist	Luciano Gobbo	California
Thomas E. Hampton	Clark Simcock	Robert Nkojo	District of Columbia
Kevin McCarty	Howard Eagelfeld		Florida
Michael McRaith	Judy P. Mottar	Sarah Fore/Chantel Long	Illinois
Sandy Praeger	Larry Bruning		Kansas
John M. Huff	Brent Kabler	David Cox	Missouri
Scott J. Kipper	Janice Moskowitz		Nevada
Steven M. Goldman		Boris Privman/William Rader/Sam Sackey	New Jersey
Eric Dinallo	Anne Kelly	Gloria Huberman/Debbie Rosenberg	New York
Teresa Miller	Rae Taylor	David Dahl	Oregon
Joel Ario	Melissa Greiner	Stephanie Ohnmacht	Pennsylvania
Scott H. Richardson	Leslie Jones	Vibha Jayasinghe	South Carolina
Kent Michie	Tomasz Serbinowski		Utah
Mike Kreidler	Lee Barclay	Eric Slavich, Lisa Smego	Washington
Jane L. Cline	Mike Riley	Tonya Gillespie/Elizabeth Webb	West Virginia
			NAIC Staff Support: Kris DeFrain/Joe Bieniek

1. Discuss Premium Deficiency Reserves Blanks Proposal
2. Discuss Actuarial Opinion Data Collection
3. Discuss *Guideline for Implementation of Medical Professional Liability Closed Claim Reporting*
4. Discuss Other NAIC Work
5. Discuss American Academy of Actuaries' Work
6. Consider Interim Minutes and Reports
   - Interim Call Minutes
   - Profitability Report (C) Working Group Summary
   - Subgroup Summaries: Catastrophe Modeling Subgroup, Line of Business Subgroup, Statistical Subgroup, and Workers' Compensation Large Deductible Subgroup
7. Any Other Business

National Association of Insurance Commissioners

Casualty Actuarial and Statistical Task Force
June 14, 2009

Profitability (C) Working Group
Summary and Action Items
June 14, 2009

The Profitability (C) Working Group did not meet in the second quarter of 2009. The Profitability (C) Working Group plans to begin discussions on the *Report on Profitability by Line by State in 2008* after the Summer National Meeting.

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Casualty Actuarial and Statistical (C) Task Force
Subgroup Reports
June 5, 2009

Catastrophe Modeling Subgroup
John Purple, Chair

The Catastrophe Modeling Subgroup held two working conference calls this quarter to discuss modifications to the NAIC's Catastrophe Modeling Handbook. The Subgroup expects to propose modifications by the Fall National Meeting.

Line of Business Subgroup
Mary Miller, Chair

The Property/Casualty Line of Business Subgroup has received responses from its survey about property/casualty financial statement line of business definitions. The survey is open until June 15th. Soon thereafter results will be compiled and distributed by NAIC staff.

Statistical Subgroup
Mr. Barclay, Chair

The Statistical (C) Subgroup met on March 31, April 21 and May 18, 2009, to review the draft *Guideline for Implementation of Medical Professional Liability Closed Claim Reporting* to supplement the model law. They are currently focusing on Part A of the guideline and have exposed a June 8, 2009, draft of Part A which is available on the website.

The Subgroup is still anticipating a letter from the Life and Health Actuarial Task Force to request aid with their mandatory statistical reporting for principles-based reserving. Expectations are that the request will ask about the property/casualty process, how regulators work with statistical agents, how statistical agents are appointed, how parties are paid, how data is kept confidential, etc.

Similar to the *Commercial Lines Competition Database Report*, a *Personal Lines Competition Database Report* is being developed by the Subgroup. Expectations are to have the database ready for discussion by the Task Force in the next quarter.

Workers' Compensation Large Deductible Subgroup
Sarah McNair-Grove, Chair

The Workers' Compensation Large Deductible Subgroup has been awaiting a response from the American Insurance Association (AIA) about their position as to whether to keep large deductible premium assessments based off of losses as they are now or whether a new method based on premiums should be developed. The AIA letter was received on June 5, 2009, and will be discussed after the National Meeting.

The next step is for the Subgroup to recommend a response to the referrals of the Workers' Compensation Task Force and its Large Deductible Study Implementation (C) Working Group. Documentation of significant issues learned in the project will also be recorded. Documentation will include the route taken in the research; a description of faults of a loss-based system; and, if applicable, explanation that even with those faults, the hurdles to a premium product is worse.

Draft: ~~December 3, 2008~~June 8, 2009
New guideline on medical professional liability closed claim reporting

Drafting Note: Only Part A is revised. The subgroup believes that it is important to agree on a draft of Part A before it proceeds to discuss Parts B through E of the December 3, 2008, draft. Parts B through E are not included in this document.

GUIDELINE FOR IMPLEMENTATION OF
MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING

PART A
SUGGESTED REGULATION ON REPORTING REQUIREMENTS

Table of Contents

Section 1. Statement of Purpose

This regulation establishes detailed reporting requirements that are consistent with the NAIC *Medical Professional Liability Closed Claim Reporting Model Law*.

Section 2. Definitions

As used in this regulation:

A. "Claim" means the same as in subsection 2A of the *Medical Professional Liability Closed Claim Reporting Model Law*.

B. "Claim identifier" means the unique ~~number~~ alphanumeric sequence assigned to a claim by the reporting entity as required by subsection 5A(1) of the *Medical Professional Liability Closed Claim Reporting Model Law*.

C. "Claimant" means the same as in subsection 2B of the *Medical Professional Liability Closed Claim Reporting Model Law*.

D. "Closed claim" means the same as in subsection 2C of the *Medical Professional Liability Closed Claim Reporting Model Law*.

E. "Commissioner" means the same as in subsection 2D of the *Medical Professional Liability Closed Claim Reporting Model Law*.

F. "Companion claims" means the same as in subsection 2E of the *Medical Professional Liability Closed Claim Reporting Model Law*.

G. "Defense and cost containment expenses" means expenses paid or incurred for defense, litigation and ~~medical~~ cost containment services. ~~Either internal staff, such as in-house counsel or professional medical staff, or external staff, such as defense counsel or expert~~

~~witnesses, may provide defense and cost containment services~~The amounts reported for an insuring entity's or self-insurer's employees should include overhead, just as an outside firm's charges would include.

(1) Defense and cost containment expenses ~~and services~~ include:

(a) ~~Defense services provided by attorneys, expert witnesses, private investigators, hearing representatives and fraud investigators~~Surveillance expenses;

(b) ~~Cost containment activities and services performed by external or internal experts to defend the claim, including case evaluation, risk assessment, case preparation and management, medical record review and settlement negotiations; and~~Fixed amounts for cost containment expenses;

(c) ~~Specific case-related expenses, such as surveillance expenses, court costs, medical examination fees, the costs of laboratory, X-ray and other medical tests, autopsy expenses, stenographic expenses, fees associated with witnesses and summonses and the costs of obtaining copies of documents~~Litigation management expenses;

(d) Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such cost is not included in losses;

(e) Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and

(f) The cost of engaging experts.

(2) Defense and cost containment expenses do not include:

(a) ~~Expenses incurred to determine whether coverage is available; and~~Fees of adjusters and settling agents (but not if engaged in a contentious defense);

(b) ~~Expenses or costs associated with external or internal claims adjusting staff~~Attorney fees incurred in the determination of coverage, including litigation between the insuring entity and the policyholder; and

(c) Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in the capacity of an adjuster.

H. "Economic damages" means the same as in subsection 2F of the *Medical Professional Liability Closed Claim Reporting Model Law*.

I. "Excess insuring entity" means an insuring entity that provides insurance coverage above the limits of primary insurance or a self-insured retention.

J. "Facility" means the same as in subsection 2G of the *Medical Professional Liability Closed Claim Reporting Model Law*.

K. "Incident" means an alleged medical error or omission or a series of related errors or omissions leading to allegations of harm. A single incident may span multiple years and involve numerous named defendants.

~~K~~L. "Incident identifier" means the unique ~~number~~ alphanumeric sequence assigned by the reporting entity to a series of closed claims that result from a single incident or related series of incidents of medical malpractice, as required by subsection 5A(2) of the *Medical Professional Liability Closed Claim Reporting Model Law*.

~~L~~M. "Insuring entity" means the same as in subsection 2I of the *Medical Professional Liability Closed Claim Reporting Model Law*.

~~M~~N. "Medical malpractice" means the same as in subsection 2J of the *Medical Professional Liability Closed Claim Reporting Model Law*.

~~N~~O. "Noneconomic damages" means the same as in subsection 2K of the *Medical Professional Liability Closed Claim Reporting Model Law*.

~~O~~P. "Primary insuring entity" means the insuring entity that originates the primary layer of insurance coverage. A self-insurer is not considered to be a primary insuring entity.

~~P~~Q. "Provider" means the same as in subsection 2H of the *Medical Professional Liability Closed Claim Reporting Model Law*.

~~Q~~R. "Reporting entity" means any person or entity required to report data under Section 4 of the *Medical Professional Liability Closed Claim Reporting Model Law*.

~~R~~S. "Self-insurer" means the same as in subsection 2L of the *Medical Professional Liability Closed Claim Reporting Model Law*.

~~S~~T. "User ID" is a permanent ~~number~~ alphanumeric sequence assigned by the commissioner to each insuring entity, self-insurer, facility or provider that reports data.

Section 3. Applicability and Scope

This regulation is intended to implement this state's medical professional liability closed claim reporting requirements in a manner that is consistent with the NAIC *Medical Professional Liability Closed Claim Reporting Model Law*. It applies to all reporting entities as defined in ~~S~~subsection 2~~Q~~R of this regulation.

Section 4. Claims Required to Be Reported

A. The types of closed medical professional liability claims that must be reported to the commissioner include:

(1) Claims closed with an indemnity payment;

(2) Claims closed with paid defense and cost containment expenses; and

(3) Claims closed with both indemnity payments and paid defense and cost containment expenses.

B. If a self-insurer, facility or provider waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under subsection 2A of the *Medical Professional Liability Closed Claim Reporting Model Law*. Reporting entities are not required to report these types of accommodations to the commissioner.

C. A claim is closed on the date the reporting entity takes final administrative action to close the claim. Final administrative action occurs after the reporting entity:

(1) Issues the final payment to the claimant in the form of a check, draft, or electronic funds transfer;

(2) Pays all outstanding bills for defense and cost containment expenses; and

(3) If applicable, receives all indemnity and defense and cost containment expense payment data needed for reporting from a facility, provider or excess insuring entity.

D. If a closed claim is reopened to update data, the reporting entity must report the updated data to the commissioner after it updates and closes the claim file.

Section 5. Assignment of Claim and Incident Identifiers

A. The reporting entity must assign a different claim identifier to each closed claim report.

(1) ~~The claim identifier must consist solely of numbers.~~ The commissioner will combine the reporting entity's user ID with the claim identifier to create a unique record identifier for each claim.

(2) The commissioner may use the record identifier to trace the claim for auditing purposes.

B. If a claimant makes claims against more than one facility or provider insured by an insuring entity or self-insurer, the insuring entity or self-insurer must report each claim separately and include an incident identifier.

~~(1) The incident identifier must consist solely of numbers.~~

~~(2) The insuring entity or self-insurer is responsible to report claims only if it provides insurance coverage for a facility or provider and defends the claim.~~

Section 6. Responsibility for Reporting Data

A. Except as provided by subsections B through F of this section, p~~P~~rimary insuring entities are principally responsible for reporting closed claim data required under the *Medical Professional Liability Closed Claim Reporting Model Law*.

(1) The primary insuring entity must report the total amounts paid to settle the claim, including any indemnity or defense and cost containment expense payments made by:

(a) An insured facility or provider;

(b) An excess insuring entity; or

(c) Any other person or entity on behalf of the facility or provider.

(2) Facilities or providers insured by the primary insuring entity must cooperate and assist the primary insuring entity in the reporting process.

(3) If a primary insuring entity and one or more excess insuring entities combine to pay a claim:

(a) The primary insuring entity must report all paid indemnity and defense and cost containment expenses; and

(b) The excess insuring entity must cooperate and assist the primary insuring entity in the reporting process.

B. If an excess insuring entity insures a self-insurer and makes indemnity payments or incurs defense and cost containment expenses, the excess insuring entity is principally responsible to report the required closed claim data.

(1) Self-insurers must report all claim payments and defense and cost containment expenses to the excess insuring entity for reporting purposes; and

(2) The excess insuring entity must report data on behalf of itself and the self-insurer.

(3) An excess insuring entity is not responsible to report closed claim data reported by a primary insuring entity under subsection 6A of this Guideline.

C. If a closed claim payment falls wholly within its self-insured retention, the self-insurer must report the required closed claim data.

D. A self-insurer may designate itself to be the principal reporting entity and report closed claim data on behalf of itself and any excess insuring entity. If the self-insurer designates itself to be the principal reporting entity, the self-insurer must:

(1) Notify the commissioner in writing of this arrangement;

(2) Report the required closed claim data on behalf of itself and the excess insuring entity; and

(3) Accept responsibility for compliance with the requirements of subsection 4A of the *Medical Professional Liability Closed Claim Reporting Model Law*.

E. A facility or provider is responsible to report the required closed claim data if:

(1) There is no insurance coverage available from an insuring entity or self-insurer to defend or pay the claim; or

(2) ~~A court of competent jurisdiction determines that the self-insurer, risk retention group or unauthorized insurer is exempt from the *Medical Professional Liability Closed Claim Reporting Model Law*; or~~The insuring entity or self-insurer fails to report the required closed claim data.

F. An insuring entity or self-insurer may designate a third party to report closed claim data. In this case the insuring entity or self-insurer must:

(1) Obtain a user ID from the commissioner;

(2) Designate the third party as the entity that will report closed claim data on its behalf;

(3) Manage the activities of the third party with respect to the insuring entity's or self-insurer's closed claim data; and

(4) Retain responsibility for all closed claim data submitted by the third party.

~~(3) The commissioner grants a waiver under subsection 4A(4)(b) of the *Medical Professional Liability Closed Claim Reporting Model Law*.~~

Section 7. Reporting of Specific Data Elements

A. Policy limits—When reporting the policy limits of the medical professional liability insurance policy covering the claim, reporting entities must report the following, if applicable:

(1) Primary policy limit, per occurrence (a self-insured retention is not a primary policy limit);

(2) Annual limit of primary policy;

(3) Excess policy limit, per occurrence; ~~and~~

(4) Annual limit of excess policy; and

(5) Available policy limits.

B. Medical specialty—When reporting medical specialties, reporting entities must use the *Field of Licensure Codes* and *Medical Specialty Codes* published by the National Practitioner Data Bank.

C. Type of health care facility—When reporting the type of health care facility, the reporting entity must use the *Type of Organization Codes* published by the National Practitioner Data Bank (NPDB). Public facilities, such as prisons and universities, must review the NPDB *Type of Organization Codes* and enter the most similar classification.

D. Primary location within a facility—When reporting the primary location within a facility where the incident occurred, the reporting entity must use the incident locations published by the Physician Insurers Association of America in conjunction with its data-sharing project. The reporting entity must report one of these locations:

(1) Catheterization lab;

(2) Critical care unit;

(3) Dispensary;

(4) Emergency department;

(5) Labor and delivery room;

(6) Laboratory;

(7) Nursery;

(8) Operating room;

(9) Outpatient department;

(10) Patient room;

(11) Pharmacy;

(12) Physical therapy department;

(13) Radiation therapy department;

(14) Radiology department;

(15) Recovery room;

(16) Rehabilitation center;

(17) Special procedure room;

(18) Location other than an inpatient facility:

(a) Clinical support center, such as a laboratory or radiology center;

(b) Office;

(c) Walk-in clinic; or

(d) Other;

(19) Other department in hospital;

(20) Unknown; and

(21) Other.

E. ~~City~~County—When reporting the ~~city where~~county in which the incident occurred, the reporting entity must report based on the location of the facility where the incident occurred. If more than one ~~incident~~ alleged medical error led to the claim, the reporting entity must choose the location where the ~~incident~~ alleged medical error leading most directly to the injury occurred. In the event that an ~~injury~~ alleged medical error occurs outside this state, but the claim is made in this state, a closed claim report must be filed in this state and the ~~city~~ county shown as "Location out of state."

F. Severity of injury—When reporting the severity of injury, the reporting entity must use the National Practitioner Data Bank severity scale. This scale shows the medical outcome for temporary and permanent injuries.

(1) Temporary injuries include:

(a) Emotional injury only, such as fright, where no physical damage occurred;

(b) Insignificant injury, such as lacerations, contusions, minor scars or rash, where no delay in recovery occurs;

(c) Minor injury, such as infection, fracture set improperly or a fall in the hospital, where recovery is complete but delayed; and

(d) Major injury, such as burns, surgical material left, drug side effect or brain damage, where recovery is complete ~~buy~~ but delayed.

(2) Permanent injuries include:

(a) Minor injury, such as loss of fingers or loss or damage to organs, where the injury is not disabling;

(b) Significant injury, such as deafness, loss of limb, loss of eye or loss of one kidney or lung;

(c) Major injury, such as paraplegia, blindness, loss of two limbs or brain damage;

(d) Grave injury, such as quadriplegia, severe brain damage, life-long care or fatal prognosis; and

(e) Death.

(3) If several injuries are involved, the reporting entity should report the ~~principal~~ most severe injury.

G. Date of notice—When reporting the date of notice to the insuring entity, self-insurer, facility or provider, the reporting entity must report the date on which:

(1) The insured notifies the primary insuring entity or self-insurer of a claim if insurance coverage is available; or

(2) The claimant notifies the facility or provider of a claim if insurance coverage is not available.

H. Claim disposition—When reporting the method of claim disposition, the reporting entity must describe the method of claim disposition using one of the following descriptions:

(1) Claim is abandoned by the claimant.

(2) Claim is settled by the parties.

(3) Claim is disposed of by a court when the court issues a:

(a) Directed verdict for the plaintiff;

(b) Directed verdict for the defendant;

(c) Judgment notwithstanding verdict for the plaintiff (judgment for the defendant);

(d) Judgment notwithstanding verdict for the defendant (judgment for the plaintiff);

(e) Involuntary dismissal;

(f) Judgment for the plaintiff;

(g) Judgment for the defendant;

(h) Judgment for the plaintiff after appeal; or

(i) Judgment for the defendant after appeal.

(4) Claim is settled by an alternative dispute resolution process, whether resolved by:

(a) Arbitration;

(b) Mediation;

(c) Private judging or private trial; or

(d) Other type of alternative dispute resolution process.

I. Timing of disposition—When reporting the timing of the claim disposition, the reporting entity must report whether the claim is settled:

(1) Before requesting arbitration, mediation, or private trial;

(2) Before trial, arbitration or mediation;

(3) During trial, arbitration or mediation;

(4) After trial or hearing, but before judgment or award;

(5) After judgment or decision, but before appeal;

(6) During an appeal;

(7) After an appeal; or

(8) During review panel or non-binding arbitration.

J. Indemnity payments and defense and cost containment expenses

(1) When reporting indemnity payments, the reporting entity must report payments on a gross basis and provide the total amount paid to the claimant to settle the claim. The reporting entity must not deduct the value of offsets or recoverables, such as:

(a) Reimbursement by the insured for a deductible;

(b) Reimbursement by a reinsurer ~~for claim payments~~or excess insuring entity; or

(c) Anticipated subrogation recoveries.

(2) When ~~damages~~ indemnity payments exceed the facility's or provider's policy limits, the reporting entity must report the total amount paid by all parties on behalf of the insured, including:

(a) The amount paid by all the insuring entit~~y~~ies. The actual amount paid may be higher or lower than the policy limit, depending on the settlement agreement.

(b) Additional payments made by the insured facility or provider to the claimant.

(3) Subrogation between insuring entities or self-insurers may occur ~~it~~ if there is a dispute over which entity should respond to a lawsuit. If an insuring entity or self-insurer receives a subrogation payment, it must report subrogation proceeds and any defense and cost containment expenses paid to obtain those proceeds. If necessary, the reporting entity may reopen the claim to report this information.

(4) Structured settlements

(a) If a claim is paid with a structured settlement agreement, the reporting entity must report the lump-sum payment for the purchase of the annuity.

(b) If a claim is paid with a combination of a lump-sum payment to the claimant and a structured settlement, the reporting entity must report the sum of both payments.

(5) If more than one claim is filed with a reporting entity due to an incident of medical malpractice, the reporting entity must report companion claim payments in this manner:

(a) Indemnity payments and defense and cost containment expenses paid to defend and settle each claim must be reported separately for each facility or provider.

(b) If indemnity payments are based on a trial verdict, the reporting entity must use the apportionment resulting from the verdict.

(c) If indemnity payments are not based on a trial verdict, t~~T~~he reporting entity must allocate indemnity payments ~~between defendants~~among facilities and providers based on an assessment of comparative fault.

(d) ~~–~~The reporting entity must allocate defense and cost containment expense payments based on the extent to which each ~~defendant~~ facility or provider benefited from the defense services.

~~(b) If the reporting entity makes payments in the absence of clear legal liability, it may allocate indemnity payments and defense and cost containment expenses equally among all defendants.~~

(e~~e~~) The reporting entity is responsible for ~~reporting incident level data~~assigning incident identifiers only for its own claims.

(6) When reporting defense and cost containment expenses, the reporting entity must report:

(a) Defense and cost containment expenses paid for defense counsel, including both in-house and outside counsel;

(b) Defense and cost containment expenses paid for experts ~~witnesses~~, including both in-house and outside experts;

(c) All other defense and cost containment expenses; and

(d) Total defense and cost containment expenses.

(7) When an insuring entity or self-insurer uses company employees, including professional medical staff and in-house legal counsel, to defend claims, the reporting entity:

(a) Must include in defense and cost containment expenses the salary, benefits and an allocation of overhead for those employees; and

(b) May use average salaries and the results of time studies when calculating these defense and cost containment expenses.

K. Estimation of economic and noneconomic damages

(1) If indemnity payments are the amounts awarded by a court for economic and noneconomic damages, respectively, the reporting entity must report those amounts.

(2) Otherwise, i~~I~~f a reporting entity makes indemnity payments to a claimant, the reporting entity must report the portion of the indemnity payments related to economic damages and the portion of the indemnity payments related to noneconomic damages based on documented evidence obtained during the claim resolution process. Reporting entities may not determine ~~economic damages~~these amounts using a fixed formula, such as fifty percent of total paid indemnity.

~~(2) When a reporting entity makes a best estimate of economic damages, the reporting entity must use reasonable judgment to estimate the following elements of loss:~~

~~(a) Medical expenses;~~

~~(b) Loss of earnings;~~

~~(c) Burial costs;~~

~~(d) Loss of use of property;~~

~~(e) Cost of replacement or repair;~~

~~(f) Cost of obtaining substitute domestic service; and~~

~~(e) Loss of business or employment opportunities.~~

~~(3) If a reporting entity makes indemnity payments to a claimant that include compensation for future economic damages, the reporting entity must estimate these future economic damages in the following manner:~~

~~(a) Project the elements of loss listed in subsection H(2) of this section for the duration of the injury or disability or, in the event of death, for the anticipated life span of the injured person;~~

~~(b) Discount damages to present value using reasonable discount factors; and~~

~~(c) Consider related factors, such as issues of negligence and liability, the relative strength of the defense, and the component of the indemnity payment driven by economic damages.~~

Comment [lb1]: The deletion of para. (2) may need further discussion, as Missouri did not participate in the May 18 call.

(43) The total indemnity payments must be equal to the sum of the reporting entity's best estimate of indemnity payments related to economic damages and the reporting entity's best estimate of indemnity payments related to noneconomic damages, and neither estimate may exceed the total indemnity payment.

F.y.i. The Model Law wording is provided here for reference during Guideline drafting and will not be attached to the Guideline upon completion.

MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING MODEL LAW

Table of Contents

Drafting Introductory Note: This model law pertains to the collection of data necessary to accomplish the purpose stated in Section 1. It is not intended to discourage states from collecting additional data for other purposes.

Section 1. Statement of Purpose

This Act is intended to ensure the availability of closed claim data necessary for thorough analysis and understanding of issues associated with medical professional liability claims, in order to support the establishment and maintenance of sound public policy.

Section 2. Definitions

As used in this Act:

A. "Claim" means:
   (1) A demand for monetary damages for injury or death caused by medical malpractice; or
   (2) A voluntary indemnity payment for injury or death caused by medical malpractice.

B. "Claimant" means a person, including a decedent's estate, who is seeking or has sought monetary damages for injury or death caused by medical malpractice.

C. "Closed claim" means a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, facility or provider. A claim may be closed with or without an indemnity payment to a claimant.

D. "Commissioner" means the commissioner of insurance.

E. "Companion claims" means separate claims involving the same incident of medical malpractice made against other providers or facilities.

F. "Economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services and loss of business or employment opportunities.

G. "Health care facility" or "facility" means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility or similar place where a health care provider provides health care to patients.

H. "Health care provider" or "provider" means:

(1) A person licensed to provide health care or related services, including an acupuncturist, doctor of medicine or osteopathy, a dentist, a nurse, an optometrist, a podiatric physician and surgeon, a chiropractor, a physical therapist, a psychologist, a pharmacist, an optician, a physician's assistant, a midwife, an osteopathic physician's assistant, a nurse practitioner or a physician's trained mobile intensive care paramedic. If the person is deceased, this includes his or her estate or personal representative; or

(2) An employee or agent of a person described in paragraph (1) of this subsection, acting in the course and scope of his or her employment. If the employee or agent is deceased, this includes his or her estate or personal representative.

I. "Insuring entity" means:
(1) An authorized insurer;
(2) A captive insurer;
(3) A joint underwriting association;
(4) A patient compensation fund;
(5) A risk retention group; or
(6) An unauthorized insurer that provides surplus lines coverage.

J. "Medical malpractice" means an actual or alleged negligent act, error, or omission in providing or failing to provide health care services.

K. "Noneconomic damages" means subjective, nonmonetary losses, including pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, humiliation and injury to reputation, and destruction of the parent-child relationship.

L. "Self-insurer" means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical professional liability.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears.

Drafting Note: If some of these terms are already defined elsewhere in this State's statutes, references to those statutes may be substituted for the definitions above. If some types of insuring entities are defined elsewhere in this State's statutes, those definitions may be cited.

Section 3. Applicability and Scope

This Act shall apply to all medical professional liability claims in this State, regardless of whether or how they are covered by medical professional liability insurance.

Section 4. Reporting Requirements

A. For claims closed on or after January 1, [insert year]:

(1) Every insuring entity or self-insurer that provides medical professional liability insurance to any facility or provider in this State must report each medical professional liability closed claim to the commissioner.

(2) A closed claim that is covered under a primary policy and one or more excess policies shall be reported only by the insuring entity that issued the primary policy. The insuring entity that issued the primary policy shall report the total amount, if any, paid with respect to the closed claim, including any amount paid under an excess policy, any amount paid by the facility or provider, and any amount paid by any other person on behalf of the facility or provider.

(3) If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties. Instances in which a claim may not be covered by an insuring entity or self-insurer include situations in which:

(a) The facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;

(b) The claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or

(c) The annual aggregate coverage limits had been exhausted by other claim payments.

(4) If a claim is covered by an insuring entity or self-insurer that fails to report the claim to the commissioner, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties.

(a) If a facility or provider is insured by a risk retention group and the risk retention group refuses to report closed claims and asserts that the federal liability risk retention act (95 Stat. 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility or provider must report all data required by this Act on behalf of the risk retention group.

(b) If a facility or provider is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by this Act on behalf of the unauthorized insurer.

(c) If a facility or provider is insured by a captive insurer and the captive insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by this Act on behalf of the captive insurer.

Drafting Note: When subsection A(4) applies, the State needs to consider inserting wording regarding who is responsible for notification to facilities and providers. Notification by either the domiciliary state regulator or the insurer must be provided in advance to insureds that they must produce all data required by this act upon behalf of the insurer.

B. Beginning in [insert year], reports required under subsection A of this section must be filed by March 1. These reports must include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years.

C. The commissioner may adopt rules that require insuring entities, self-insurers, facilities and providers to submit all required closed claim data electronically.

Drafting Note: Many State insurance codes specify penalties for failure to timely file statutorily required reports or for submitting materially incorrect data. Each State should determine the applicability of such penalties to this Act. If it is determined that the State does not possess an adequate means to enforce this Act, the State may wish to consider inserting additional enforcement wording in this section.

Drafting Note: The year inserted in subsection B should be the year following the year inserted in subsection A.

Section 5. Required Data Elements

Reports required under section 4 of this Act must contain the following information in a format and coding protocol prescribed by the commissioner. To the greatest extent possible while still fulfilling the purposes of this Act, the format and coding protocol shall be consistent with the format and coding protocol for data reported to the National Practitioner Data Bank.

A. Claim and incident identifiers, including:
   (1) A claim identifier assigned to the claim by the insuring entity, self-insurer, facility or provider; and
   (2) An incident identifier if companion claims have been made by a claimant;

B. The policy limits of the medical professional liability insurance policy covering the claim;

C. The medical specialty of the provider who was primarily responsible for the medical malpractice incident that led to the claim;

D. The type of health care facility where the medical malpractice incident occurred;

E. The primary location within a facility where the medical malpractice incident occurred;

F. The geographic location, by city and county, where the medical malpractice incident occurred;

G. The injured person's sex and age on the incident date;

H. The severity of malpractice injury using the National Practitioner Data Bank severity scale;

I. The dates of:
   (1) The earliest act or omission by the defendant that was the proximate cause of the claim;

(2) Notice to the insuring entity, self-insurer, facility or provider;
(3) Suit, if a suit was filed;
(4) Final indemnity payment, if any; and
(5) Final action by the insuring entity, self-insurer, facility or provider to close the claim;

J. Settlement information that identifies the timing and final method of claim disposition, including:

(1) Claims settled by the parties;
(2) Claims disposed of by a court, including the date disposed;
(3) Claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial and other common dispute resolution methods; and
(4) Whether the settlement occurred before or after trial, if a trial occurred;

K. Specific information about the indemnity payments and defense and cost containment expenses, including:

(1) For claims disposed of by a court that result in a verdict or judgment that itemizes damages:

(a) The indemnity payment made on behalf of the defendant;
(b) Economic damages;
(c) Non-economic damages;
(d) Punitive damages, if applicable; and
(e) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses; and

(2) For claims that do not result in a verdict or judgment that itemizes damages:

(a) The total amount of the settlement on behalf of the defendant;
(b) The insuring entity's or self-insurer's best estimate of economic damages included in the settlement;
(c) The insuring entity's or self-insurer's best estimate of noneconomic damages included in the settlement; and
(d) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses;

L. The reason for the medical professional liability claim. The reporting entity must use the same allegation group and specific allegation codes that are used for mandatory reporting to the National Practitioner Data Bank; and

M. Any other closed claim data the commissioner determines to be necessary to accomplish the purpose of this Act and requires by adopting a rule.

Section 6. Confidentiality of Data

Drafting Note: Each state should determine the extent to which the data collected may be made available to other parties and insert wording consistent with that determination. Options include:

- All data are available to the public.
- All data are subject to release under certain restricted conditions, such as to applicants submitting a research proposal and signing a confidentiality agreement.
- Only individual records that have been "anonymized" may be released. For example, the data can be anonymized to varying degrees by removing elements that may permit identification of

the parties to a case, by removing place references such as counties, and by limiting the representation of dates to the corresponding year.

- All data are confidential except data released in summary or aggregate form. Data would be aggregated to a high enough level that readers would not be able to deduce information on any particular provider, facility, claimant, or claim.

Section 7. Authority to Adopt Rules

The commissioner shall adopt any rules needed for implementing the provisions of this Act.

Section 8. Effective Date

This Act shall take effect on [insert date].

99 Cardinal Lane
Westwood, NJ 07675
June 1, 2009

Mr. John Purple, FCAS, MAAA
Casualty Actuarial and Statistical Task Force
National Association of Insurance Commissioners

Re: Premium Deficiency Reserve -- Reply to Comments & Teleconference Discussion

Dear Mr. Purple:

I am writing this second letter to provide my additional thoughts as pertain to the comment letters received and the discussion of this topic during the teleconference of the CASTF on May 12. I will address myself in turn to the major points raised, without particular regard to the order in which they were raised or by whom. The statements below reflect my own personal and professional opinion on these issues.

Zero PDR

It is very important that all companies' PDR be formally opined upon. I do not think there should be a "safe-harbor disclosure" of the adequacy of zero PDR unless it is in the form of an opinion signed by a qualified actuary. A disclosure or an attestation, particularly one by a non-actuary, may perpetuate the same problems that have apparently plagued the PDR since its institution: a widespread "hear no evil, see no evil" approach that relies heavily on conventional wisdom and underwriter reassurances in justifying a zero PDR. Clearly the PDR has in the past often been set in a casual way (sometimes even by actuaries; but without the formality and rigor imposed by an opinion requirement), with underwriting loss ratios used in the reserve and offsets across lines tacitly allowed -- all of these with the apparent, and usually successful, goal of justifying a zero reserve. This could best be changed by instituting an affirmative opinion from an appointed actuary. One way or another companies would have to perform the supporting analysis, especially if an attestation is to be required -- having the actuary review the analysis and sign an opinion is a small additional step if the analysis was done correctly.

Level of Guidance

For the most part the actuarial community should be able to craft reasonable practice in the light of existing accounting guidance, and extensive prescriptions should not be needed before implementing this requirement. It is not necessary to set a premium floor for by-line PDR considerations, for example; or to tell actuaries how to reflect expenses or investment income. Some literature already exists on this reserve, and practice will develop very quickly as the implementation date approaches.

Nevertheless, current practice seems to make it clear that some further guidance will be needed in certain areas. For example, it seems to be a widespread practice to evaluate the PDR at the level of "all commercial lines" and "all personal lines," when the SSAP #53 guidance requires that it be established "in a manner consistent with how policies are marketed, serviced and measured." I am nonplussed by this seemingly obvious disparity. Apparently it should be clarified in the Annual Statement Instructions, or in the SSAP, that the PDR is to be reviewed at the much finer level clearly implied by the SSAP language. It should also be made clear that the PDR is to be opined on separately, with its own reasonableness standard, and not commingled or aggregated with the loss reserve, the UPR, or any other reserve; and that profitable lines are not permitted to offset unprofitable ones in establishing the reserve.

Actuarial Involvement

This entire initiative falls squarely within the purview of the actuarial profession. Investment income and underwriting expenses are all part of the ratemaking process. I do not believe it is necessary to complicate the PDR requirement by ceding part or all of the responsibility to another profession. If the opining actuary needs input from another area (claims, underwriting, or accounting) to form his or her opinion, the actuary will certainly seek it.

The results of the surveys discussed on the call show very few non-zero PDR's, and a very low typical level of current actuarial involvement in this reserve. To me this argues in favor of an actuarial PDR requirement. The actuaries should be monitoring pricing already, and be familiar -- to a far greater extent than the accountants -- with all the components thereof. If the pricing is already being adequately monitored, it should be straightforward to convert that into a PDR estimate, whether zero or positive.

Cost / Benefit

Even substantial additional costs are justified if there is a sufficient benefit. I cannot agree that PDR is never important to short-duration contracts. Until actuaries begin reviewing them we cannot know how large they will be. We cannot reasonably presume they are already being set correctly. Plus, there is more to this reserve than accounting materiality: even a small PDR is valuable as a marker pointing up, almost in "real time", the existence of actuarially evaluated rate inadequacy.

Unlike long-duration contracts, PDR for short-duration contracts is strictly a function of rate adequacy, tempered by the treatment of prepaid expenses. To say that a single line's rate adequacy, as evaluated by an actuary, will almost never be poor enough to require a PDR almost seems disingenuous, given the uneven history of rate level adequacy in this industry, especially in highly regulated or highly competitive lines and states. Many significant inadequacies could be detected by the actuary at or near the time of policy writing if the actuary were involved in the rate setting or monitoring process, and were asked to convert this metric to a reserve.

Logistics / Other Details

It seems very reasonable to separate the PDR opinion from the loss reserve opinion, and to change the timing of the PDR opinion (if that can be reconciled with accounting requirements). It also seems reasonable to permit the appointed PDR actuary to be a different person than the loss reserve opinion signer.

I would argue, for consistency purposes, that the PDR should be reviewed and included in the opinion on both a "gross" (direct plus assumed) and "net" basis. It should be supported by an actuarial analysis in a manner similar to the loss reserve report.

* * *

Thank you for the opportunity to again comment on this important issue. I regret that I will be unable to attend the CASTF meeting at which this will be discussed on June 14, and hope the discussions continue to be productive and fruitful.

Sincerely,

Kenneth Quintilian, FCAS, MAAA
(212) 576-9743

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

	DATE: ??, 2009	**FOR NAIC USE ONLY**
CONTACT PERSON:	Kris DeFrain, NAIC Staff	Agenda Item #_____ Year _____ Changes to Existing Reporting [ ] New Reporting Requirement [ ]
ON BEHALF OF:	John Purple & Casualty Actuarial & Stat TF	**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**
NAME:	John Purple	No Impact [ ] Modifies Required Disclosure [ ]
TITLE:	Chair, Casualty Actuarial & Stat TF	**DISPOSITION**
AFFILIATION:	Connecticut Department of Insurance	[ ] Rejected For Public Comment [ ] Referred To Another NAIC Group [ ] Received For Public Comment [ ] Adopted [ ] Rejected [ ] Deferred [ ] Other (Specify)_____
ADDRESS:	P.O. Box 816 Hartford, CT 06142	
TELEPHONE:	860-297-3856	

BLANK(S) TO WHICH PROPOSAL APPLIES

[X] **ANNUAL STATEMENT** [ ] **QUARTERLY STATEMENT** [ ] **INSTRUCTIONS**

[ ]	Life and Accident & Health	[X]	Property/Casualty	[ ]	Health
[ ]	Separate Accounts	[ ]	Fraternal	[ ]	Title
[ ]	Other Specify				

Anticipated Effective Date: 2010 Annual Statement

IDENTIFICATION OF ITEM(S) TO CHANGE

While the option currently exists, this creates a requirement to express an opinion in the Statement of Actuarial Opinion about premium deficiency reserves.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Currently there is no requirement to express an opinion in the Statement of Actuarial Opinion about premium deficiency reserves. Because these reserves can be significant and in some cases reserves are not even being booked when they should be, we believe an opinion should be required.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:_____

Other Comments:

**** This section must be completed on all forms.** **Revised 01/18/05**

ACTUARIAL OPINION

1. There is to be included or attached to Page 1 of the Annual Statement, the statement of a Qualified Actuary, entitled "Statement of Actuarial Opinion," setting forth his or her opinion relating to reserves specified in the SCOPE paragraph. The Actuarial Opinion, both the narrative and required Exhibits, shall be in the format of and contain the information required by this Section of the *Annual Statement Instructions Property and Casualty*. The Qualified Actuary must be appointed by the Board of Directors, or its equivalent, or by a committee of the Board, by December 31 of the calendar year for which the opinion is rendered.

   If an actuary who was the Appointed Actuary for the immediately preceding filed Actuarial Opinion is replaced by an action of the Board of Directors, the insurer shall within five (5) business days notify the Insurance Department of the state of domicile of this event. The insurer shall also furnish the domiciliary Commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty four (24) months preceding such event there were any disagreements with the former Appointed Actuary regarding the content of the opinion on matters of the risk of material adverse deviation, required disclosures, scopes, procedure, or data quality. The disagreements required to be reported in response to this paragraph include both those resolved to the former actuary's satisfaction and those not resolved to the former actuary's satisfaction. The insurer shall also in writing request such former actuary to furnish a letter addressed to the insurer stating whether the actuary agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he does not agree; and the insurer shall furnish such responsive letter from the former actuary to the domiciliary Commissioner together with its own.

   The Appointed Actuary must report to the Board of Directors or the Audit Committee each year on the items within the scope of the Actuarial Opinion. The Actuarial Opinion and the Actuarial Report must be made available to the Board of Directors. The minutes of the Board of Directors should indicate that the Appointed Actuary has presented such information to the Board of Directors or the Audit Committee and that the Actuarial Opinion and the Actuarial Report were made available. A separate Actuarial Opinion is required for each company filing an Annual Statement. When there is an affiliated company pooling arrangement, one Actuarial Report for the aggregate pool is sufficient, but there must be addendums to the Actuarial Report to cover non-pooled reserves for individual companies.

   The Statement of Actuarial Opinion and the supporting Actuarial Report and Workpapers, should be consistent with the appropriate Actuarial Standards of Practice (ASOPs), including but not limited to ASOPs 9, 23, and 36, as promulgated by the Actuarial Standards Board, and Statements of Principles adopted by the Casualty Actuarial Society.

1A. Definitions

   "Qualified Actuary" is a person who is either:

   (i) A member in good standing of the Casualty Actuarial Society, or

   (ii) A member in good standing of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries.

   "Insurer" means an insurer or reinsurer authorized to write property and/or casualty insurance under the laws of any state and who files on the Property and Casualty Blank.

   "Actuarial Report" means a document or other presentation, prepared as a formal means of conveying the actuary's professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the actuary's opinion or findings and that documents the analysis underlying the opinion. The expected content of the report is further described in paragraph 7.

   "Long Duration Contracts" refers to contracts, excluding financial guaranty contracts, mortgage guaranty contracts and surety contracts, that fulfill both of the following conditions: (1) the contract term is greater than or equal to thirteen months and (2) the insurer can neither cancel nor increase the premium during the contract term.

1B. Exemptions

An insurer who intends to file for one of the exemptions under this Section must submit a letter of intent to its domiciliary commissioner no later than December 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to December 31 of the same year if he or she deems the exemption inappropriate.

A copy of the approved exemption must be filed with the Annual Statement in all jurisdictions in which the company is authorized.

Exemption For Small Companies

An insurer that has less than $1,000,000 total direct plus assumed written premiums during a calendar year, and less than $1,000,000 total direct plus assumed loss and loss adjustment expense reserves at year-end, in lieu of the Actuarial Opinion required for the calendar year, may submit an affidavit under oath of an officer of the insurer that specifies the amounts of direct plus assumed written premiums and direct plus assumed loss and loss adjustment reserves.

Exemption for Insurers under Supervision or Conservatorship

Unless ordered by the domiciliary commissioner, an insurer that is under supervision or conservatorship pursuant to statutory provision is exempt from the filing requirements contained herein.

Exemption for Nature of Business

An insurer otherwise subject to the requirement and not eligible for an exemption as enumerated above may apply to its domiciliary commissioner for an exemption based on the nature of business written.

Financial Hardship Exemption

An insurer otherwise subject to this requirement and not eligible for an exemption as enumerated above may apply to the commissioner for a financial hardship exemption. Financial hardship is presumed to exist if the projected reasonable cost of the Actuarial Opinion would exceed the lesser of:

(i) One percent of the insurer's capital and surplus reflected in the insurer's latest quarterly statement for the calendar year for that the exemption is sought; or

(ii) Three percent of the insurer's direct plus assumed premiums written during the calendar year for which the exemption is sought as projected from the insurer's latest quarterly statements filed with its domiciliary commissioner.

1C. Special Requirements for Pooled Companies

The following paragraphs apply to companies that are members of an intercompany pooling arrangement whereby there is one lead company that has 100% of the pooled business and all other companies have a 0% share of the pool (no reported Schedule P data).

All companies in the pool shall submit a "pooled opinion" that includes a description of the pool, identification of the lead company, and a listing of all companies in the pool. The IRIS ratios, risk of material adverse deviation discussion, and other relevant comments shall relate to the pooled risks and to the surplus of the lead company.

Exhibits A and B for each company in the pool should represent the company's share of the pool and should reconcile to the financial statement for each company. For non-lead companies, the responses in Exhibit B to question 5 should be $0 and to question 6 should be "not applicable." Also for the non-lead companies, Exhibits A and B of the lead company should be attached as an addendum to the PDF file and/or hard copy being filed (but would not be reported by the non-lead company in their data capture).

2. The Statement of Actuarial Opinion must consist of an IDENTIFICATION paragraph identifying the Appointed Actuary; a SCOPE paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the actuary's work; an OPINION paragraph expressing his or her opinion with respect to such subjects; and one or more additional RELEVANT COMMENTS paragraphs. These four Sections must be clearly designated.

3. The IDENTIFICATION paragraph should specifically indicate the Appointed Actuary's relationship to the company, qualifications for acting as appointed actuary, date of appointment, and specify that the appointment was made by the Board of Directors, or its equivalent, or by a committee of the Board.

   A member of the American Academy of Actuaries qualifying under paragraph 1.A. (ii) must attach, each year, a copy of the approval letter from the Academy.

   These Instructions require that a "qualified actuary" prepare the Opinion. Nevertheless, if a person who does not meet the definition of a "qualified actuary" has been approved by the insurance regulatory official of the domiciliary state, the company must attach, each year, a letter from that official stating that the individual meets the state's requirements for rendering the Opinion.

4. The SCOPE paragraph should contain a sentence such as the following:

   "I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20__."

   Exhibit A should list those items and amounts with respect to which the Appointed Actuary is expressing an opinion. The premium deficiency reserve should be included in the scope of the opinion and the amount of the reserve should be included on the line titled "Other Premium Reserve". The appropriateness of a zero premium deficiency reserve should also be included in the opinion.

   Comment [k1]: Corrected from "non-zero"

   The Appointed Actuary should state that the items in the SCOPE, on which he or she is expressing an opinion, reflect the Loss Reserve Disclosure items (8 thru 13) in Exhibit B.

   The SCOPE paragraph should include a paragraph such as the following regarding the data used by the Appointed Actuary in forming the opinion:

   "In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by _____ (name, affiliation and relation to Company). I evaluated that data for reasonableness and consistency. I also reconciled that data to Schedule P – Part 1 of the company's current Annual Statement. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations as I considered necessary."

5. The OPINION paragraph should include a sentence that at least covers the points listed in the following illustration: "In my opinion, the amounts carried in Exhibit A on account of the items identified:

   A. Meet the requirements of the insurance laws of (state of domicile).

   B. Are computed in accordance with accepted actuarial standards and principles.

   C. ~~C.~~ Make a reasonable provision for all unpaid loss and loss expense obligations of the Company under the terms of its contracts and agreements."

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   ~~C.~~D. Make a reasonable provision for premium deficiency reserves.

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   If the Scope includes material Unearned Premium Reserves for Long Duration Contracts, the Opinion should cover the following illustration:

   E~~D~~. "Make a reasonable provision for the unearned premium reserves for long duration contracts of the Company under the terms of its contracts and agreements.

If there is any aggregation or combination of items in Exhibit A, the opinion language should clearly identify the combined items.

Insurance laws and regulations shall at all times take precedence over the actuarial standards and principles.

If the actuary has relied on the Actuarial Opinion of another actuary (such as for pools and associations, for a subsidiary, or for special lines of business), the other actuary must be identified by name and affiliation within the OPINION paragraph.

A statement of actuarial opinion should be made in accordance with one of the following sections (a-e). The actuary must explicitly identify in Exhibit B which category applies.

a. Determination of Reasonable Provision. When the stated reserve amount is within the actuary's range of reasonable reserve estimates, the actuary should issue a statement of actuarial opinion that the stated reserve amount makes a reasonable provision for the liabilities associated with the specified reserves.

b. Determination of Deficient or Inadequate Provision. When the stated reserve amount is less than the minimum amount that the actuary believes is reasonable, the actuary should issue a statement of actuarial opinion that the stated reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves.

c. Determination of Redundant or Excessive Provision. When the stated reserve amount is greater than the maximum amount that the actuary believes is reasonable, the actuary should issue a statement of actuarial opinion that the stated reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves.

d. Qualified Opinion. When, in the actuary's opinion, the reserves for a certain item or items are in question because they cannot be reasonably estimated or the actuary is unable to render an opinion on those items, the actuary should issue a qualified statement of actuarial opinion. Such a qualified opinion should state whether the stated reserve amount makes a reasonable provision for the liabilities associated with the specified reserves, *except for* the item, or items, to which the qualification relates. The actuary is not required to issue a qualified opinion if the actuary reasonably believes that the item or items in question are not likely to be material.

e. No Opinion. The actuary's ability to give an opinion is dependent upon data, analyses, assumptions, and related information that are sufficient to support a conclusion. If the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions, or related information, then the actuary may issue a statement of no opinion. A statement of no opinion should include a description of the reasons why no opinion could be given.

6. The Appointed Actuary must provide RELEVANT COMMENT paragraphs to address the following topics of regulatory importance.

a. Risk of Material Adverse Deviation

The Appointed Actuary must provide specific RELEVANT COMMENT paragraphs to address the risk of material adverse deviation. The actuary must identify the materiality standard and the basis for establishing this standard. The materiality standard must be disclosed in $US in Exhibit B: Disclosures. The actuary should explicitly state whether or not he or she reasonably believes that there are significant risks and uncertainties that could result in material adverse deviation. If such risk exists, the actuary should include an explanatory paragraph to describe the major factors, combination of factors, or particular conditions underlying the risks and uncertainties that the actuary reasonably believes could result in material adverse deviation. The explanatory paragraph should not include general, broad statements about risks and uncertainties due to economic changes, judicial decisions, regulatory actions, political or social forces, etc., nor is the actuary required to include an exhaustive list of all potential sources of risks and uncertainties.

b. Other Disclosures in Exhibit B

RELEVANT COMMENT paragraphs should describe the significance of each of the remaining Disclosure items in Exhibit B. The actuary should address the items individually and in combination when commenting on a material impact.

c. Reinsurance

RELEVANT COMMENT paragraphs should address retroactive reinsurance, financial reinsurance and reinsurance collectibility. Before commenting on reinsurance collectibility, the actuary should solicit information from management on any actual collectibility problems, review ratings given to reinsurers by a recognized rating service, and examine Schedule F for the current year for indications of regulatory action or reinsurance recoverable on paid losses over 90 days past due. The comment should also reflect any other information the actuary has received from management or that is publicly available about the capability or willingness of reinsurers to pay claims. The actuary's comments do not imply an opinion on the financial condition of any reinsurer.

Retroactive reinsurance refers to agreements referenced in SSAP No. 62, Property and Casualty Reinsurance, of the NAIC *Accounting Practices and Procedures Manual* (SSAP No. 62).

Financial reinsurance refers to contracts referenced in SSAP No. 62, of the NAIC *Accounting Practices and Procedures Manual* in which credit is not allowed for the ceding insurer because the arrangements do not include a transfer of both timing and underwriting risk that the reinsurer undertakes in fact to indemnify the ceding insurer against loss or liability by reason of the original insurance.

d. IRIS Ratios

If the company reserves will create exceptional values using the NAIC IRIS Tests for One-Year Reserve Development to Surplus, Two-Year Reserve Development to Surplus and Estimated Current Reserve Deficiency to Surplus, the actuary must include RELEVANT COMMENT on the factors that led to the unusual value(s).

e. Methods and Assumptions

If there has been any significant change in the actuarial assumptions and/or methods from those previously employed, that change should be described in a RELEVANT COMMENT paragraph.

7. The Actuarial Opinion must include assurance that an Actuarial Report and underlying actuarial workpapers supporting the actuarial opinion will be maintained at the company and available for regulatory examination for seven years. The Actuarial Report contains significant proprietary information. It is expected that the Report be held confidential and is not intended for public inspection. The report must be available by May 1 of the year following the year-end for which the opinion was rendered or within two weeks after a request from an individual state commissioner.

The Actuarial Report should be consistent with the documentation and disclosure requirements of ASOP #9. The Actuarial Report should contain both narrative and technical components. The narrative component should provide sufficient detail to clearly explain to company management, the regulator, or other authority the findings, recommendations and conclusions, as well as their significance. The technical component should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work. This technical component must show the analysis from the basic data, e.g., loss triangles, to the conclusions.

The Report must also include:

- An exhibit which ties to the Annual Statement and compares the Actuary's conclusions to the carried amounts;
- Summary exhibit(s) of either the actuary's best estimate, range of reasonable estimates, or both, that led to the conclusion in the OPINION paragraph regarding the reasonableness of the provision for all unpaid loss and loss adjustment expense obligations;

- Summary exhibit(s) that led to the conclusion in the OPINION paragraph regarding the reasonableness of premium deficiency reserves.

- Documentation of the required reconciliation from the data used for analysis to the Annual Statement Schedule P;

- Extended comments on trends that indicate the presence or absence of risks and uncertainties that could result in material adverse deviation; and

- Extended comments on factors that led to unusual IRIS ratios for One-Year Reserve Development to Surplus, Two-Year Reserve Development to Surplus, or Estimated Current Reserve Deficiency to Surplus, and how these factors were addressed in prior and current analyses.

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8. The statement should conclude with the signature of the Appointed Actuary responsible for providing the Actuarial Opinion and the date when the opinion was rendered. The signature and date should appear in the following format:

_____
Signature of actuary
Printed name of actuary
Address of actuary
Telephone number of actuary
Date opinion was rendered

9. The insurer required to furnish an Actuarial Opinion shall require its Appointed Actuary to notify its Board of Directors or its audit committee in writing within five (5) business days after any determination by the Appointed Actuary that the Opinion submitted to the domiciliary Commissioner was in error as a result of reliance on data or other information (other than assumptions) that, as of the balance sheet date, was factually incorrect. The Opinion shall be considered to be in error if the Opinion would have not been issued or would have been materially altered had the correct data or other information been used. The Opinion shall not be considered to be in error if it would have been materially altered or not issued solely because of data or information concerning events subsequent to the balance sheet date or because actual results differ from those projected.

Notification shall be required for any such determination made between the issuance of the Opinion and the balance sheet date that the next Opinion will be issued. The notification should include a summary of such findings and an amended Opinion.

An insurer who is notified pursuant to the preceding paragraphs shall forward a copy of the summary and the amended Opinion to the domiciliary Commissioner within five (5) business days of receipt of such and shall provide the Appointed Actuary making the notification with a copy of the summary and amended Opinion being furnished to the domiciliary Commissioner. If the Appointed Actuary fails to receive such copy within the five (5) business day period referred to in the previous sentence, the Appointed Actuary shall notify the domiciliary Commissioner within the next five (5) business days that the submitted Opinion should no longer be relied upon or such other notification recommended by the actuary's attorney.

If the Appointed Actuary learns that the data or other information relied upon was factually incorrect, but cannot immediately determine what, if any, changes are needed in the Actuarial Opinion, the actuary and the company should undertake as quickly as is reasonably practical those procedures necessary for the actuary to make the determination discussed above. If the insurer does not provide the necessary data corrections and other support (including financial support) within ten (10) business days, the actuary should proceed with the notification discussed above.

No Appointed Actuary shall be liable in any manner to any person for any statement made in connection with the above paragraphs if such statement is made in a good faith effort to comply with the above paragraphs.

10. Data in Exhibits A and B are to be filed in both print and data capture format.

Exhibit A: SCOPE
DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS

	Column 1 Amount
Loss Reserves:	
1. Reserve for Unpaid Losses (Liabilities, Surplus and Other Funds page, Col 1, Line 1)	$
2. Reserve for Unpaid Loss Adjustment Expenses (Liabilities, Surplus and Other Funds page, Col 1, Line 3)	$
3. Reserve of Unpaid Losses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 13 and 15, Line 12 * 1000)	$
4. Reserve for Unpaid Loss Adjustment Expenses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 17, 19 and 21, Line 12 * 1000)	$
5. The Page 3 write-in item reserve, "Retroactive Reinsurance Reserve Assumed"	$
6. Other Loss Reserve items on which the Appointed Actuary is expressing an Opinion (list separately)	$
Premium Reserves:	
7. Reserve for Direct and Assumed Unearned Premiums for Long Duration Contracts	$
8. Reserve for Net Unearned Premiums for Long Duration Contracts	$
9. Other Premium Reserve items on which the Appointed Actuary is expressing an Opinion (list separately)	$

Exhibit B: DISCLOSURES
DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS

NOTE: Exhibit B should be completed for Net dollar amounts included in the SCOPE. If an answer would be different for Direct and Assumed amounts, identify and discuss the difference within RELEVANT COMMENTS.

	Column 1	Column 2	Column 3	Column 4
1. Name of the Appointed Actuary		Last	First	Mid
2. The Appointed Actuary's Relationship to the Company. Enter E or C based upon the following: E if an Employee; C if a Consultant				
3. The Appointed Actuary is a Qualified Actuary based upon what qualification? Enter F, A, M, or O based upon the following: F if a Fellow of the Casualty Actuarial Society (FCAS); A if an Associate of the Casualty Actuarial Society (ACAS); M if not a member of the Casualty Actuarial Society, but a Member of the American Academy of Actuaries (MAAA) approved by the Casualty Practice Council, as documented with the attached approval letter.; O for Other				

4. Type of Opinion, as identified in the OPINION paragraph. Enter R, I, E, Q, or N based upon the following:
   - R if Reasonable
   - I if Inadequate or Deficient Provision
   - E if Excessive or Redundant Provision
   - Q if Qualified. Use Q when part of the OPINION is Qualified.
   - N if No Opinion
5. Materiality Standard expressed in US dollars (Used to Answer Question #6) $
6. Is there a Significant Risk of Material Adverse Deviation? Yes [ ] No [ ] Not Applicable [ ]
7. Statutory Surplus (Liabilities, Col 1, Line 35) $
8. Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P (should equal Part 1 Summary, Col 23, Line 12 * 1000) $
9. Discount included as a reduction to loss reserves and loss expense reserves as reported in Schedule P
   - 9.1 Nontabular Discount [Notes, Line 31B23, (Amounts 1, 2, 3 & 4)], Electronic Filing Cols 7, 8, 9, & 10, $
   - 9.2 Tabular Discount [Notes, Line 31A23, (Amounts 1 & 2)], Electronic Filing Col 7 & 8. $
10. The net reserves for losses and expenses for the company's share of voluntary and involuntary underwriting pools' and associations' unpaid losses and expenses that are included in reserves shown on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines. $
11. The net reserves for losses and loss adjustment expenses that the company carries for the following liabilities included on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines. *
    - 11.1 Asbestos, as disclosed in the Notes to Financial Statements (Notes, Line 32A03D, ending net asbestos reserves for current year) Electronic Filing Col 11 $
    - 11.2 Environmental, as disclosed in the Notes to Financial Statements (Notes, Line 32D03D, ending net environmental reserves for current year), Electronic Filing Col 11 $
12. The total claims made extended loss and expense reserve (Schedule P Interrogatories).
    - 12.1 Amount reported as loss reserves $
    - 12.2 Amount reported as unearned premium reserves $
13. Other items on which the Appointed Actuary is providing Relevant Comment (list separately) $_____

* The reserves disclosed in item 11 above, should exclude amounts relating to contracts specifically written to cover asbestos and environmental exposures. Contracts specifically written to cover these exposures include Environmental Impairment Liability (post 1986), Asbestos Abatement, Pollution Legal Liability, Contractor's Pollution Liability, Consultant's Environmental Liability, and Pollution and Remediation Legal Liability.

Statement of Actuarial Opinion Electronic Data Filings
Letters to Vendors and Companies

DRAFT 5/18/09

Letter to Vendors
From John Purple, chair
Re: Electronic Data Submission from the P&C Statement of Actuarial Opinion

Given that the requirements for insurance companies to submit electronic data from their Appointed Actuary's Property/Casualty Statement of Actuarial Opinion is relatively new, the NAIC's Casualty Actuarial and Statistical (C) Task Force would like to draw your attention to a few areas in need of improvement.

First, we have found that the implementation of cross-checks sent the wrong signal to you as vendors and perhaps implied that these numbers could be pre-populated for your companies from other parts of the annual statement. However, this is not the case. **The numbers need to be entered by companies to match the numbers in Exhibits A and B of the Statement of Actuarial Opinion supplied by the designated Appointed Actuary.** The appointed actuary's Opinion and Exhibits are the only relevant source for this table.

Second, **there are many companies who have not submitted data at all**. There will be some companies who are exempt from filing a Statement of Actuarial Opinion, however all others are required to submit data.

And last, **there are numerous invalid entries in the data submissions**. We will be implementing new cross-checks to catch invalid entries going forward.

Thank you for attention to these three matters and for helping to improve the actuarial opinion data submissions.

Sincerely,
John Purple

Optional Letter to be sent by the state to a Company

Dear ___Company's Annual Statement contact__,

We have noticed the following error(s) in your submission of electronic data from the Property/Casualty Statement of Actuarial Opinion. Would you please correct the error and resubmit the electronic data to the NAIC.

[Alternatively, "Would you please fix this error with your submission next year.]

- The data entered does not match that supplied by your Appointed Actuary in the Statement of Actuarial Opinion. This may be a situation where the vendor pre-populated the numbers from the annual statement or there may be a data entry error where the wrong key was pushed. The data submission needs to match the actuary's document.
- The data submission was incomplete and not all entries were submitted.

[Note – these are Drafting Choices, so choose the bullet that is appropriate for the particular company.]

Thank you for your attention to this matter.

Sincerely,
_____Signature____

Optional Letter to be sent to all Companies
The letter to companies above would come after the comparison reveals a failure to match the SAO. Another option would be a preemptive strike prior to year-end 2009.

From John Purple, chair *(or from each state to their domestics)*
Re: Electronic Data Submission from the P&C Statement of Actuarial Opinion

Dear ___Company's Annual Statement contact__,

The requirements for insurance companies to submit electronic data from their Appointed Actuary's Property/Casualty Statement of Actuarial Opinion is relatively new. The Casualty Actuarial and Statistical (C) Task Force identified a number of errors in the data submissions. We would like to draw your attention to two areas in need of attention.

First, entries in the electronic filing need to be drawn **directly and exactly** from Exhibits A and B of the Statement of Actuarial Opinion supplied by the designated Appointed Actuary. The appointed actuary's Opinion and Exhibits are the only relevant source for this table. If differences from numbers in the remainder of the annual statement exist, you need to resolve the issue with the actuary prior to submitting the electronic filing.

Second, **there are numerous invalid entries in the data submissions**. For example, Exhibit B, Line 2, column 2 should be "E" or "C" and nothing else. Please refer to the document prepared by your Appointed Actuary and the Annual Statement Instructions.

Thank you for attention to these matters and for helping to improve the actuarial opinion data submissions.

From: DeFrain, Kris [kdefrain@naic.org]
Sent: Tuesday, June 16, 2009 11:29 AM
To: DeFrain, Kris
Subject: FW: CASTF June 14 Meeting & Documents

At the CASTF meeting June 14, Ralph Blanchard asked to have his written comments about PDR distributed to supplement what he said orally at the meeting. Here are those comments.

It was nice seeing those in attendance in Minneapolis. Look in Monday's NAIC "Daily News" for a picture of John Purple on page 3 with the announcement of CASTF's recognition of his leadership and service to the NAIC.
http://www.naic.org/meetings0906/03_daily_monday.pdf

Kris

From: Blanchard III,Ralph S [mailto:RBLANCHA@travelers.com]
Sent: Monday, June 08, 2009 4:38 PM
To: DeFrain, Kris
Subject: RE: CASTF June 14 Meeting & Documents

Kris,

I was not able to respond in time for the deadline (due to CAS travel demands), but would like to add the following if possible. (I will also mention this orally during the June 14th meeting).

Ralph

To the CASTF for consideration during the PDR discussion:

Regarding the level of detail at which the PDR is required to be calculated, please note that the existing SSAP 53 wording was meant to be consistent with the current FAS 60 requirement. Note the following comparison (with the fonts changed to highlight the relevant wording):

1. FAS 60 language (paragraph 32) says:
"… Insurance contracts shall be grouped consistent with the enterprise's manner of acquiring, servicing, and measuring the profitability of its insurance contracts to determine if a premium deficiency exists."

2. SSAP 53 language (paragraph 15) says:
"… For purposes of determining if a premium deficiency exists, insurance contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured."

As can be seen, the language is nearly identical. This was the clear intent of the drafters, as was evident during the dialog at the time (which I was a party to). The intent was to minimize any unnecessary differences between statutory and GAAP accounting in the U.S.. As U.S. GAAP currently treats the segmentation for PDR calculations to be generally consistent with that used for determining reporting segments, the drafters intended such a similar aggregation to be applied for statutory. FYI, most companies have only a few reporting segments, such as personal versus commercial lines.

Any desire for more detailed analysis would probably require a change to SSAP 53.

Ralph Blanchard

P.S. I would not support a requirement for a more detailed PDR breakdown. That would not be consistent with how the loss reserve is handled, as the actuarial opinion is only with regard to the reserve in the aggregate, and not by Schedule P line or some other fine level of detail. In addition, if the focus is solvency, then please consider the fact that solvency is only considered on a legal entity basis and not on a line of business basis.

From: DeFrain, Kris [mailto:kdefrain@naic.org]
Sent: Friday, June 05, 2009 6:19 PM
To: DeFrain, Kris
Subject: CASTF June 14 Meeting & Documents

Casualty Actuarial and Statistical (C) Task Force

Minneapolis Meeting

Sunday, June 14, 2009

1:00-2:30 p.m. Central

Documents will be loaded to the website next week: http://www.naic.org/committees_c_catf.htm

Agenda:

1. Discuss Premium Deficiency Reserves Blanks Proposal (See the April proposal that is not yet updated and an additional comment letter from Ken Quintilian)

2. Discuss Actuarial Opinion Data Collection (See document)
3. Discuss *Guideline for Implementation of Medical Professional Liability Closed Claim Reporting* (See document)
4. Discuss Other NAIC Work
5. Discuss American Academy of Actuaries' Work
6. Consider Interim Minutes and Reports

    - Interim Call Minutes (See document)
    - Profitability Report (C) Working Group Summary (See document)
    - Subgroup Summaries: Catastrophe Modeling Subgroup, Line of Business Subgroup, Statistical Subgroup, and Workers' Compensation Large Deductible Subgroup (See document)

7. Any Other Business

<<Casualty Actuarial_Stat.doc>> <<Premium Deficiency Apr 8 proposal_2.doc>> <<PDR Quintilian follow-up comment letter.doc>> <<SAO Data Errors May 18 version.doc>> <<med liab closed claim (6-8-09) Part A only.doc>> <<05-12 min-REV.doc>> <<Profit WG Summary.doc>> <<Subgroup Reports.doc>>

calling the NAIC Help Desk at (816)783-8500.
