NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Financial Analysis Handbook

Property/Casualty

Life/A&H

Health

Title

2025 Annual
2026 Quarterly

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Financial Analysis Handbook

Property/Casualty, Life/A&H, Health

2025 Annual/2026 Quarterly Edition

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

The NAIC is the authoritative source for insurance industry information. Our expert solutions support the efforts of regulators, insurers and researchers by providing detailed and comprehensive insurance information. The NAIC offers a wide range of publications in the following categories:

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Information about statutory accounting principles and the procedures necessary for filing financial annual statements and conducting risk-based capital calculations.

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Important answers to common questions about auto, home, health and life insurance — as well as buyer's guides on annuities, long-term care insurance and Medicare supplement plans.

Financial Regulation
Useful handbooks, compliance guides and reports on financial analysis, company licensing, state audit requirements and receiverships.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: **1/1/2026**

To: **Users of the NAIC's Financial Analysis Handbook**

From: **NAIC Staff**

This edition of the *NAIC Financial Analysis Handbook* (Handbook) is to be used in conjunction with the 2025 Annual and 2026 Quarterly Financial Statements. The following summarizes the most significant changes since the prior edition:

Guidance Related to Contractor Oversight

I.A Department Organization and Communication

II. Framework

The Risk-Focused Surveillance (E) Working Group received a referral from the Financial Regulation Standards and Accreditation (F) Committee related to standards and expectations for state insurance departments in using contractors to conduct financial analysis and examination projects. The guidance is consistent with the Financial Condition Examiners Handbook and the Accreditation Review Team Guidelines.

Branded Risk General Guidance

III.A.7 Use of Branded Risk General Guidance

The General Guidance in each branded risk assessment was removed to eliminate redundancy, and this section was renamed to Use of Branded Risk General Guidance and applies to all branded risks. Guidance was added to encourage analysts to customize risk component names.

Principal Based Bond Definition

III.B.1 Credit Risk Assessment

III.B.3 Liquidity Risk Assessment

III.B.4 Market Risk Assessment

Beginning in 2025, investment schedules and certain other Notes to the Financial, General Interrogatories, 5-Year History, and related pages of the quarterly and annual financial statement were amended for the implementation of the statutory accounting principles-based bond definition (PBBD) revisions.

Separate Accounts General Interrogatories Disclosures on Guarantees

III.B.8.b.i Reserves Life Statement of Actuarial Opinion

III.B.8.b.ii Reserves Life Risk Assessment

Updates to the life reserves risk assessment chapter include guidance and a procedure on the new disclosures under *Actuarial Guideline LV – Application of the Valuation Manual for Testing the Adequacy of Reserves Related to Certain Life Reinsurance Treaties* (AG 55) related to asset adequacy testing (AAT) on reinsurance. There are additional updates related to statutory financial statement blanks changes for separate account guarantees.

Notes to the Financial Statement

IV.B. Notes

There were several Statutory Financial Statement Blanks Instruction changes that impacted notes to the financials, tax credit structures withheld, commitments and financing arrangements, reinsurance, and health care receivables.

Risk Assessment Insurer Profile Summary (IPS) and Group Profile Summary (GPS) Examples

III.A.5 Risk Assessment IPS Example

VI.C.1 GPS Example

Updates to the IPS and GPS examples were proposed by committee support. One of the updates was a description of a reinsurance program in the Business Summary section of the IPS. This description is from the Interrogatory on Catastrophe Reinsurance PR027A. The description of a reinsurance program was also summarized in the "Strategic" branded risk. Another update was the removal of the optional "Other" branded risk.

If you have questions regarding the Financial Analysis Handbook, contact: Ralph Villegas, Life/A&H Financial Analysis Manager at (816) 783-8411, rvillegas@naic.org; Rodney Good, Property/Casualty Financial Analysis Manager at (816) 786-8430, rgood@naic.org; or John Murray, Health Financial Analysis Program Manager at (816) 783-8142, jmurray@naic.org.

PROCEDURES OF THE FINANCIAL ANAYLSIS SOLVENCY TOOLS (E) WORKING GROUP IN CONNECTION WITH PROPOSED AMENDMENTS TO THE *FINANCIAL ANALYSIS HANDBOOK*

The following establishes procedures of the Financial Analysis Solvency Tools (E) Working Group ("the Working Group") for proposed changes, amendments and/or modifications to the NAIC *Financial Analysis Handbook* ("the Handbook").

1. The Working Group may consider relevant proposals to change the Handbook at any conference call, interim or national meeting ("the meeting") throughout the year as scheduled by the Working Group.

2. If a proposal for suggested changes, amendments and/or modifications is submitted to, or filed with, NAIC staff support it may be considered at the next regularly scheduled meeting of the Working Group.

3. The Working Group publishes a formal submission form and instructions that can be used to submit proposals and is available on the Group's webpage. However, proposals may also be submitted in an alternate format provided that they are stated in a concise and complete format. In addition, if another NAIC committee, task force or working group is known to have considered this proposal, that committee, task force or working group should provide any relevant information.

4. Any proposal that would change the Handbook will be effective for analysis conducted in the year following the NAIC Fall National Meeting (i.e. of the preceding year) in which it was adopted (e.g., a change proposed to be effective January 1, 2027 must be adopted no later than the 2026 Fall National Meeting).

5. Upon receipt of a proposal, the Working Group will review the proposal at the next scheduled meeting and determine whether to consider the proposal for public comment. The public comment period shall be thirty days unless extended by the Working Group. The Working Group will consider comments received on each proposal at its next meeting and take action. Proposals under consideration may be deferred by the Working Group until the following scheduled meeting. The Working Group may form an ad hoc group to study the proposal, if needed. The Working Group may also refer proposals to other NAIC committees for technical expertise or review. If a proposal has been referred to another NAIC committee, the proposal will come off the Working Group's agenda until a response has been received.

6. NAIC staff support will prepare an agenda inclusive of all proposed changes. The agenda and relevant materials shall be sent via e-mail to each member of the Working Group, interested regulators and interested parties and posted to the Working Group's webpage approximately 5-10 business days prior to the next regularly scheduled meeting during which the proposal would be considered.

7. In rare instances, or where emergency action may be required, suggested changes and amendments can be considered as an exception to the above stated process and timeline based on a two-thirds majority consent of the Working Group members present.

8. NAIC staff support will publish the Handbook on or about February 1 each year. NAIC staff will post to the NAIC Publications Web site any material subsequent corrections to these publications.

EXAMINATION OVERSIGHT (E) TASK FORCE
FINANCIAL ANALYSIS SOLVENCY TOOLS (E) WORKING GROUP

SUBMIT TO
NAIC – KC
By June 1, 2026

Financial Analysis Handbook Proposed Revision Form

INSTRUCTIONS	FOR NAIC USE ONLY
1. Complete this form for EACH Handbook proposal. Under "Identification of Item(s) to be Changed," include section & page number, line or item identifier. 2. All attachments should be presented in a format wherein new language is underscored and deletions struck through. 3. Please consider whether this revision proposal is also addressed elsewhere in the Handbook. 4. CAUTION: before completing this form, please read additional instructions on reverse side of this form.	DISPOSITION [ ] ADOPTED [ ] REJECTED [ ] DEFERRED [ ] OTHER (SPECIFY) [ ] _____
DATE: _____ NAME: _____ TITLE: _____ STATE: _____ ADDRESS: _____ TELEPHONE: _____ CONTACT PERSON : _____	NOTES

HANDBOOK SECTION NAME AND NUMBER TO WHICH PROPOSAL APPLIES

If STATEMENT TYPE SPECIFIC, ALSO IDENTIFY THE TYPE:

[ ] Life/A&H [ ] Property & Casualty [ ] Title [ ] Health

IDENTIFICATION OF ITEM(S) TO BE CHANGED

REASON OR JUSTIFICATION FOR CHANGE **
(STATE, IN SPECIFIC TERMS, THE BENEFIT TO BE DERIVED FROM THIS PROPOSAL)

**** This section must be completed on all forms.**

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Additional Instructions and Information

The Financial Analysis Solvency Tools (E) Working Group meets via conference call throughout the year to consider proposed changes to the NAIC *Financial Analysis Handbook* (Handbook). Suggestions to the Handbook should be submitted by **June 1, 2026**. Send proposals via email to Ralph Villegas, Life/Health Financial Analysis Manager, rvillegas@naic.org, or send to Rodney Good, Property/Casualty Financial Analysis Manager, rgood@naic.org. Original copies may be sent to:

National Association of Insurance Commissioners
Financial Analysis & Examination Unit
Financial Regulatory Services Department
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

For questions, call the Financial Analysis & Examination Unit at (816) 842-3600.

Proposed Revisions

- During the Working Group's review, changes proposed via this form will be considered along with an analysis conducted by the NAIC Financial Analysis & Examination Unit of the effectiveness and usefulness of procedures, ratio limits and language.

- The NAIC Financial Analysis & Examination Unit also studies adopted changes to the Annual Statements and provides revision proposals to the Working Group. The NAIC Financial Analysis & Examination Unit automatically makes changes to the Handbook for minor changes, such as for page and line numbers.

- The Handbooks are automated on i-Site+. The Handbook is intended to be a dynamic tool. The Working Group is interested in feedback on both analytical and software features. Please contact the NAIC Help Desk at (816) 842-3600 before submitting a form. Many enhancements have been proposed which could not be implemented. Also, some proposals may relate to existing features that the Help Desk may be able to explain.

**** This section must be completed on all forms.**

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Preface

The NAIC *Financial Analysis Handbook* (Handbook) was developed and originally released by the NAIC in 1997 for Property/Casualty and Life/A&H, and in 2004 for Health. It is maintained by the Financial Analysis Solvency Tools (E) Working Group of the Examination Oversight (E) Task Force. In 2017, the Handbook was revised to incorporate a risk-focused framework approach for financial analysis. This analysis framework identifies and assesses risks based on the nine branded risk classifications to complete and document an overall assessment of the financial solvency condition of the insurer and insurance holding company group.

The Handbook does not include state-specific information or regulations and does not establish guidelines that insurance companies must follow. Parameters or benchmarks utilized within the guidance are not regulatory requirements to be complied with by insurance companies.

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B. Interstate Communication and Cooperation

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D. NAIC Information

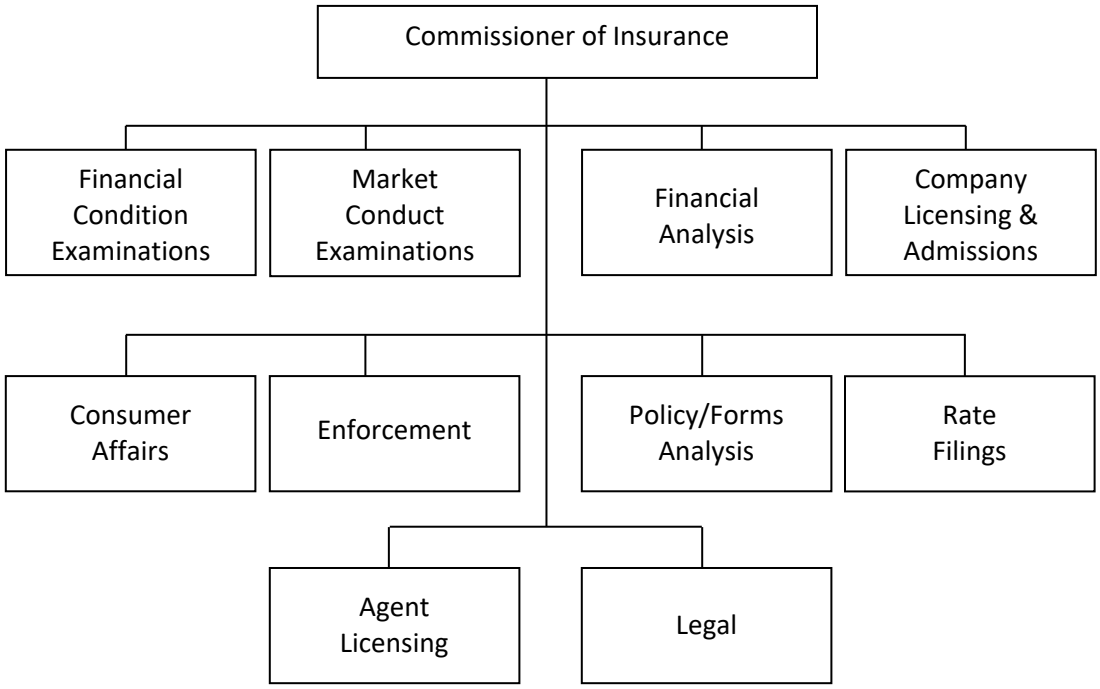
E. SAP vs. GAAP

F. Prioritization of Work

ORGANIZATION CHART

The organizational structure of a state insurance department varies by state. There are several basic functions that are performed by all departments. It is important for the analyst to understand the purpose of each function and the information obtained that may assist the analyst in the financial monitoring and solvency surveillance process. Due to the variance in organizational structure, the chart below depicts typical state insurance department functions rather than trying to highlight a typical organizational structure.

Chart of State Insurance Department Functional Units



In many states, more than one of the above functions may be performed or supervised by the same individuals. For example, financial analysts may also perform financial examinations, and financial examiners may also perform market conduct examinations. Additionally, some state insurance departments rely on the Attorney General's office for legal assistance rather than having separate department counsel.

RISK-FOCUSED FINANCIAL CONDITION EXAMINATIONS

The insurance code in most states allows the state insurance department to examine insurers as often as the insurance commissioner deems appropriate and requires that each insurer be examined at least once every three to five years (as determined by each state). Risk-focused financial condition examinations performed by the state insurance departments include full-scope periodic examinations and limited-scope or targeted examinations, which focus on the review and evaluation of an insurer's business process and controls (including the quality and reliability of corporate governance) to assist in assessing and monitoring its current financial condition and prospective solvency. Through the risk-focused financial condition examinations, the state insurance department gains knowledge about all aspects of the insurer, including its risk management practices and key business activities, which can be useful information to incorporate into the department's ongoing solvency analysis.

The results of a financial condition examination are documented in an examination report that assesses the financial condition of the insurer and sets forth findings of fact (together with citations of pertinent laws,

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regulations, and rules) with regard to any material adverse findings disclosed by the examination. Examiners complete Exhibit AA – Summary Review Memorandum (SRM), or something similar, at the conclusion of the exam. The SRM includes discussion of potential ongoing or prospective solvency concerns, corporate governance, examination adjustments, risk mitigation strategy issues, report findings, management letter comments, responses to issues raised by financial analysts, subsequent events, and other residual risks the examiner may want to communicate to state insurance department personnel. The SRM is a useful tool to communicate information and findings to the analyst, chief examiner, and other state insurance regulators. The final section of the SRM, prioritization level and changes to the supervisory plan, provides discussion of the examiner's overall conclusions regarding ongoing monitoring, including specific follow-up recommended to the analyst.

Additionally, key documents should be available to analysts, including examination reports and management letter comments, which may also include corrective actions required to be taken by the insurer and/or recommendations for improvements.

MARKET CONDUCT EXAMINATIONS

The market conduct examination focuses on such areas as sales, advertising, rating, and the handling of claims. Market conduct examinations evaluate an insurer's business practices and its compliance with statutes and regulations relating to dealings with policyholders and claimants. The results of a market conduct examination are documented in an examination report, which summarizes examination findings so that the insurer's performance can be assessed. The report may also recommend a corrective action to deal with significant problem areas. Because financial conditions and market conduct problems are often interrelated, examinations are frequently conducted simultaneously. Market conduct examinations are conducted by financial condition examiners in many of the states, usually an impact of the size of the state insurance department.

RISK-FOCUSED FINANCIAL ANALYSIS

Risk-focused financial analysis provides continuous off-site monitoring of the state's domestic insurers' financial condition, significant internal/external changes relating to all aspects of the insurer, maintains a prioritization system, provides input into the state insurance department's priority of each insurer, works with the examination staff to develop an ongoing Supervisory Plan and updates the Insurer Profile Summary (IPS), providing department management with timely information of significant events relating to the domestic insurers in assessing prospective risks. The analyst should refer to all available information to monitor the insurer's statutory compliance and solvency on a continuous basis in coordination with the periodic on-site field examination process. As part of the analysis process and the review of the examination report and summary review memorandum, the analyst should incorporate into his/her analysis information gained about the corporate governance and risk management processes of the insurer. If desired, regulators can request the IPS, if applicable, for non-domestic insurers from the domestic or lead state.

As a result of concerns identified during the risk-focused financial analysis process, the insurance department may take a variety of actions, including but not limited to contacting the insurer seeking explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting from the insurer, calling for a targeted or limited-scope financial condition examination, engaging an independent expert to assist in determining whether a problem exists, meeting with the insurer's management, obtaining a corrective plan from the insurer, and/or restricting, suspending, or revoking an insurer's Certificate of Authority.

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Financial Analyst Qualifications

Financial analysts and supervisors (including those reviewing contract supervisor work) should generally have an accounting, insurance, financial analysis and/or actuarial background, and insurance backgrounds should primarily be financial in nature. College degrees should generally focus on accounting, insurance, finance, business, risk management, or actuarial science. Professional designations and credentials (i.e., AFE/CFE, APIR/PIR, CPA, CPCU, FLMI) may also demonstrate expertise in insurance and/or financial analysis.

Financial Analyst Salary Guidelines

The compensation guidelines in this section of the Handbook were developed in recognition of the importance of compensation particularly as it affects an Insurance Department's ability to hire and retain well-qualified employees. The guidelines were developed based on surveys of analyst pay across Insurance Departments, as well as external comparisons to other similar professions, including other financial regulators, internal auditors, and external auditors. In using the information below, the following are brief descriptions of the associated positions listed:

Financial Analyst
Financial analysts are responsible for conducting a risk-focused financial analysis on assigned insurers under the supervision of an analyst supervisor. The financial analyst reviews annual and quarterly insurer financial statements and all related supplemental regulatory filings to assess and monitor the current financial condition and prospective financial solvency of insurance companies.

Senior Financial Analyst
Senior financial analysts are responsible for conducting a risk-focused financial analysis on assigned insurers under the supervision of the supervising analyst. The senior financial analyst reviews annual and quarterly insurer financial statements and all related supplemental regulatory filings to assess and monitor the current financial condition and prospective financial solvency of more complex and higher priority insurance companies. Senior financial analysts may also be asked to provide guidance, support, and training to financial analysts.

Supervising and Assistant Chief Analyst
A supervising or assistant chief analyst is responsible for supervising the financial analysts and senior financial analysts conducting a risk-focused financial analysis on assigned insurers. This position provides input on technical matters, acts as a reviewer of the work performed by the financial analysts and senior financial analysts, and ensures that analyst work is an appropriate execution of the risk-focused analysis approach.

Chief Analyst
This position is responsible for overall staff performance and development and should serve as the department's main point of contact for analysis and ongoing monitoring of regulated entities. This position should oversee company assignments and priority ratings. This position should work under the general direction of a commissioner or deputy commissioner and should oversee a consistent risk-focused financial analysis process across the department.

Use of Salary Tables

The salary tables included below generally require certain adjustments before being applied by a state or jurisdiction in setting analyst compensation. Factors to consider in setting analyst compensation include:

- Specific job responsibilities and expectations
- Location or market-based adjustments
- Complexity of industry

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- Specialization requirements (e.g., reinsurance/investment/information technology [IT] specialist)
- Travel expectations (including consideration of amount of travel and in consideration of work from home or other similar arrangements)
- Retirement and other benefits (not included in table)

	Salary Range	
Position	**Low End**	**High End**
Financial Analyst	$58,000	$95,000
Senior Financial Analyst	$77,000	$123,000
Supervisor/Assistant Chief Analyst	$95,000	$165,000
Chief Analyst	$115,000	$210,000

Note: The data above is based on a national average and is not appropriate to be applied to all locations without consideration of market and cost of living variances.

COMPANY LICENSING AND ADMISSIONS

An insurer that wishes to obtain a Certificate of Authority to write business in a state must generally complete an application indicating the line(s) of business it plans to write and submit the application (along with other information, including the most recent Annual Financial Statement, Audited Financial Report, Actuarial Opinion, etc., to support its financial condition of the insurer) to the insurance department for review and evaluation. In addition, insurance departments frequently request information supporting the insurer's experience and expertise in writing the line(s) of business requested, background information regarding the insurer's management and board of directors, a business plan, and a multi-year pro-forma financial projection. After reviewing this information and any other information obtained, the insurance department makes a determination on whether to issue a Certificate of Authority.

The Uniform Certificate of Authority Application, also known as the UCAA or Uniform Application, is a process designed to allow insurers to file copies of the same application for admission to numerous states. The National Treatment and Coordination (E) Working Group currently maintains and updates the UCAA application. Each state that accepts the UCAA is designated as a uniform state. While each uniform state still performs its own independent review of each application, the need to file different applications in different formats has been eliminated for all states that accept the uniform application. The Uniform Application is available to any insurer in good standing with its domiciliary state, regardless of size. Currently, all 50 states and the District of Columbia are uniform.

The UCAA includes three applications. The Primary Application is for use by newly formed companies seeking a Certificate of Authority in their domicile state and by companies wishing to re-domesticate to a uniform state. The Expansion Application is for use by companies in good standing in their state of domicile that wish to expand their business into a uniform state. The Corporate Amendments Application is for use by an existing insurer for requesting amendments to its certificate of authority.

CONSUMER AFFAIRS

Consumer Affairs is responsible for developing and distributing information regarding insurance products and the insurance industry to consumers. Consumer Affairs is also generally responsible for addressing complaints filed with the insurance department by policyholders and claimants against insurers and agents. Detailed statistics regarding complaints, both in number and type of complaint, and the resolutions may be maintained as a part of this function. Complaints are recorded on the Complaints Database System if filed with the NAIC.

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ENFORCEMENT

Punitive actions taken against companies, agents, and other licensees found to be in violation of the insurance code are handled by the enforcement function. This function issues orders, and levies fines and other penalties based on the results of investigations performed by other functions within the insurance department. Detailed records are maintained by the department on all regulatory actions taken against companies, agents, and other licensees. In addition, regulatory actions are also recorded in the Regulatory Information Retrieval System (RIRS) database if filed with the NAIC.

POLICY/FORMS ANALYSIS AND RATE FILINGS

Every state requires an insurer to file policy forms for most lines of business for review and/or approval prior to selling the policies. The primary purpose of this review is to determine statutory compliance regarding policy provisions and benefits.

Information regarding premium rates, including actuarial rate development assumptions, is generally required to be filed with the insurance department for certain lines of business. Some states are “file and use” states, which allow insurers to begin selling policies at the rates filed as soon as the filing is made. In other states, rates must be approved by the insurance department prior to use by the insurer. Rate filings, including the actuarial assumptions, are reviewed for reasonableness and statutory compliance as a part of this function.

The NAIC’s System for Electronic Rate and Form Filing (SERFF) is an electronic platform used by industry for form submittal, document management and state insurance regulatory review that accelerates the pace of market-entry for new and renewing products, while ensuring compliance with consumer protection requirements. The NAIC’s Speed to Market (EX) Working Group governs the SERFF product.

AGENT/PRODUCER LICENSING

Agents must be licensed by the insurance department in order to write business in the state. The agent licensing function administers tests for agents, reviews new and renewal applications from agents, and performs background checks on agents. In addition, many states have continuing education requirements for agents, and agent licensing monitors compliance with these requirements. Detailed records of licensed agents are maintained by agent licensing, including information regarding the insurers for which the agents produce business.

The National Insurance Producer Registry (NIPR) is a nonprofit affiliate of the NAIC. NIPR developed and implemented the Producer Database (PDB) and the NIPR Gateway. The PDB is an electronic database consisting of information relating to insurance agents and brokers (producers). The PDB links participating state regulatory licensing systems into one common repository of producer information. The PDB also includes data from the RIRS to provide a more comprehensive producer profile. The NIPR Gateway is a communication network that links state insurance regulators with the entities they regulate to facilitate the electronic exchange of producer information.

LEGAL

Legal is generally involved in the review of proposed changes of control of insurers and other holding company transactions and frequently supports the other functions. Legal may also draft statutes and regulations to assist the insurance department in regulating insurers, agents, and other licensees; hold administrative hearings

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between the commissioner and insurers, agents, and other licensees; and represent the department in judicial and other proceedings.

INTRA-DEPARTMENTAL COMMUNICATION

Communication with other divisions or areas within the state insurance department on a timely basis is an important element of effective solvency surveillance and is essential to the coordination of results of the risk-focused surveillance approach. Upon identifying a problem or concern during the risk-focused financial analysis process, the financial analyst should communicate this information to other divisions within the department. In addition, other divisions within the department should communicate certain information to the financial analyst so that the analyst has all of the relevant information available regarding the insurer being analyzed. (Refer to the example of an IPS in the Analyst Reference Guide for Risk Assessment.)

To assist in the coordination of risk-focused financial condition examination, state insurance regulators use the NAIC's Financial Exam Electronic Tracking System (FEETS). FEETS allows state insurance regulators to call an examination of a multistate insurer, facilitate coordination via various functionality within the program, communicate the completion of an examination, and share the completed version of the state insurance department's examination report. Use of FEETS on iSite+ is required by the NAIC when calling examinations on multistate insurers and is recommended for all examinations.

COMMUNICATION FROM THE FINANCIAL ANALYST TO FINANCIAL EXAMINERS

The analyst may identify concerns as a result of the risk-focused financial analysis process that, when communicated to the financial condition examinations division, may lead to a targeted or limited scope financial condition examination. In addition, since the risk-focused analysis and examinations are interactive processes, the analyst should be familiar with the insurer's current financial condition; including any changes in its operations since the last periodic financial condition examination as well as the insurer's exposure to branded risks, which include prospective risks.

In communicating information to the examiners for examination planning, the analyst should review the examiner's Exhibit B – Examination Planning Questionnaire to note any items already accumulated and provide access to relevant information that has already been obtained by the analyst function and is available at the state insurance department.

Communication between examiners and analysts should occur for examination planning and at the conclusion of the examination. Specifically, regarding exam planning, results of ongoing analysis procedures should be shared with the financial examiners to assist in examination planning through a coordination meeting. An email exchange alone, between analyst and examiner, is not considered sufficient communication in planning an examination. During the preplanning process of each examination, the analyst should communicate areas of concern and specific issues to address during the examination. To assist in communication, the analyst should provide a current copy of the IPS, as well as other supporting analyst work papers and other documentation already on file at the department to communicate current or prospective concerns or observations and suggested procedures.

Regarding exam follow-up, the financial analyst should participate in a collaborative follow-up meeting or conference call at the end of the examination to discuss the following:

- Examination results and/or findings

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- Insurer's prioritization level
- Ongoing supervisory plan and the completed Summary Review Memorandum
- Reassessment of branded risks as contained in the IPS

Such information may be shared by providing and discussing the current IPS, as well as other supporting analysis documentation necessary to support the branded risk assessment or other issues noted in the analysis. Statutory violations identified as a part of the analysis should be communicated to the enforcement division for the issuance of appropriate penalties and/or corrective orders against the insurer. Additionally, solvency related concerns, when communicated to the legal division, may result in the restriction, suspension, or revocation of an insurer's Certificate of Authority.

The avoidance of redundancy in the risk-focused analysis and examination is of critical importance for an enhanced and more efficient overall regulatory process that will benefit both regulators and industry. An efficient regulatory process fosters clarity and consistency, which results in a better understanding of how individual insurers operate across the different aspects of the regulatory spectrum, including the areas of financial analysis, financial examination, and other solvency-related regulations.

The information that insurers submit to the insurance department which are received and reviewed by the analysts as well as the analysts' final work product should be documented in a clear and consistent format that can be easily understood and utilized by analysts, their supervisors, and financial examination staff. In particular, workpapers supporting and summarizing the analysts' risk-focused analysis, an outline of mapping of what documentation was reviewed and a summary of conclusions reached, i.e., an updated Insurer Profile Summary, should be maintained in a manner that can be easily shared and discussed during the pre-examination planning meeting with the examiner.

Refer to the III.A.4 Analyst Reference Guide for further guidance on communication between analysts and examiners.

COMMUNICATION FROM OTHER DIVISIONS OR AREAS TO THE FINANCIAL ANALYST

In addition to intra-department communication, which originates within the financial analysis division, it is equally important that the department's procedures be designed to ensure relevant information and data received by the other divisions within the department be directed to the financial analysis division. The following are some examples of information or data that may be received by other divisions within the department (including an indication of the functional unit that would likely have received the information or data), which should be directed to the financial analysis division for consideration as a part of the financial analysis process:

1. Information from Risk-Focused Financial Examination:
    a. If recently completed, the SRM, financial condition examination reports and management letter comments that include significant adjustments to the financial information reported to the department, corrective actions required to be taken by the insurer, and/or recommendations for improvements based on examination results. (See above)
    b. If an examination is in progress, communication from examination staff should include information on the planning, progress and preliminary findings, based on the phase of the examination Risk-Focused Financial Examination.
    c. Any relevant information obtained in planning the financial examination stage.

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2. Market conduct examination reports containing corrective actions required to be taken by the insurer as a result of violations in sales, advertising, rating, and/or claim practices, which might be an indication of financial problems or lead to the risk of financial losses through class action suits or regulatory fines (market conduct examinations).
3. An increase in the number or type of complaints filed by policyholders, claimants, employees, agents, or third parties that could indicate liquidity or internal control problems (consumer affairs).
4. Corrective orders and other regulatory actions taken against an insurer and fines and penalties levied (enforcement).
5. New policy form filings or expansion into new lines of business, including high-risk and long-tail lines of business, which might imply planned rapid growth to obtain premiums in order to improve liquidity or cover prior losses (policy/forms analysis).
6. Requests for significant premium rate increases, which might be an indication of insufficient rates to cover losses and expenses in the past (rate filings).
7. An increase in the licensing of agents, including managing general agents or third-party administrators, which could indicate planned rapid expansion or relaxed underwriting standards (agent licensing).
8. The use of managing general agents or third-party administrators, which might be an indication that the insurer is not in control of its operations (agent licensing).
9. Information that management personnel of an insurer (including officers, directors, or any other persons who directly or indirectly control the operations of the insurer) fail to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such a position (legal).
10. The unexpected resignation of an insurer's officer(s), director(s), or other key management personnel, which might indicate internal turmoil or dissatisfaction with the insurer's goals or operating practices (legal).

INTRA-DEPARTMENT COMMUNICATION SYSTEM

Intra-department communication in most state insurance departments is primarily informal due to the size of the department and the location of personnel. The commissioner may hold periodic meetings with the division heads to discuss current developments and concerns in each division. In some states, division heads prepare monthly activity reports highlighting current developments which are circulated to the other divisions within the department. Departments should have a formal structured mechanism to ensure appropriate ongoing intra-department communication. Adequate controls should be implemented to ensure that recommendations, decisions, actions, and results are effectively communicated and documented. Among the key objectives of a department's intra-department communication system are the following:

1. Key insurance department officials should possess all relevant information to permit decisions to be made on a timely basis.
2. The department should ensure that all levels of staff have the appropriate knowledge, information, and feedback to effectively perform the assigned functions.
3. Managers within various functional units or divisions should be responsible for the proper internal communications and documentation of decisions and actions taken under their authority.
4. The department should establish procedures to ensure that orders and directives are effectively communicated to the appropriate staff and that the staff observes such orders and directives.

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CONSIDERATIONS FOR TROUBLED INSURANCE COMPANIES

In troubled or potentially troubled insurance company situations, proactive and timely communication to the appropriate persons within the department and with non-domiciliary state departments (for multistate companies) is critical. It is also important that the non-domiciliary state communicate with the domestic regulator prior to taking any action against the insurer. In certain circumstances, it may also be appropriate to communicate certain information with other parties (e.g., other regulatory bodies, company management, state guaranty funds, etc.). Establishing a coordinated communication system among the relevant parties will help facilitate the domestic regulator's surveillance of the troubled or potentially troubled insurance company. The *Troubled Insurance Company Handbook* (regulator only) provides additional guidance to assist in enhancing a state's monitoring and surveillance of troubled insurance companies, including communication and coordination of troubled or potentially troubled insurance companies.

At some point, the insurance department may determine that a corrective action plan cannot be implemented or completed successfully. Under these circumstances, the department may determine that the appropriate course of action is to place the troubled company in receivership. The *Troubled Insurance Company Handbook* outlines specific steps the department should take at all times during the development and implementation of a corrective action plan to prepare itself for this eventuality. This includes knowledge and control over the company's assets, determining and reviewing the company's obligations, operational considerations, information gathering, data/IT systems, other jurisdiction/regulatory considerations, etc. In addition to the *Troubled Insurance Company Handbook,* the *Receiver's Handbook for Insurance Company Insolvencies*[i] provides detailed information and guidance regarding pre-receivership considerations. Both handbooks emphasize the benefits of early communication in a pre-receivership situation. The handbooks offer state insurance regulators tools and best practices for communication and coordination with other relevant parties in a pre-receivership situation, including other state insurance departments, federal and international regulatory authorities, guaranty associations, etc. Examples of tools include checklists to assist in the takeover phase of the receivership process and an optional memorandum of understanding template for advance communication with guaranty associations in a property/casualty (P/C) liquidation.[ii]

[i] The *Receiver's Handbook for Insurance Company Insolvencies* is available on the NAIC website at: https://content.naic.org/sites/default/files/publication-rec-bu-receivers-handbook-insolvencies.pdf.

[ii] The optional memorandum of understanding template is available on the NAIC website at: https://content.naic.org/sites/default/files/inline-files/2022_PreLiquidation_PC_MOU.docx.

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COORDINATION OF REGULATORY EFFORTS

The operations of an insurance company often are not limited to one jurisdiction. Therefore, state insurance departments need to coordinate its regulatory efforts with those of other state insurance departments where its insurers do business. The *Troubled Insurance Company Handbook* states that opportunities to coordinate efforts should be sought throughout the entire process, from the monitoring and surveillance of insurers through regulatory actions regarding identified troubled insurers. Coordinated activities may take various forms, including:

- Communication of information regarding the troubled company with other departments through established department procedures
- Participation in coordinated examinations
- Lead states coordination in situations involving troubled insurance groups with affiliated insurers
- Assignment of specific regulatory tasks to different insurance departments to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise
- Establishment of task forces consisting of personnel from various insurance departments to carry out coordinated actions

Additionally, in some cases, coordination on nonfinancial issues may also be necessary. This is quite common when dealing with health entities because regulatory agencies, such as the federal Centers for Medicare & Medicaid Services (CMS), maintain authority in dealing with issues related to Medicare and Medicaid products and certain comprehensive health care issues under the federal Affordable Care Act (ACA).

ACCREDITATION STANDARDS AND GUIDELINES

The NAIC Financial Regulation Standards and Accreditation Program indicates that a state insurance department should generally follow and observe the procedures set forth in the *Troubled Insurance Company Handbook*. The *Troubled Insurance Company Handbook* provides guidance regarding communication with other state insurance departments about domestic insurers identified as troubled. Once the department has identified an insurance company as troubled or potentially troubled, the department should make efforts to communicate proactively with other state insurance regulators where the insurance company has a significant amount of written, assumed or ceded insurance business and with states in which affiliates of the troubled company are domiciled or those states where the troubled company has significant market share. Department files should contain written evidence of such communication(s). To a lesser extent, oral verification may provide such evidence.

REGULATORY INFORMATION

The department should establish and implement procedures to ensure that regulatory actions are reported to the Regulatory Information Retrieval System (RIRS), summary information on consumer complaints is reported to the Complaints Database System (CDS), and that the status of receivership actions is reported to the Global Receivership Information Database (GRID). These databases are discussed in more detail in section I.D. NAIC Information.

INTERDEPARTMENTAL COMMUNICATION

Effective interdepartmental action requires timely and effective communication among the various state insurance departments. Insurance departments should develop methods of multilateral communication in order to coordinate the prompt sharing of pertinent information regarding troubled insurers that may impact other jurisdictions. Open lines of communication may provide additional information to a department to assist in its

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surveillance, as well as provide information to other state insurance departments. Such communications should be established to foster cooperation among the various state insurance departments, so that each department works toward the satisfactory resolution of all troubled insurer situations, regardless of the insurer's domicile, license, or operating status. Communications with other state insurance departments regarding troubled insurers should be made in an atmosphere of appropriate confidentiality. Knowledge by outsiders of actual or contemplated regulatory activities may cause undue negative consequences to the insurer (e.g., cancellation of policies or unavailability of reinsurance coverage), which may diminish the insurer's ability to receive assistance or to remain solvent.

The *Troubled Insurance Company Handbook* indicates that the effects on policyholders in all jurisdictions that may result from the actions of a department should be considered. Although the department should consider any adverse consequences that could possibly result from making certain information known to other state departments, those possible disadvantages may be outweighed by the advantages gained from sharing information and working with the other state insurance departments.

An insurance department may go beyond routine communications to allow other departments to participate in decision-making activities related to an insurer that operates in more than one jurisdiction. Any such joint action depends on the nature of the decisions to be made and the relative impact on a particular jurisdiction. However, cooperation of this nature can significantly improve communications between departments, and the resulting increased knowledge of the insurer's condition and circumstances can lead to more effective regulatory action.

The NAIC and its various committees, task forces, and working groups may also provide a means for facilitating coordination and communication among the various departments. For example, the NAIC Financial Examiners Coordination (E) Working Group promotes coordination by assisting and advising domiciliary regulators and exam coordination states as to what might be the most appropriate regulatory strategies, methods, and actions regarding financial examinations of holding company groups. The Financial Analysis (E) Working Group functions as a peer review by identifying insurance companies of national significance that are or may be financially troubled and determining whether appropriate regulatory action is being taken. The NAIC may also assist in organizing and facilitating other cooperative regulatory efforts, such as the formation of working groups to address specific troubled insurance company situations.

REDOMESTICATION AND ACQUISITION– COMMUNICATION OF REGULATORY ACTIONS AND ANALYSIS

Communication between states in situations where a company has redomesticated or is being acquired by a party that owns other insurers since the last annual analysis is an important step in conducting effective solvency oversight. In addition to the review of the application for redomestication or Form A, the state insurance regulator should engage the domestic state insurance regulator of the former state in the case of redomestication or the lead state or domestic state(s) of other insurers in the new group in the case of Form A in communication to request the Insurer Profile Summary (IPS), supervisory plan and other relevant solvency monitoring information to effectively incorporate insights from the other domestic state's supervisory plan into the current analysis. In these situations, it is imperative that state insurance regulator concerns and supervisory plans be appropriately transitioned to avoid losing regulatory insights accumulated over years of oversight. Communication should include (but not be limited to) such items as:

- IPS and supervisory plan, including analysis detail for significant risks
- History of regulatory actions
- History of communication with the insurer/group
- Assessment of senior management, board of directors and corporate governance

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- Findings (i.e., Summary Review Memorandum (SRM), exam report and management letter) from the most recent financial and market conduct examinations, including the status of the resolution to issues identified
- Assessment of Enterprise Risk Management (ERM), including risks from Form F that are provided in the GPS or provided by the lead state
- Group Profile Summary (GPS) and Supervisory Plan from the holding company analysis, including detail on any significant risks obtained from the lead state Assessment of Own Risk and Solvency Assessment (ORSA) Summary Report, if applicable.

In situations where the company seeking redomestication is considered a priority company (i.e., NAIC 1 or 2) by the current domestic state, the department should communicate the company's intent to redomesticate with all licensed states prior to approval. This type of communication will ensure that all licensed states are informed of the company's plan and encourage an open dialogue between all interested regulators as part of the approval process.

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In addition to the NAIC information, there are several external sources of information available credit rating agencies, industry analysts and external news sources. The analyst should refer to these sources of information in order to increase his or her knowledge of the insurer's financial position and to corroborate the financial information filed by the insurer with the NAIC and state insurance departments. These sources of information are all available through direct purchase or subscription order from the credit rating agencies and/or industry analysts. Following is a discussion of a few of the major sources of external information available.

CREDIT RATING AGENCIES

There are ten credit rating agencies currently registered with the U.S. Securities and Exchange Commission (SEC) as Nationally Recognized Statistical Rating Organizations (NRSROs) under the Credit Rating Agency Reform Act of 2006. Each has its own unique methodology for assigning ratings. The rating agencies also produce other types of financial information that may be helpful to the analyst. The following is a current list of NRSROs and the classes of ratings for which the rating agency is currently registered. Specific details on the rating agency's rating methodology and other types of financial information available can be found on the agency's Website.

Rating Agency	Classes of Ratings	
A.M. Best Rating Services, Inc. www.ambest.com	• insurance companies • corporate issuers	• issuers of asset-backed securities
DBRS, Inc. www.dbrsmorningstar.com	• financial institutions • insurance companies • corporate issuers	• issuers of asset-backed securities • issuers of government securities
Demotech, Inc. www.demotech.com	• insurance companies	
Egan-Jones Ratings Company www.egan-jones.com	• financial institutions • insurance companies	• corporate issuers
Fitch Ratings, Inc. www.fitchratings.com	• financial institutions • insurance companies • corporate issuers	• issuers of asset-backed securities • issuers of government securities
HR Ratings de Mexico, S.A. de C.V. www.hrratings.com	• financial institutions • corporate issuers	• issuers of government securities
Japan Credit Rating Agency, Ltd. www.jcr.co.jp	• financial institutions • insurance companies	• corporate issuers • issuers of government securities
Kroll Bond Rating Agency, Inc. www.kbra.com	• financial institutions • insurance companies • corporate issuers	• issuers of asset-backed securities • issuers of government securities
Moody's Investors Services, Inc. www.moodys.com	• financial institutions • insurance companies • corporate issuers	• issuers of asset-backed securities • issuers of government securities
S&P Global Ratings www.standardandpoors.com	• financial institutions • insurance companies • corporate issuers	• issuers of asset-backed securities • issuers of government securities

Other rating organizations not registered as NRSROs may provide useful information to the analyst in addition to a NRSRO ratings report, or when a rating is not provided by a NRSRO. An example of a non-NRSRO would be Weiss Ratings, LLC.

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INDUSTRY ANALYSTS

In addition to the rating agencies, many of the investment houses and stock research firms do considerable research into the insurance industry. The following paragraphs briefly describe several sources.

1. ***Investment Houses*** — The major Wall Street firms dedicate considerable resources toward researching insurance industry issues. In general, much of this research is oriented towards emerging issues facing the industry. Specific insurance company research is also available but is generally limited to companies with publicly traded debt or equity securities.

2. ***Ward's Results*** — Annually, Ward Financial Group publishes a financial reference series entitled *Ward's Results*, available in separate Life, Health & Annuity and Property/Casualty editions. The books include financial benchmarks for U.S. domiciled insurers, including unique peer group benchmarks. Each company is grouped into peer groups that consider the insurer's asset size, premium volume, geographic mix of business and ownership structure. In addition to peer group benchmarks, the books also include top performing stock company and mutual company benchmarks.

SECURITIES AND EXCHANGE COMMISSION FILINGS

Insurers that offer debt or equity securities to the public must register with the SEC and fulfill various reporting requirements. Where applicable, the various SEC filings provide significant background information about the insurer and can assist the analyst in corroborating the information filed by the insurer with the NAIC or state insurance departments. Most of the filings are available through SEC's Electronic Data Gathering Analysis and Retrieval (EDGAR) system via the SEC's website (www.sec.gov) at no charge, as well as on CD-ROM. While the SEC filing requirements are quite comprehensive, the following summarizes three of the SEC filing forms that may be of particular interest to the analyst.

1. ***Form 10-K*** is used to fulfill the SEC's annual reporting requirements. The 10-K must be filed with the SEC within 90 days after the company's year-end for a non-accelerated filer. Accelerated filers must file the 10-K 60 or 75 days after their fiscal year-end, depending on whether they are considered a large filer. Information incorporated into the 10-K includes:

   - Item 1 – Business
   - Item 1A – Risk factors
   - Item 1B – Unresolved staff comments
   - Item 1C – Cybersecurity
   - Item 2 – Properties
   - Item 3 – Legal proceedings
   - Item 4 – Mine safety disclosures
   - Item 5 – Market for registrant's common equity, related stockholder matters and issuer purchases of equity securities
   - Item 6 – [Reserved]
   - Item 7 – Management's discussion and analysis of financial condition and results of operations
   - Item 7A – Quantitative and qualitative disclosures about market risk
   - Item 8 – Financial statements and supplementary data
   - Item 9 – Changes in and disagreements with accountants on accounting and financial disclosure

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- Item 9A – Controls and procedures
- Item 9B – Other information
- Item 9C – Disclosure regarding foreign jurisdictions that prevent inspections
- Item 10 – Directors, executive officers and corporate governance
- Item 11 – Executive compensation
- Item 12 – Security ownership of certain beneficial owners and management and related stockholder matters
- Item 13 – Certain relationships and related transactions, and director independence
- Item 14 – Principal accountant fees and services
- Item 15 – Exhibits and financial statement schedules
- Item 16 – Form 10-K summary

2. ***Form 10-Q*** is used to fulfill the SEC's quarterly reporting requirements. The 10-Q must be filed with the SEC within 40 days for an accelerated filer and 45 days for a non-accelerated filer after the end of each of the first three fiscal quarters and must include a condensed income statement, a condensed balance sheet, and an abbreviated statement of cash flow.

3. ***Form 8-K*** is used to report material events or corporate changes that have not yet been reported. The 8-K is required after any of the following events occur (see SEC website for a complete list):
   - Section 1: Registrant's Business and Operations
     - Entry into or Termination of a Material Definitive Agreement
     - Bankruptcy or Receivership
   - Section 2: Financial Information
     - Completion of Acquisition or Disposition of Assets
     - Results of Operations and Financial Condition
     - Material Impairments
   - Section 3: Securities and Trading Markets
     - Notice of Delisting
     - Material Modification to Rights of Security Holders
   - Section 4: Matters Related to Accountants and Financial Statements
     - Changes in Registrant's Certifying Accountant
   - Section 5: Corporate Governance and Management
     - Changes in Control of Registrant
     - Departure of Directors or Certain Officers; Election of Directors; Appointment of Certain Officers; Compensatory Arrangements of Certain Officers
     - Amendments to Articles of Incorporation or Bylaws; Change in Fiscal Year

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OTHER EXTERNAL RESEARCH AND NEWS SOURCES

In addition to the specific sources referenced above, other resources that provide updates about the industry and specific insurers include:

- *BestWeek*
- *Best Review*
- *Bloomberg Financial*
- *Business Insurance*
- *Factiva*
- *Insurance Journal*
- *National Underwriter*
- *The Wall Street Journal*
- Individual company websites

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In addition to the external information discussed in the previous chapter, there is a considerable amount of information available from the NAIC to assist the analyst in analyzing insurance companies. Most insurers are required to file Annual and Quarterly Financial Statements with the NAIC. Much of the information available from the NAIC is based on data included in these filings, which is made available on the Financial Data Repository. In addition, other NAIC databases contain information input by the various state insurance departments regarding regulatory actions taken against insurers, regulatory concerns about insurers or individuals, and consumer complaints filed against insurers. Following is a discussion of the more significant information available to the analyst from the NAIC.

FINANCIAL ANALYSIS SOLVENCY TOOLS

Financial Analysis Solvency Tools (FAST) is a collection of analytical tools within the Insurance Regulatory Information System (IRIS) designed to provide state insurance departments with an integrated approach to screening and analyzing the financial condition of insurance companies. In addition, FAST assists state insurance departments in allocating resources to those insurers in greatest need of regulatory attention targeting those specific aspects of an insurer's financial position that could put the insurer at risk of future insolvency.

Scoring System

The Scoring System consists of a series of ratios, calculated annually and quarterly, for which an insurer scores a given number of points based on certain parameters set for each ratio. Certain insurers writing both life and accident and health (A&H) insurance meet the requirements for "hybrid" status. For these hybrid insurers, both life and A&H ratios are available. There are 11 annual ratios and 9 quarterly ratios for life insurers, 11 annual ratios and 12 quarterly ratios for A&H insurers, 16 annual ratios and 13 quarterly ratios for health entities, and 20 annual ratios and 16 quarterly ratios for property/casualty (P/C) insurers. These ratios focus on an insurer's financial position, results of operations, cash flow and liquidity, and leverage. Insurers with the highest scores would generally be considered a higher risk of potential insolvency. The Scoring System is designed so that an analyst can screen insurers on a total score basis or analyze each ratio result separately. Annually, the NAIC Financial Analysis and Examination Unit, under the direction of the Financial Analysis Solvency Tools (E) Working Group, is responsible for ensuring that the Scoring System ratios are current and continue to be relevant to solvency monitoring, and that scoring parameters remain appropriate.

Financial Profile Reports

Financial Profile Reports are generated from data in an insurer's Annual and Quarterly Financial Statements. The Financial Profile Report provides a condensed summary of an insurer's financials on either a quarterly or annual basis, also displaying the current period and four prior periods. The Financial Profile Report can assist the analyst in identifying unusual fluctuations, trends, or changes in the mix of an insurer's assets, liabilities, capital and surplus, and operations.

IRIS Ratio Application

The NAIC IRIS ratio application is a tool that assists in identifying those insurers that merit highest priority in the allocation of the state insurance department's resources, thus directing those resources to the best possible use.

The IRIS ratio application uses key financial data from the Annual Financial Statement to calculate ratio results. There are 13 IRIS ratios calculated for P/C insurers and 12 for life insurers. The calculated results for each insurer are compared to the usual range of results for each ratio. Falling outside the usual range is not considered a failing result. For example, an increase in surplus or premiums that is larger than usual is not necessarily a problem. Furthermore, in some years it may not be unusual for financially stable insurers to have several ratios with results outside the usual range.

IRIS ratio results are dependent on the accuracy of the Annual Financial Statement filed by insurers. The ratios cannot identify a misstatement of financial condition or the application of improper accounting practices or

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procedures. In fact, the NAIC warns state insurance departments not to rely on IRIS ratios as the only form of financial surveillance of insurers. IRIS ratios should be used in conjunction with the other NAIC solvency tools.

Jumpstart Reports

Jumpstart Reports, which are available through iSite+, were developed by the NAIC to assist examiners in performing financial condition examinations. Numerous reports can be generated pertaining to an insurer's reinsurance program and investment portfolio based on the information included in the NAIC database from the insurer's Annual Financial Statement. Although the Jumpstart Reports were developed to assist examiners in performing financial condition examinations, many of the applications may be of interest to the financial analyst as well. Following is a brief discussion of some of the Jumpstart Reports available that may assist the financial analyst in the analysis process. Additional information can be found on iSite+ under the Welcome/ Documentation tab.

1. Assumed/Ceded Reinsurance Reports—Verifies reinsurance ceded for an insurer by comparing reserves and premiums ceded per the reinsurance schedules of the insurer being analyzed with reserves and premiums assumed per the assuming insurers' reinsurance schedules.
2. Company Valuation Exception Report—This report compares the company reported price to the Securities Valuation Office (SVO) unit price, and the low, average, high, and median prices along with the reported designation and values.
3. Investment Committee on Uniform Security Identification Procedures (CUSIP) Exception Report—Matches the insurer's Schedule D with the SVO database and produces an exception report of all securities with CUSIP numbers not listed on the SVO database.
4. Investment Designation Exception Report—Matches the insurer's Schedule D with the SVO database and produces an exception report of all securities with SVO designations different from those listed on the SVO database.
5. Investment Market Value Exception Report—Matches the insurer's Schedule D with the SVO database and produces an exception report of all securities with market values different from those listed on the SVO database.
6. Investment Material Holdings Report—Produces a listing of all securities owned by issuer, where the market value of all securities of an individual issuer owned by the insurer is greater than a specified percentage of the insurer's prior year admitted assets or capital and surplus.
7. Investment Specified Designation Report—Produces a listing of all securities owned by an insurer whose designations match a specified designation.

Loss Reserves

Loss reserve analysis for a specific line of business can be performed for P/C insurers via iSite+. The following is a brief discussion of some of the loss reserve reports.

1. Data Triangles—Formats Schedule P, Parts 2, 3, and 6 data into a triangle that is traditionally used to analyze loss data.
2. Age-To-Age Development Factors—Creates age-to-age development factors in a triangle format for various projection methods.
3. Loss Ratios—Computes loss ratios based on premium and loss information by line of business in a triangle format.
4. Loss Reserve Projections—Creates a loss projection report by line of business using case reserves or paid numbers using various projection methods.

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Financial Exam Electronic Tracking System (FEETS)

To assist in the coordination of risk-focused financial condition examination, state insurance regulators use the NAIC's Financial Exam Electronic Tracking System (FEETS). FEETS allows state insurance regulators to call an examination of a multistate insurer, facilitate coordination via various functionality within the program, communicate the completion of an examination and share the completed version of the department's examination report. Use of FEETS on iSite+ is required by the NAIC when calling examinations on multistate insurers and is recommended for all examinations.

Regulatory Information Retrieval System (RIRS) Regulatory Actions

The Regulatory Information Retrieval System (RIRS) Regulatory Actions is a computerized database that contains information regarding formal administrative and regulatory actions taken against insurers and insurance agents. Information on the RIRS includes the insurer or insurance agent against which formal administrative or regulatory action was taken, the date of the action, the state taking the action, the reason for the action, the disposition, and the amount of monetary penalty levied. The RIRS relies on input from state insurance departments of all final actions taken and is available online to all state insurance departments.

Complaints Database System

The Complaints Database System (CDS) is a computerized database that contains information regarding consumer complaints filed against a firm or individuals in the insurance industry. The CDS provides state insurance departments with the ability to evaluate an insurer's comparative performance in the marketplace. Complaint reports can be generated by coverage, complaint reason, count, or time depending on the criteria selected.

Market Actions Tracking System (MATS)

The Market Action Tracking System (MATS) provides state insurance regulators a way to communicate action schedules and results. Actions include market conduct examinations or other actions on the continuum of regulatory responses. MATS includes functions for calling market regulation actions, reporting and access to full information about the people involved in the market action. MATS can also be used to view or update action information for a specific entity, individual, non-risk bearing entity or company.

Market Analysis Review System (MARS)

The Market Analysis Review System (MARS) is available to specific state regulator users for the purpose of tracking, recording and reviewing Level 1 analysis and Level 2 analysis completed by other state regulators. A Level 1 analysis requires an analyst to analyze specific company information to determine if any market conduct issues are present. The Level 1 analysis is a detailed review of certain information contained in NAIC databases. A Level 2 analysis requires the market analyst to seek input and gather information from sources outside of the NAIC databases and the company's financial and market conduct annual statements. By its very nature, a Level 2 Analysis is much more labor intensive than a Level 1 Analysis.

Global Receivership Information Database

The iSite+ application Global Receivership Information Database (GRID) allows the regulator to review the status of a receivership (e.g., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal data, financial data, and reporting data.

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ACCOUNTING GUIDANCE

Statutory Accounting Principles (SAP) are those accounting principles or practices that are prescribed or permitted by the insurer's domiciliary state insurance department. SAP is prescribed in the insurance statutes, regulations, administrative rules of the various states, and in the NAIC's *Accounting Practices and Procedures Manual* (AP&P Manual), *Annual Statement Instructions*, *Financial Condition Examiners Handbook*, *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), and subcommittee and task force minutes. In addition, certain accounting practices are explicitly or implicitly permitted by various state insurance departments on an issue-by-issue and/or company-by-company basis.

Financial statements filed with state insurance departments are prepared on a SAP basis. Since the primary concerns of insurance regulators are the protection of the policyholders and the solvency of each insurer, SAP places emphasis on the adequacy of statutory capital and surplus. Adequate capital and surplus provides protection against adverse operating results and also permits an insurer to expand its business. In addition, SAP emphasizes the balance sheet rather than the income statement. Statutory accounting is primarily directed toward the determination of an insurer's financial condition and its ability to satisfy its obligations to policyholders and creditors as of a certain date.

As stated in the preamble to the AP&P Manual, SAP is based on the concepts of conservatism, consistency, and recognition. Each of these concepts is discussed in more detail below.

- **Conservatism**—Financial reporting by insurers requires the use of substantial judgments and estimates by management. Such estimates may vary from the actual amounts for various reasons. To the extent that factors or events result in adverse variation from management's accounting estimates, the ability to meet policyholder obligations may be lessened. In order to provide a margin of protection for policyholders, the concept of conservatism should be followed when developing estimates as well as establishing accounting principles for statutory reporting.

  Conservative valuation procedures provide protection to policyholders against adverse fluctuations in financial condition or operating results. Statutory accounting should be reasonably conservative over the span of economic cycles and in recognition of the primary responsibility to regulate for financial solvency. Valuation procedures should, to the extent possible, prevent sharp fluctuations in surplus.

- **Consistency**—The regulators' need for meaningful, comparable financial information to determine an insurer's financial condition requires consistency in the development and application of SAP. Because the marketplace, the economic and business environment, and insurance industry products and practices are constantly changing, regulatory concerns are also changing. An effective statutory accounting model must be responsive to these changes and address emerging accounting issues. Precedent or historically accepted practice alone should not be sufficient justification for continuing to follow a particular accounting principle or practice that may not coincide with the objectives of regulators.

- **Recognition**—The principal focus of solvency measurement is determination of financial condition through analysis of the balance sheet. However, protection of the policyholders can only be maintained through continued monitoring of the financial condition of the insurer. Operating performance is another indicator of an insurer's ability to maintain itself as a going concern. Accordingly, the income statement is a secondary focus of statutory accounting and should not be diminished in importance to the extent contemplated by a liquidation basis of accounting.

  The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than fulfilling policyholder obligations, or those assets that may be unavailable due to encumbrances or other third-party interests should not be recognized on the balance sheet but rather should be charged against surplus when acquired or when availability otherwise becomes questionable.

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Liabilities require recognition as they are incurred. Certain statutorily mandated liabilities may also be required to arrive at conservative estimates of liabilities and probable loss contingencies (e.g., interest maintenance reserves, asset valuation reserves, and others).

Revenue should be recognized only as the earnings process of the underlying underwriting or investment business is completed. Accounting treatments that tend to defer expense recognition do not generally represent acceptable SAP treatment.

SAP income reflects the extent that changes have occurred in SAP assets and liabilities for current period transactions, except changes in capital resulting from receipts or distributions to owners. SAP income also excludes certain other direct charges to surplus that are not directly attributable to the earnings process (e.g., changes in nonadmitted assets).

Although the insurers' Annual and Quarterly Financial Statements and Audited Financial Reports filed with the state insurance departments are prepared on a statutory basis, financial analysts also review Holding Company Form B filings and U.S. Securities and Exchange Commission (SEC) filings that may include financial statements prepared based on generally accepted accounting principles (GAAP). Therefore, the analyst must also have a general understanding of GAAP.

Though most non-publicly traded insurers are not required to produce financial statements on a GAAP basis, many do for internal purposes. Therefore, the analyst should consider requesting and analyzing GAAP financial statements in addition to SAP financial statements, if concerns warrant. Comparing financial results based on SAP to those based on GAAP for an insurer can provide meaningful information to the analyst regarding the insurer's financial status.

There are two main conceptual differences between SAP and GAAP.

1. SAP stresses measurement of the ability to pay claims in the future
2. GAAP stresses measurement of emerging earnings of a business from period to period (e.g., matching revenue to expenses)

Appendix D of the *AP&P Manual* is a useful reference in understanding how SAP addresses an issue that has been adopted by GAAP. Additionally, the NAIC *Statutory Accounting Principles Self-Study Program* provides additional guidance on the difference between GAAP and SAP. The following is a discussion of the more significant specific differences between SAP and GAAP for property/casualty, life/A&H insurers, fraternal societies and health entities:

- **Acquisition Costs—Under Statement of Statutory Accounting Principles *(SSAP) No. 71—Policy Acquisition Costs and Commissions***, all acquisition costs, such as commissions and other costs incurred in acquiring and renewing business, are expensed as they are incurred. Under GAAP, those acquisition costs that are primarily related to, and vary with, the volume of premium income are capitalized as an asset and are then amortized by periodic charges to earnings over the terms of the related policies.
- **Valuation of Bonds and Redeemable Preferred Stocks—Under *SSAP No. 26—Bonds* and *SSAP No. 32—Preferred Stock*,** bonds and redeemable preferred stocks are carried at amortized cost or NAIC values in accordance with the NAIC designation of the securities. Under GAAP, bonds and redeemable preferred stocks are carried at amortized cost only if the insurer has the ability and intent to hold the securities to maturity and there are no (other than temporary) declines in fair value, otherwise, they are carried at market value.
- **Nonadmitted Assets—Under *SSAP No. 4—Assets and Nonadmitted Assets*,** assets having economic value, other than those that can be used to fulfill policyholder obligations or other third-party interests, should not be recognized on the balance sheet and are, therefore, considered nonadmitted. SSAP No. 4 defines nonadmitted assets as an asset that is accorded limited or no value in statutory reporting and is one that is either specifically identified as a nonadmitted asset or not specifically identified as an admitted asset within

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the AP&P Manual. *SSAP No. 20—Nonadmitted Assets*, specifically identifies the following as nonadmitted assets: deposits in suspended depositories; bills receivable not for premium and loans unsecured or secured by assets that do not qualify as investments; loans on personal security, cash advances to, or in the hands of, officers or agents and travel advances; all non-bankable checks (e.g., non-sufficient funds); trade names and other intangible assets; automobiles, airplanes, and other vehicles; furniture, fixtures, and equipment; and company's stock as collateral for loan.

- **Deferred Income Taxes—Under *SSAP No. 101—Income Taxes,*** deferred income tax assets are limited under admissibility test and amounts over the criterion are nonadmitted. Under GAAP, a valuation allowance is used to reduce the asset to what can be realized. Also, under SSAP No. 101, changes in deferred tax assets (DTAs) and deferred tax liabilities (DTLs) are reported as a separate line in the surplus section. Under GAAP, changes in DTAs and DTLs are recognized in earnings.
- **Goodwill—Under *SSAP No. 68—Business Combinations and Goodwill***, goodwill represents the difference between the cost of acquiring the entity and the reporting entity's share of the book value of the acquired entity. Under GAAP, goodwill represents the difference between cost of acquiring the entity and the fair value of the assets less liabilities acquired.
- **Surplus Notes—Under *SSAP No. 41—Surplus Notes***, surplus notes meeting certain requirements are considered as surplus. Under GAAP, surplus notes are considered to be debt.

The following discusses the specific differences between SAP and GAAP for property/casualty insurers only:

- **Reinsurance in Unauthorized Companies—Under *SSAP No. 62—Property and Casualty Reinsuranc*e**, reserves are required for the excess of unearned premiums and losses recoverable over funds held on business reinsured with companies not authorized to do business in the insurer's state of domicile. Under GAAP, reinsurance recoverables are allowed regardless of whether the reinsurer is authorized, subject to tests of recoverability.

The following addresses reporting for insurers filing on a basis of accounting that deviates from SAP (e.g., GAAP or other permitted practices):

State regulators use financial analysis tools and risk-based capital (RBC) standards to evaluate the financial condition of insurance companies. The benchmarks for these tools are based on SAP. If an insurer prepares statements utilizing accounting practices that deviate from SAP, consider the impact to the RBC results.

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PRIORITIZATION FRAMEWORK

The financial analysis process should be priority-based to ensure that insurers are reviewed promptly and at a level commensurate with the nature of their risks, complexity, and solvency position. To facilitate priority-based analysis, state insurance departments should utilize the following general framework to prioritize or classify insurance companies according to each insurer's relative stability and the perceived need for enhanced analysis:

- **Priority 1 (Troubled)** – The highest priority insurers from a solvency monitoring perspective, based on significant financial solvency risks. Insurers prioritized at this level are considered troubled and subject to comprehensive annual and quarterly analysis procedures, detailed considerations outlined with the *Troubled Insurance Company Handbook,* and a significantly elevated level of ongoing regulatory monitoring and oversight. Upon designating an insurer as a Priority 1, the domestic state should follow required procedures for troubled companies in communicating with other state insurance regulators. Insurers prioritized at this level would also be considered priority insurers for accreditation timeliness purposes and should generally be analyzed ahead of Priority 2, Priority 3, and Priority 4 insurers.
- **Priority 2 (Priority)** – High-priority insurers that are not yet considered troubled but may become so if recent trends or unfavorable metrics are not addressed. High-priority insurers may also include those subject to heightened monitoring for reasons other than financial solvency risks, as determined by the department. Insurers prioritized at this level may be subject to full quarterly analysis procedures and are subject to comprehensive annual analysis and an elevated level of ongoing regulatory monitoring and oversight. Insurers prioritized at this level would also be considered priority insurers for accreditation timeliness purposes and should generally be analyzed ahead of Priority 3 and Priority 4 insurers.
- **Priority 3 (Non-Priority)** – Moderate priority insurers that indicate some need for additional monitoring. Insurers prioritized at this level should be subject to comprehensive annual analysis procedures, should generally be analyzed ahead of Priority 4 insurers, and may be subject to an enhanced level of ongoing regulatory monitoring and oversight.
- **Priority 4 (Non-Priority)** – Low priority insurers that are fundamentally sound, not overly complex and/or nationally significant, and do not currently indicate a need for additional monitoring as no material regulatory concerns have been identified and their solvency risk is viewed as remote. Such insurers demonstrate a track record of stable operations, strong capitalization, and effective corporate governance. In addition, such insurers are not subject to significant business fluctuations or major changes to their core operations and strategies. These insurers should be subject to a basic level of regulatory monitoring and oversight, including annual analysis.

The prioritization framework outlined above is primarily intended for use in communicating the prioritization of insurers on a uniform basis across state insurance departments. Therefore, state insurance regulators should present the prioritization of its insurers in accordance with the NAIC framework above when preparing and sharing information on insurers (i.e., Insurer Profile Summary) with other regulators. However, each state insurance department may adjust, enhance and/or develop an alternate prioritization framework and scale for its own internal purposes, as long as the framework outlined above is used in external communication with other regulators.

An insurer's priority level should be reconsidered as the result of each review performed to determine whether the designation is still appropriate and the rationale for changes in priority ratings should be clearly documented within analysis files. However, changes in priority levels should only be made after approval by senior insurance department personnel.

[i] The use of the term "nationally significant" is not intended to reference the nationally significant monitoring criteria utilized by the NAIC's Financial Analysis (E) Working Group. Regulators may use judgment in evaluating the significance of an individual insurer to the national insurance market to determine which domestic insurers qualify for low priority treatment.

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PRIORITIZATION FACTORS

Although prioritization is, to a large extent, subjective, a state insurance department should establish guidelines to assist in the consistent assignment of priority designations to its insurers. These guidelines may consist of both quantitative and qualitative considerations. Factors that may be given consideration in the state insurance department's prioritization system include, but are not limited to, the following:

- Results of the most recently completed risk-focused analysis, including branded risk exposures and assessments (based on analysis of the Annual Financial Statement, Quarterly Financial Statements, supplemental filings, holding company analysis and any other documents reviewed by the analyst)
- Level of capitalization and identification of unfavorable trends
- Negative trends in profitability and/or cash flow from operations
- Insurance Regulatory Information System (IRIS) ratio results
- Annual and Quarterly Scoring System ratio results
- Changes in the insurer's officers or board of directors
- Changes in the insurer's business strategy or operations
- Summary of results of the automated quantitative data and benchmarks in the *Financial Analysis Handbook* risk repositories
- Issues/questions identified by the NAIC Financial Analysis (E) Working Group
- Examination findings and recommendations (financial condition and market conduct)
- Information from other divisions or areas within the insurance department
- Independent organization ratings and reports
- Information obtained from other regulatory agencies (including federal)
- RBC and RBC Trend Test results
- Impact on the public of an insurer's insolvency (policyholders and jurisdictions potentially affected)
- Structure and complexity of the insurer or insurance group
- Current or pending regulatory actions
- Standing of insurer in relation to statutes that impact financial solvency (e.g., hazardous financial condition)

As a general rule, financial statements and other materials pertaining to those insurers that are deemed higher in priority should be reviewed before those materials pertaining to lower priority insurers. In addition, the review of higher priority insurers should typically be more in-depth than the review of lower priority insurers.

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II. Risk-Focused Financial Analysis Framework

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OVERVIEW OF RISK-FOCUSED SURVEILLANCE PROCESS

The intent of the risk-focused surveillance process is to broaden and enhance the identification of risk inherent in an insurer's operations and use that evaluation in formulating the ongoing surveillance of the insurer. Through their activities, insurers assume a variety of risks, which is the essence of an insurance transaction. The type of risk and its significance vary by activity. Investment activities may involve credit risk, market risk and liquidity risk. In product sales, insurers may assume market risk, pricing/underwriting risk, strategic risk or liquidity risk in varying degrees, depending on the product. Over the years, state insurance regulators have developed numerous tools to address the risks insurers assume. Investment laws limit the market and credit risk insurers can assume. Limitations on net retentions help reduce catastrophe risk. Risk-based capital requirements establish capital levels in recognition of a variety of risks. State insurance regulators have always considered the risk profiles of licensed insurers and the activities that may pose risk to the company in the future. The risk-focused surveillance process uses an organization-wide risk assessment process to enhance evaluation and to better coordinate the activities of financial solvency surveillance through greater consistency within the state insurance department, and with other departments.

A risk-focused surveillance process includes identifying significant risks, assessing and analyzing those risks, documenting the results of the analysis, and developing recommendations for how the analysis can be applied to the ongoing monitoring of the insurer. This increased attention by state insurance regulators to risk assessment and risk management processes used by insurers will be a positive development.

The enhancements included in the risk-focused surveillance process, including examination and analysis, intend to provide the following benefits:

1. Strengthen regulatory understanding of the insurer's corporate governance function by documenting the composition of the insurer's board of directors and the executive management team, as well as the quality of guidance and oversight provided by the board and management.

2. Enhance evaluation of risks through assessment of inherent risks and risk management processes to determine if there are weaknesses of management's ability to identify, assess and manage risk.

3. Improve early identification of emerging risks at individual insurers on a sector-wide basis.

4. Enhance effective use of regulatory resources through increased focus on higher risk areas.

5. Increase regulatory understanding of the insurer's quality of management, the characteristics of the insurer's business and the risks it assumes.

6. Enhance the value of surveillance work and establishment of risk assessment benchmarks performed by insurers and state insurance regulators, who have common interest in ensuring that risks are properly identified and that adequate, effective control systems are established to monitor and control risks.

7. For examinations, better formalize and document the risk assessment process via the use of the risk assessment matrix tool to assist in examination planning and resource assignment.

8. Expand risk assessment to provide a more comprehensive and prospective look at an insurer's risks through identification of the insurer's current and/or prospective high-risk areas.

9. For examinations, coordinate the results of the risk-focused examination process with other financial solvency surveillance functions (i.e., establishing/updating the priority score and supervisory plan).

In full, the risk-focused surveillance process provides effective procedures to monitor and assess the solvency of insurers on a continuing basis. The risk-focused approach consists of a structured methodology designed to

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establish a forward-looking view of an insurer's risk profile and the quality of its risk management practices. This approach permits a direct and specific focus on the areas of greatest risk to an insurer. Through this approach, state insurance regulators can be more proactive and better positioned to identify and respond to any serious threat to the stability of the insurance company from any current or emerging risks. This regulatory approach will benefit all participants in the insurance marketplace.

Role of the Financial Analyst

In the risk-focused surveillance approach, the financial analyst's role is to provide continuous off-site monitoring of the state's domestic insurers' financial condition, monitor internal/external changes relating to all aspects of the insurer, maintain a prioritization system and provide input into the state insurance department's priority of each insurer, work with the examination staff to develop an ongoing Supervisory Plan as well as update the Insurer Profile Summary (IPS), and provide state insurance department management with timely knowledge of significant events relating to the domestic insurers.

Risk-Focused Surveillance Cycle

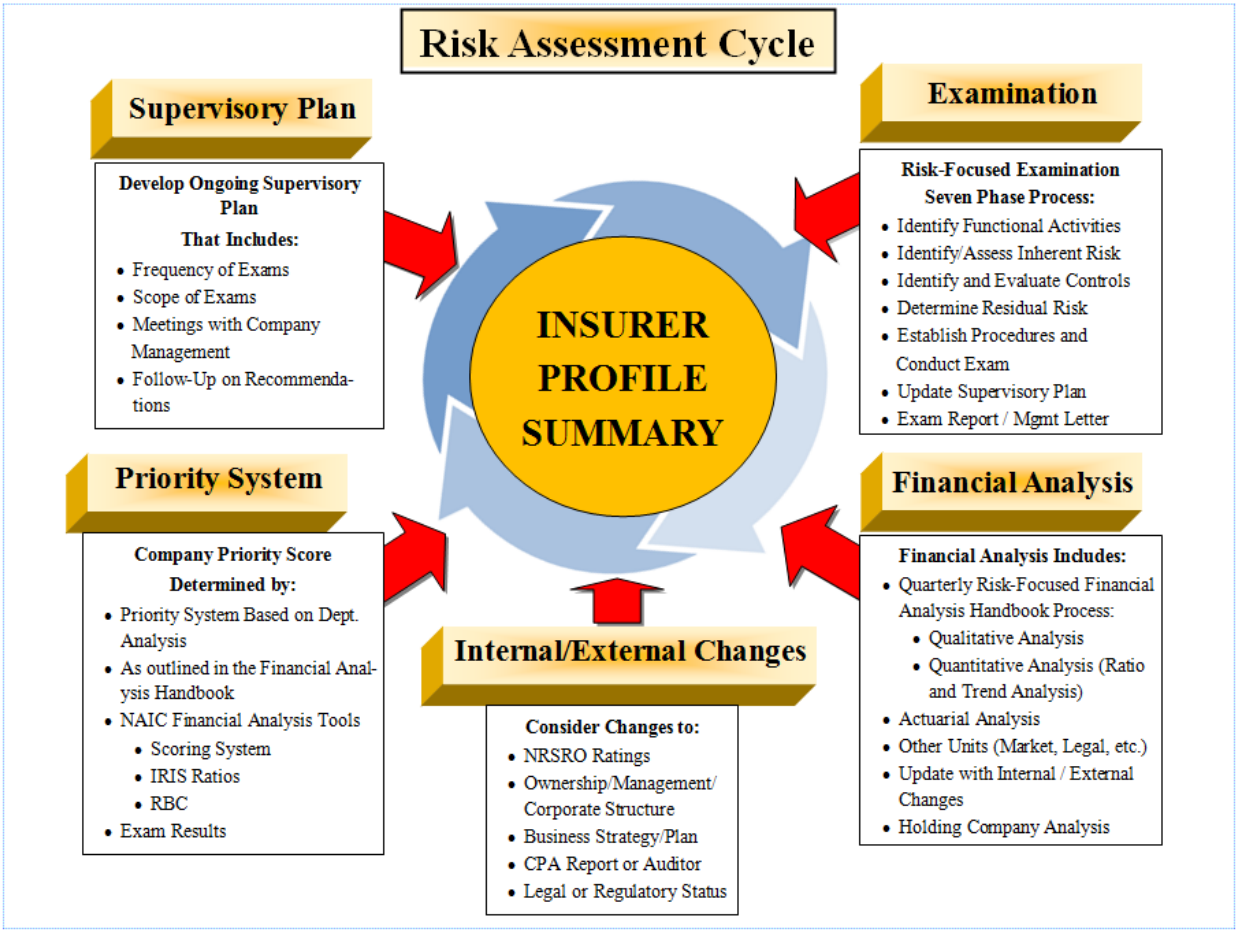
The risk-focused surveillance framework is designed to provide continuous regulatory oversight. The risk-focused approach requires fully coordinated efforts between the financial examination function and the financial analysis function. There should be a continuous exchange of information between the field examination function and the financial analysis function to ensure that all members of the state insurance department are properly informed of solvency issues related to the state's domestic insurers.

The regulatory Risk-Focused Surveillance Cycle involves five functions, most of which are performed under the current financial solvency oversight role. The enhancements coordinate all of these functions in a more integrated manner that should be consistently applied by state insurance regulators. The five functions of the risk assessment process are illustrated within the Risk-Focused Surveillance Cycle.

As illustrated in the Risk-Focused Surveillance Cycle diagram, elements from the five identified functions contribute to the development of an IPS. Each state will maintain an IPS for its domestic companies. State insurance regulators that wish to review an IPS for a non-domestic company will be able to request the IPS from the domestic or lead state. The documentation contained in the IPS is considered proprietary, confidential information that is not intended to be distributed to individuals other than state insurance regulators.

Please note that once the Risk-Focused Surveillance Cycle has begun, any of the inputs to the IPS can be changed at any time to reflect the changing environment of an insurer's operation and financial condition.

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The elements of the risk assessment process are:

- **IPS:** This profile is used to "house" summaries of risk-focused examinations, financial analyses, internal/external changes, priority scores, supervisory plan and other standard information. This profile is intended to be a "living document" and preferably shared with other state insurance regulators who have signed the NAIC *Master Information Sharing and Confidentiality Agreement* verifying that such shared information would remain confidential.
- **Risk-Focused Examinations:** These examinations consist of a seven-phase process that can be used to identify and assess risk, assess the adequacy and effectiveness of strategies/controls used to mitigate risk, and assist in determining the extent and nature of procedures and testing to be used in order to complete the review of that activity. The risk-focused surveillance process can be used to assist examiners in targeting areas of high-risk.
- **Risk-Focused Financial Analysis:** This function consists of a risk-focused analysis processes performed by state insurance regulators as outlined in the *Financial Analysis Handbook* (Handbook). This analysis process identifies and assesses risk based on the nine branded risk classifications to complete and document an overall assessment of the financial condition of the insurer.
- **Internal/External Changes:** Changes in rating agency ratings, ownership/management/corporate structure, financial condition/risk profile, business strategy or plan, external audit reports, and legal or regulatory status should be considered in developing the priority and supervisory plan.
- **Priority System:** The prioritization of the insurer, changes in priority or rationale for changes. See chapter I.F. Prioritization of Work for details.

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- **Supervisory Plan:** At least once a year, a supervisory plan should be developed or updated by the domestic state for each domestic insurer. The supervisory plan should be concise and outline the type of surveillance planned, the resources dedicated to the oversight, and the consideration and communication and/or coordination with other states.

OVERVIEW OF THE RISK-FOCUSED FINANCIAL ANALYSIS PROCESS

Financial analysis is an ongoing process that can be divided into annual cycles, each of which includes the analysis of the Annual Financial Statement, Quarterly Financial Statements and the various supplemental filings, such as the Actuarial Filings, Management's Discussion and Analysis (MD&A), Audited Financial Report and holding company filings. The financial analysis process is designed to assist the analyst in reviewing and analyzing insurers throughout the annual cycle in a logical manner, focusing on areas of concern within the nine branded risk classifications. The end result of this process is a financial analysis of each insurer specifically tailored to the concerns of that insurer as a result of its unique risks.

Procedure Description	Expectation
Risk Assessment Procedures and Insurer Profile Summary (annual and quarterly).	Complete for all domestic insurers.
Non-Lead State Holding Company Analysis (applies only to non-lead state domestic insurance regulators).	Complete for all domestic insurers that are part of an insurance holding company system.
Lead State Holding Company Analysis Documented within the Group Profile Summary (applies only to lead state domestic insurance regulators).	Complete for all insurance holding company system groups.

ANNUAL/QUARTERLY RISK ASSESSMENT PROCEDURES – DOMESTIC INSURER

Annual and Quarterly Financial Statements

An insurer is required to file an Annual Financial Statement with its state of domicile, the NAIC and all jurisdictions in which the insurer is authorized to transact business by March 1 of each year for the 12 months ended December 31 of the previous year. An insurer is required to file Quarterly Financial Statements for the first, second and third quarters with the state of domicile, the NAIC and, in most instances, all states in which the insurer is authorized to do business by May 15, August 15 and November 15, respectively. The Financial Statement information is loaded onto the NAIC database, at which time automated financial analysis solvency tools are calculated, and the Handbook's quantitative results are generated. All of this information is available to the state insurance departments via iSite+.

Scope and Depth of Risk-Focused Analysis

The depth of review will depend on the complexity, financial strengths and weaknesses, and known risks of the insurer and the priority designation established by the state insurance department. Other factors—such as the insurer's past regulatory history, accuracy of filing, age of insurer, stability of business plan, knowledge of insurer's operations, and materiality of the regulatory concerns, etc.— may affect the scope and depth of analysis. The flexibility to customize the scope and depth of the analysis is determined at the state insurance

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department's discretion and should include analyst and supervisor input. Therefore, the state insurance department should tailor the data and procedures used and the level of documentation to sufficiently address the specific risks of the insurer.

The Risk Assessment procedures for annual analysis consists of an overall analysis of the insurer documented in the nine branded risk classifications. Refer to section III.A.4 Risk Assessment – Analyst Reference Guide for further explanation of the risk classifications. The analyst should perform a background analysis, a current period analysis, and a review of data and procedures within the nine branded risk classifications. All of these data and procedures provide the basis for the completion of a thorough review of the insurer's financial solvency.

The nine branded risk classification chapters contain guidance and highlight data, benchmarks and procedures the analyst may use to perform his/her analysis of that risk category. The analyst's review should use data relevant to each specific risk classification and customized for the insurer such that it is sufficient to perform and document his/her analysis and investigation of risks. Analysts are not expected to complete every suggested procedure in the branded risk guidance. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address specific risks of the insurer and document the completion of the analysis. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.

At the conclusion of the risk assessment, the analyst should develop and document an overall summary and conclusion based on the results of the risk-focused analysis performed, prospective risks of the insurer, follow-up analysis or regulatory actions, any correspondence and the impact of the holding company on the insurer. The analyst should update the IPS (and supervisory plan, if applicable) to document this summary and conclusion. Note that an analyst's documentation of the risk assessment represents the *detail* of the analysis of risks, which may be more in-depth for certain material risks or complex insurers, whereas the IPS represents a *summary* of the risks of the insurer. Refer to section III.A.4 Risk Assessment – Analyst Reference Guide for further explanation on completing the IPS.

The analysis of annual statements for priority insurers (see section I.F. Prioritization of Work for definitions), including supervisory review, should be completed by the end of April. The analysis of annual statements for non-priority insurers, including supervisory review, should be completed by the end of June, unless a preliminary analysis (see section III.A.4. Risk Assessment ARG for description) indicates no immediate concerns. In that case, the analysis of non-priority insurers should be completed by the end of July.

The analysis of quarterly statements, unless the insurer passes the quarterly non-troubled qualitative review referenced below, should be completed within 60-days of receipt for priority insurers, and within 90-days of receipt for non-priority insurers.

Supplemental Filings

Other supplemental filings to the Annual Statement, Management's Discussion and Analysis filings, and the Annual Audited Financial Statements and related filings, are required to be reviewed within 60-days of receipt for priority insurers, and within 120- days of receipt for non-priority insurers.

Quarterly Non-Troubled Quantitative Review

For first-, second- and third-quarter financial statement analysis, if the results for the non-troubled automated system calculation (see section III.A.4. Risk Assessment ARG for description) indicates a full quarterly risk assessment should be completed and if it is not, then the analyst should justify and document the reason(s) why. If the results indicate that a full quarterly risk assessment is not required, no quarterly analysis documentation is required to be completed.

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If the insurer has been identified as troubled (i.e., Priority 1) or the results of the non-troubled automated system calculation indicate a full quarterly risk assessment should be completed and no justification for not completing one is provided, then the analysis of quarterly statements should be completed within 60-days of receipt for priority insurers, and within 90-days of receipt for non-priority insurers.

Prioritization of Analysis Work

The analyst should ensure that those insurers identified as having significant concerns will be analyzed on a priority basis for future filings. Those insurers with the highest priority should receive the most in-depth review and are required to be analyzed more frequently, and earlier in each review period. Refer to section I.F. Prioritization of Work for further guidance.

Supervisor Input and Review

It is important for the analyst's supervisor to be actively involved in the financial analysis performed, including determination of the scope and depth of analysis. It also is important that the review and supervision be performed on a timely basis.

The branded risk guidance offers suggestions for the types of information the analyst may consider requesting from the insurer. It is important that the analyst's proposed follow-up procedures be discussed with the analyst's supervisor.

Use of Contractors in Financial Analysis Work

An insurance department's decision to engage an independent contractor to assist in the completion of financial analysis work may arise due to insufficient department staff or the need for specialized expertise. While the foregoing circumstances may lead an insurance department to contract the services of an independent contractor, the department should consider the long-term effects of not maintaining an appropriate level of qualified staff.

If the department utilizes a contractor to perform the primary supervisory review of financial analysis, an additional level of review is required on the IPS and/or Group Profile Summary (GPS) by a qualified department employee in accordance with the overall timeliness expectations. This review should result in the department employee understanding and assessing the overall quality of the analysis work performed.

An independent contractor is defined as anyone employed by the state insurance department that is outside of the department's staff. When selecting and overseeing an independent contractor to assist in the completion of financial analysis work, the insurance department should evaluate the following:

- **Independence/Conflicts of Interest** – Conflicts of interest may occur if analysis of a company is performed, or related advice regarding the company is provided, by an independent contractor who has a significant relationship with the company, its affiliates, or their management (financial or nonfinancial) that may impair in fact, or appearance, the independent contractor's independence. To evaluate any such conflicts of interest, the insurance department should request information from the independent contractor on a regular basis regarding its past, present or planned relationships, both financial and non-financial, with the company or its affiliates and utilize this information to ensure that the selected contractor is truly independent from the insurer/group being analyzed.

    - Additionally, if relevant, the insurance department should request and review information provided on all relationships between the contractor, the contractor's firm or any affiliates of the firm with entities that are regulated by the department for which the anticipated services of the contractor may have some impact, directly or indirectly, on the department's oversight of such entities. To the extent that other services are potentially impacted, the department should

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request and review information on controls put in place by the contractor to ensure that potential conflicts do not exist and/or are not created through assignment of analysis work.

- **Confidentiality Protections** – The state insurance department should ensure that adequate confidentiality protections are incorporated into contracts with independent contractors to ensure that confidential and proprietary information of the insurer/group shared with the contractor for purposes of conducting financial analysis work is adequately protected in accordance with state law and recommended best practices. Such contracts should indicate that any non-public or proprietary information or data to which the contractor has access during financial analysis work on behalf of the state insurance department may not be utilized for any other purpose. For example, such information should not be utilized to benefit consulting/advisory engagements for the contractor's other clients or otherwise to promote the contractor's business. In certain situations, state insurance departments may be required to include specific confidentiality language in the contract and/or inform the insurer prior to sharing confidential and proprietary information (e.g., ORSA, Corporate Governance Annual Disclosure) with the independent contractor. As such, state insurance departments are encouraged to review their state requirements before sharing confidential information with an independent contractor.

- **Security and Data Governance** – The state insurance department should ensure that adequate security and data governance practices are in place at the contractor to keep all information and data reviewed or obtained during the engagement with the department confidential and maintained in a secure environment with access limited only to listed authorized personnel. Such practices should include an obligation to report any breach or unauthorized access or disclosure to the department and should include the use of secure file transfer protocol for delivering information and employ best practices for encryption and/or access to the information.

Captives and/or Insurers Filing on a U.S. GAAP Basis

These procedures are designed for insurers filing on a U.S. generally accepted accounting principles (GAAP) (or modified GAAP) basis, after the completion of the traditional Risk Assessment Procedures. (See section III.C.1. Special Analysis Procedures – Captives and/or Insurers Filing on a U.S. GAAP Basis Worksheet.) The procedures provide guidance on the review of a GAAP filer on a statutory blank and address the following areas:

- Management assessment
- Balance Sheet assessment
- Operations assessment
- Investment practices
- Review of disclosures
- Assessment of results from prioritization and analytical tools

DOMESTIC AND/OR NON-LEAD STATE HOLDING COMPANY SYSTEM ANALYSIS

Procedures for evaluating and considering the impact of an insurance holding company system on individual insurers should be completed for all domestic insurers. For lead states, this consideration is included within the VI.C Insurance Holding Company System Analysis Guidance (Lead State). For non-lead states, this consideration is included in V.A Holding Company Procedures (Non-Lead State). The depth of the holding company analysis of an insurer in a holding company system will depend on the characteristics (e.g., sophistication, complexity and financial strength) of the holding company system, availability of information, and existing potential issues and

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problems found during review of the holding company filings. Non-lead states should obtain, utilize and rely on holding company analysis work performed by the lead-state, as appropriate, in fulfilling their review responsibilities. Lead state and non-lead state responsibilities are further defined in section VI.C.

The following procedures are also included within section V.A. Note that Form A, Form D, Form E and Extraordinary Dividends/Distributions are transaction-specific and are not part of the regular annual/quarterly analysis process. The review of these transactions may vary as some states may have regulations that differ from these Forms.

- **FORM A**
  The Form A review is to be completed for all acquisitions, mergers or changes in control. Form A is filed with the domestic state of each insurer in the group. The analyst should review the transaction and all applicable documents and complete the Form A Procedures, when necessary.

- **FORM D**
  The Form D review is to be completed for all prior notices of material transactions. Form D must be filed with the domestic state. The analyst should review the transaction and all applicable documents and complete the Form D Procedures, when necessary.

- **FORM E OR OTHER REQUIRED INFORMATION ON COMPETITIVE IMPACT**
  The Form E or other review of competitive impact is to be completed for all pre-acquisition notifications regarding the potential competitive impact of a proposed merger or acquisition by a non-domiciliary insurer doing business in the state or by a domestic insurer. Form E or other required information must be filed with the domestic state. The insurer may also be required to file documents with the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) under the federal Hart-Scott-Rodino (HSR) Act. The analyst should review the transaction and all applicable documents and complete the Form E Procedures, when necessary.

- **EXTRAORDINARY DIVIDENDS/DISTRIBUTIONS**
  The extraordinary dividends/distributions review is to be completed for any domestic insurers planning to pay any extraordinary dividend or make any other extraordinary distribution to its shareholders. Such dividends and distributions must receive proper prior regulatory approval. The analyst should review the transaction and all applicable documents and complete V.E Extraordinary Dividends/Distributions Procedures, when necessary.

At the end of section V.A., the analyst is asked to develop and document a conclusion regarding the impact of the holding company system on the domestic insurer and update the IPS accordingly by Dec. 31 each year. In addition, the analyst is encouraged to notify the lead state of any material risks or events that the lead state may not be aware of, that should be considered in the evaluation of the overall financial condition of the holding company system.

GROUP-WIDE SUPERVISION

The Group-Wide Supervision procedures establish guidance for lead state use in the analysis of insurance company holding systems. This includes a risk-focused approach to group regulation where specific risks that are relevant to insurance holding company structures are addressed.

- **INSURANCE HOLDING COMPANY SYSTEM ANALYSIS DOCUMENTED IN THE GROUP PROFILE SUMMARY (GPS) (LEAD STATE)**:
  - Understanding the insurance holding company system (lead state)
  - Addressing lead state analysis considerations

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- Evaluating the overall financial condition of the holding company system by completing a detailed analysis through the group's exposure to each of the nine branded risk classifications
- Assessing corporate governance and enterprise risk management
- Documenting material concerns or conditions in the group that affect the lead state's domestic companies
- Performing additional procedures on key risk areas, as needed
- Sharing the results of the analysis, through the GPS, with other impacted regulators on a timely basis (i.e., by October 31 for groups with insurers domiciled in multiple states)

- **CORPORATE GOVERNANCE DISCLOSURE PROCEDURES**
  The *Corporate Governance Annual Disclosure Model Act* (#305) and *Corporate Governance Annual Disclosure Model Regulation* (#306) require an insurer, or an insurance group, to file a summary of an insurer or insurance group's corporate governance structure, policies and practices with the commissioner by June 1 of each calendar year. The lead state should take primary responsibility for reviewing the CGAD filing, if it is filed on a group basis, and should incorporate any takeaways or concerns into the GPS. Any concerns relevant only to a specific insurance entity in the group should be communicated to the domestic state in a timely manner.

- **OWN RISK AND SOLVENCY ASSESSMENT (ORSA) PROCEDURES**
  The *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) requires insurers above a specified premium threshold, and subject to further discretion, to submit a confidential annual ORSA Summary Report.

- **FORM F PROCEDURES**
  The Form F is filed with the lead state commissioner of the insurance holding company system for every insurer subject to registration under the *Insurance Holding Company System Regulatory Act* (#440). The Form F review is to be completed by the lead state in conjunction with the review of Form B. The lead state analyst should identify the material risks within the insurance holding company system that could pose enterprise risk to the insurers in the group. Takeaways and concerns from the review should be documented in the GPS. Any concerns relevant only to a specific insurance entity in the group should be communicated to the domestic state in a timely manner.

- **PERIODIC MEETING WITH THE GROUP PROCEDURES**
  These procedures are intended to demonstrate the type of potential questions a lead state may want to consider when it conducts a periodic meeting with the group.

- **TARGETED EXAMINATION PROCEDURES**
  The targeted examination procedures provide examples of potential risk areas where the lead state may want to perform certain limited examination procedures as part of the continual risk assessment process.

Lead State Report

The Lead State Report is located in iSite+, within Summary Reports, and is designed to improve communication and coordination between state insurance regulators. It provides a list of all insurance groups and the companies within each group, which can be sorted in various ways. The report also contains current contact information for the state's assigned insurance company analyst and the state's chief analyst, which is maintained by state insurance department staff.

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III. Annual/Quarterly Worksheets, and Risk Assessment Guidance

A. Risk Assessment (All Statement Types)

1. Annual Risk Assessment Worksheet
2. Quarterly Risk Assessment Worksheet
3. Quarterly Quantitative Assessment of Non-Troubled Insurers
4. Analyst Reference Guide
5. Insurer Profile Summary Example
6. Template for Planning Meeting with Financial Examiner
7. Use of Branded Risk Assessment Guidance

B. Risk Assessment Guidance

1. Credit Risk Assessment
2. Legal Risk
    a. Assessment
    b. Audited Financial Report Worksheet
    c. MD&A Worksheet
3. Liquidity Risk Assessment
4. Market Risk Assessment
5. Operational Risk Assessment
6. Pricing & Underwriting Risk Assessment
7. Reputational Risk Assessment
8. Reserving Risk
    a. Property & Casualty and Title
        i. Statement of Actuarial Opinion Worksheet
        ii. Reserving Risk Assessment
    b. Life, Accident & Health
        i. Statement of Actuarial Opinion Worksheet
        ii. Reserving Risk Assessment
    c. Health
        i. Statement of Actuarial Opinion Worksheet
        ii. Reserving Risk Assessment
9. Strategic Risk Assessment

C. Special Analysis Procedures and Worksheets

1. Insurers Filing on a U.S. GAAP Basis Worksheet (P&C)
2. XXX/AXXX Captive Reinsurance Transactions Procedures (Life)
3. Title Insurer Worksheet (Title)

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Legend of Abbreviations

Branded Risk Classifications		
Symbol	**Risk**	**Description**
CR	Credit	Amounts actually collected or collectible are less than those contractually due or payments are not remitted on a timely basis.
LG	Legal	Non-conformance with laws, rules and regulations, prescribed practices or ethical standards (in any jurisdiction in which the entity operates) will result in a disruption in business and financial loss.
LQ	Liquidity	Inability to meet contractual obligations as they become due because of an inability to liquidate assets and/or obtain adequate funding without incurring unacceptable losses.
MK	Market	Movement in market rates or prices (such as interest rates, foreign exchange rates or equity prices) adversely affect the reported and/or market value of the investments.
OP	Operational	The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events.
PR/UW	Pricing/ Underwriting	Pricing and underwriting practices are inadequate to provide for risks assumed.
RP	Reputation	Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.
RV	Reserving	Actual losses and/or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
ST	Strategic	Inability to implement appropriate business plan, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

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Analyst:	Date:
Supervisor Review:	Date:
Supervisor Comments:	

Overall Risk Assessment Instructions

The insurance department should generally follow the risk-focused financial analysis process outlined in The *Financial Analysis Handbook* to ensure that appropriate analysis procedures are performed on each domestic insurer. The documentation must be prepared in sufficient detail to provide a clear understanding of the work performed and conclusions reached.

Risk Assessment procedures should be completed and tailored to address the specific risks of the insurer based on the complexity, financial strengths and weaknesses, and known risks of the insurer. Analysts should document the detailed results of the review in Section III: Risk Assessment and the summary in the Insurer Profile Summary (IPS) report.

The Risk Assessment procedures are comprised of the following four sections, which collectively represent a full analysis of an insurer: I) Background Analysis; II) Current Period Analysis; III) Risk Assessment; and IV) Update the IPS.

Section I: Background Analysis

1. **Prior Year Analysis and Prioritization:** Review the analysis performed on the insurer for the prior year and prior quarters.
    a. Review and consider the state's priority designation, prioritization tool results (if applicable) as of the last review and start of the current review and the Preliminary Analysis (if applicable) as of the current review.
    b. In preparing for current year analysis, review and consider the issues, concerns and prospective risks, noted in previous annual or quarterly analyses work papers, the IPS and supervisory plan, including analysis of the Own Risk and Solvency Assessment (ORSA) Summary Report (if applicable), completed in the prior year that affects the current analysis.
    c. Consider any follow-up conducted and correspondence with the insurer, along with any conclusions.
2. **Communication**: Review any inter-departmental communication, as well as communication with other state, federal or international insurance regulators and the insurer. Consider in the current analysis any unusual items or prospective risks that indicate further analysis or follow-up is necessary. Document risks identified and assessed in the appropriate branded risk category in Section III: Risk Assessment.
3. **Examination Planning:** If a financial examination is currently being planned, meet with the assigned examiner in-charge (EIC) or examination supervisor to:
    a. Discuss information on risks and concerns provided in the IPS, as well as additional information on the company's financial condition, operating results since the last examination, and reasons for any unusual trends, abnormal ratios and transactions that are not easily discernible.
    b. Communicate and provide access to relevant information that has already been obtained by the analyst function and is available to the state insurance department. It may be helpful for the analyst to review the Examiner's Exhibit B questionnaire and note specific items that have already been accumulated and available to the examiner.
4. **Examination Analysis Follow-Up:** Review the Annual Financial Statement, General Interrogatories, Part 1, #3 and determine if a financial examination report was released by the domiciliary state since the last review.

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Document risks identified and assessed in the appropriate branded risk category in Section III: Risk Assessment.

a. Balance sheet date of the latest financial examination of the insurer	[Data]
b. Balance sheet date of the latest financial examination report available from either the state of domicile or the insurer	[Data]
c. Release date of the latest financial examination report available from either the state of domicile or the insurer, and what state insurance department or departments completed the Financial Examination Report	[Data]
d. Have any financial statement adjustments within the latest financial examination report not been accounted for in a subsequent financial statement filed with the state insurance department?	[Data]
e. Have any of the recommendations within the latest financial examination report not been complied with?	[Data]

If 4.d. or 4.e. is "yes," or if follow-up was required from the review of the examination report, management letter or summary review memorandum in a previous analysis period, document risks identified and assessed in the appropriate branded risk category of Section III: Risk Assessment.

f. Implementation of financial examination report recommendations or management letter comments.

g. Impact of any financial statement adjustments on the insurer's financial condition.

h. Findings from the results of the examination represent risks being monitored, procedures performed or yet to be performed and prospective risks.

Section II: Current Period Analysis

The intent of the current period analysis section is for an analyst to perform a review of current results that may identify a change in a risk assessment either with new risks or by updating previously identified risks in Section III: Risk Assessment. Analysts should identify and assess changes in the insurer's current financial status compared to the prior period, new or continuing trends, and unusual items. The following procedures do not constitute an all-inclusive list to be considered. Analysts should use their knowledge, expertise and professional judgement to complete a thorough analysis of the current period financial results.

5. **Financial Reporting and Data Applications:** Review and assess material changes and trends in the balance sheet, income statement, cash flow, and related financial metrics. Document risks identified and assessed in the appropriate branded risk category of Section III: Risk Assessment.

- Annual Financial Statement including the Risk-based Capital Report (March 1st and April 1st Filings)[i]
- Actuarial filings[ii]
- Financial Ratios and Financial Analysis Solvency Tools[iii], such as the Financial Profile Report, Scoring System, Insurance Regulatory Information System (IRIS), Investment and Reinsurance Jumpstart Reports, Investment Snapshot Reports, market conduct information, etc.
- Industry reports, news releases, ratings and information about emerging issues

[i] The analyst should review and consider information from these data sources in conducting a risk-focused analysis. The review should be evidenced by sign-off and dating of the information source, procedure step or simplified checklist.
[ii] See footnote i
[iii] See footnote i

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6. **Management Assessment:** Review the Annual Financial Statement, including the Jurat page and General Interrogatories and other available information, to determine compliance with and if any changes have occurred in the following areas. Document risks identified and assessed in the appropriate branded risk category of Section III: Risk Assessment. (e.g., Operational or Strategic)

In the review of the following, note any risks in the Operational or Strategic branded risks within Section III Risk Assessment.	*Benchmark*	*Result*	*Outside Benchmark*
a. Properly executed and notarized Jurat page			
b. Change(s) in officers, directors or trustees since the previous Annual Financial Statement filing	= "#" after name	[Data]	[Data]
i. If 6.b. is "yes," review of the Biographical Affidavit(s) for any new officers, directors or trustees indicated above. Assess any areas of concern that would indicate further review is necessary. (i.e., suitability and other governance-related concerns)			
ii. Assess any follow-up analysis or communication on any previously identified corporate governance issues.			
iii. Assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in its business culture or business plan.			
c. If the insurer has been a party to a merger or consolidation, note any observations or concerns and ensure Form A or additional filings have been approved. [Annual Financial Statement, General Interrogatories, Part 1, #5.1 and #5.2]	=YES	[Data]	[Data]
d. Identify if any Certificates of Authority, licenses or registrations have been suspended or revoked. [Annual Financial Statement, General Interrogatories, Part 1, #6.1 and #6.2]	=YES	[Data]	[Data]

7. **Compliance Analysis:** Review and assess state-specific compliance or other analysis required by the state insurance department. Document risks identified and assessed in the appropriate branded risk category of Section III: Risk Assessment.

   a. Identify if the insurer is compliant with state statutes and regulations, including those that are new or revised (e.g., hazardous financial condition analysis, investment limitation analysis, etc.).

   b. Assess if surplus meets the statutory minimum amount required by state law (varies by state and business type).

8. **Supplemental Filings:** Review and assess supplemental filings (other than the March 1 and April 1 financial statement) for compliance and identification of risks. Document risks identified and assessed in the appropriate branded risk category of Section III: Risk Assessment.

   a. Management Discussion & Analysis (MD&A) (April 1)[iv]

   b. Audited Financial Statement Report (June 1)[v]

[iv] See footnote i
[v] See footnote i

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c. For holding company groups, if performing the review of the group as the lead state, or receiving the lead state's group analysis summary, and assessing the impact of the group on the domestic insurer, incorporate risks identified and assessed related to the domestic insurer into Section III: Risk Assessment.

d. For ORSA Summary Reports, if required, when receiving and performing the review of the ORSA Summary Report or receiving the lead state's review, incorporate risks identified and assessed that relate to the domestic insurer into Section III: Risk Assessment.

9. **Business Plan and Projections (If Available):** Document risks identified and assessed in the appropriate branded risk category of Section III: Risk Assessment.

   a. Identify and assess any material variances between actual financial results compared to the most recent business plan and financial projections.

   b. Identify and assess any material changes in the business strategy.

   The following procedures related to the insurer's business plan and projections are required for all Risk Retention Groups (RRGs) regardless of accounting treatment (Generally Accepted Accounting Principles [GAAP]/Statutory Accounting Principles [SAP]) or organizational structure (captive/traditional laws):

   c. Review the insurer's business plan (plan of operation) to ensure that it is unchanged from the prior year.

   d. If changes were made to the plan, ensure that the changes have been approved.

   e. Review the Annual Financial Statement, General Interrogatories, Part 2, #13.1 to identify the insurer's largest net aggregate risk insured. Measure this exposure as a percent of surplus to ensure that it is in compliance with state guidelines.

   f. Ensure that the financial projections on file accurately reflect the operations as presently conducted.

   g. Ensure that the notes relating to the operation of the company agree with the approved plan.

10. **Analyst Notes of Current Period Results (Optional):** Include any analytical notes of material information.

Source	Notes	Risk Category

11. **Information Request:** If based on the above procedures performed and information gathered, the analyst does not have a sufficient understanding of the insurer's operations and strategies, consider requesting information from the insurer to complete the Section III: Risk Assessment. Refer to the Analyst Reference Guide for instructions.

Section III: Risk Assessment

Risk Assessment Instructions

Risk assessment entails gathering information from the aforementioned sections, along with analyzing the data and benchmarks for each of the nine branded risks included in the annual financial profile report and procedures provided in each of the nine branded risk assessment chapters to develop and document a risk assessment of each relevant material risk of the insurer. Analysts should review and use all relevant and necessary data to focus on specific risks to complete the analysis, which may include data from other financial analysis tools such as the annual scoring report and IRIS ratios. The depth of review will depend on the complexity, financial strengths and weaknesses, and known risks of the insurer.

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Analysts should not rely solely on the annual financial profile report or the risk assessment chapters for identification of all risks (or risk metrics) as it is not an analysis checklist and does not represent a complete list of possible risks for every analysis. Analysts should customize their analysis to include risks unique to the insurer and utilize risk metrics (whether quantitative or qualitative) that are best suited for measuring the insurer's exposure to those risks. Note that procedures included in risk assessment chapters are "best fit" as some procedures may identify risks that could be categorized in more than one branded risk category. Analysts should use their knowledge of the insurer and analytical skills to exercise discretion in re-categorizing risks as needed to document the details of the analysis and to update the IPS. Analysts are not expected to respond separately to results in the annual financial profile report that fall outside the industry benchmarks, rather, analysts should use their expertise and knowledge of the insurer to customize the analysis to address those risks deemed material or that require further investigation.

Complete the following to identify, document and explain each of the nine branded risks below. Refer to the Risk Assessment chapter for further guidance. Documentation of the analysis should contain sufficient detail to adequately explain the risks identified, the metrics/benchmarks used to assess the insurer's exposure to the identified risks, and the results of the risk assessment (i.e., the level and trend of the insurer's risk exposure).

1. **Credit Risk Assessment:** Amounts actually collected or collectible are less than those contractually due, or payments are not remitted on a timely basis. Document the analysis of Credit risk.

Detail of Analysis	Assessment	Trend	IPS Y/N
#1 [Risk Component]		↑	
#2		↔	
#3		↓	

2. **Legal Risk Assessment:** Non-conformance with laws, rules, regulations, prescribed practices or ethical standards (in any jurisdiction in which the entity operates) will result in a disruption in business and financial loss. Document the analysis of Legal risk.

Detail of Analysis	Assessment	Trend	IPS Y/N
#1 [Risk Component]		↑	
#2		↔	
#3		↓	

3. **Liquidity Risk Assessment:** Inability to meet contractual obligations as they become due because of an inability to liquidate assets and/or obtain adequate funding without incurring unacceptable losses. Document the analysis of Liquidity risk.

Detail of Analysis	Assessment	Trend	IPS Y/N
#1 [Risk Component]		↑	
#2		↔	
#3		↓	

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4. **Market Risk Assessment:** Movement in market rates or prices (such as interest rates, foreign exchange rates or equity prices) adversely affects the reported and/or market value of investments. Document the analysis of Market risk.

Detail of Analysis	Assessment	Trend	IPS Y/N
#1 [Risk Component]		↑	
#2		↔	
#3		↓	

5. **Operational Risk Assessment:** The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events. Document the analysis of Operational risk.

Detail of Analysis	Assessment	Trend	IPS Y/N
#1 [Risk Component]		↑	
#2		↔	
#3		↓	

6. **Pricing/Underwriting Risk Assessment:** Pricing and underwriting practices are inadequate to provide for risks assumed. Document the analysis of Pricing/Underwriting risk.

Detail of Analysis	Assessment	Trend	IPS Y/N
#1 [Risk Component]		↑	
#2		↔	
#3		↓	

7. **Reputational Risk Assessment:** Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions. Document the analysis of Reputational risk.

Detail of Analysis	Assessment	Trend	IPS Y/N
#1 [Risk Component]		↑	
#2		↔	
#3		↓	

8. **Reserving Risk Assessment:** Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated. Document the analysis of Reserving risk.

Detail of Analysis	Assessment	Trend	IPS Y/N
#1 [Risk Component]		↑	
#2		↔	
#3		↓	

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9. **Strategic Risk Assessment:** Inability to implement appropriate business plans, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition. Document the analysis of Strategic risk.

Detail of Analysis	Assessment	Trend	IPS Y/N
#1 [Risk Component]		↑	
#2		↔	
#3		↓	

Section IV: Update Insurer Profile Summary (IPS)

Prioritization: Consider any recommendation for a change in the priority designation of the insurer, including justification. Document it by updating the IPS.

PRIOR YEAR PRIORITY DESIGNATION=	[Analyst Input]
CURRENT YEAR PRIORITY DESIGNATION=	[Analyst Input]
	Current Year
i. RBC Ratio	[Data]
ii. RBC Trend Test	[Data]
iii. Scoring System Result	[Data]
iv. IRIS Ratio Result	[Data]
v. Net Income (Loss)	[Data]
vi. Capital and Surplus	[Data]
vii. Hazardous Financial Condition Regulation	[Analyst Input]
viii. [Insert Other State Specific Prioritization Criteria]	[Analyst Input]
Rationale for Change:	

Summary and Conclusion: Develop an overall summary and conclusion based on the completion of the risk-focused analysis performed, and document it by updating the IPS, including the Supervisory Plan, if applicable, for the following:

1. Summary of the above risk-focused analysis results by risk classification
2. Prospective risks of the insurer in current analysis, as well as to identify future areas for analysis
3. Impact of the holding company on the insurer
4. Completed or in-progress communication or other follow-up with the insurer, other areas of the Department of Insurance (DOI), financial examiners and other state insurance regulators
5. Additional analysis yet to be performed
6. Regulatory actions
7. Any other factors or information that, in the analyst's judgment, are relevant to evaluating the insurer's overall financial condition

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Analyst:	Date:
Supervisor Review:	Date:
Supervisor Comments:	

Overall Risk Assessment Instructions

The insurance department should generally follow the risk-focused financial analysis process outlined in the Financial Analysis Handbook to ensure that appropriate analysis procedures are performed on each domestic insurer. The documentation must be prepared in sufficient detail to provide a clear understanding of the work performed and conclusions reached.

Risk Assessment procedures should be completed and tailored to address the specific risks of the insurer based on the complexity, financial strengths and weaknesses, and known risks of the insurer. The quarterly procedures include a review that focuses primarily on changes from the prior year that may identify new or changing risks. Analysts should document the detailed results of the review in Section III: Risk Assessment and update the summary in the Insurer Profile Summary (IPS) report.

The Risk Assessment Procedures are comprised of the following four sections, which collectively represent a full analysis of an insurer: I) Background Analysis, II) Current Period Analysis, III) Risk Assessment, and IV) Update the IPS.

Section I: Background Analysis

1. **Prior Year and Prior Quarter Analysis and Prioritization:** Review the analysis performed on the insurer for the prior year and prior quarters.
   a. Review and consider the state's priority designation, any prioritization tool results (if applicable) as of the last review and start of the current review.
   b. In preparing for current quarter analysis, review and consider the issues, concerns and prospective risks, noted in previous annual or quarterly analyses work papers, the IPS and supervisory plan, including analysis of the Own Risk and Solvency Assessment (ORSA) Summary Report (if applicable), completed in the prior year that affects the current analysis.
   c. Consider any follow-up conducted and correspondence with the insurer, along with any conclusions.
2. **Communication:** Review any inter-departmental communication, as well as communication with other state, federal or international insurance regulators and the insurer. Consider in the current analysis any unusual items or prospective risks that indicate further analysis or follow-up is necessary. Document risks in the appropriate branded risk category in Section III: Risk Assessment.
3. **Examination Analysis Follow-Up:** Review the Quarterly Financial Statement, General Interrogatories, Part 1, #6, and determine if a financial examination report was released by the domiciliary state since the last review. Document risks in the appropriate branded risk category in Section III: Risk Assessment.

a. Balance sheet date of the latest financial examination of the insurer	[Data]
b. Balance sheet date of the latest financial examination report available from either the state of domicile or the insurer	[Data]
c. Release date of the latest financial examination report available from either the state of domicile or the insurer, and what state insurance department or departments completed the Financial Examination Report	[Data]
d. Have any financial statement adjustments within the latest financial examination	[Data]

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report not been accounted for in a subsequent financial statement filed with the state insurance department?	
e. Have any of the recommendations within the latest financial examination report not been complied with?	[Data]

If 3.d. or 3.e. is "yes," or if follow-up was required from the review of the examination report, management letter or summary review memorandum in a previous analysis period, document the following, as applicable, in the appropriate branded risk category of the Section III: Risk Assessment:

f. Implementation of financial examination report recommendations or management letter comments,

g. Impact of any financial statement adjustments on the insurer's financial condition.

h. Findings from the results of the examination represent risks being monitored, procedures performed or yet to be performed and prospective risks.

Section II: Current Period Analysis

The intent of the current period analysis section is for an analyst to perform a review of current results that may identify a change in a risk assessment either with new risks or by updating previously identified risks in the Section III: Risk Assessment. Analysts should identify and assess changes in the insurer's current financial status compared to the prior period, new or continuing trends, and unusual items. The following bulleted lists do not constitute an all-inclusive list to be considered. Analysts should use their knowledge, expertise and professional judgement to complete a thorough analysis of the current period financial results.

4. **Financial Reporting and Data Applications:** Review and assess material changes and trends in the balance sheet, income statement, cash flow, and related ratios and financial metrics. Document risks in the appropriate branded risk category of Section III: Risk Assessment.
   - Quarterly Financial Statement including the Risk Based Capital (RBC) Report[i]
   - Financial Ratios and Financial Analysis Solvency Tools[ii], such as the Financial Profile Report, Scoring System, RBC Forecasting, market conduct information, etc.
   - Industry reports, news releases, ratings and information about emerging issues

5. **Management Assessment:** Review the Quarterly Financial Statement, including the Jurat page and General Interrogatories and other available information, to determine compliance with and if any changes have occurred in the following areas. Incorporate risks identified and assessed into Section III: Risk Assessment (e.g., operational or strategic).

In the review of the following, note any risks in the Operational or Strategic branded risks within Section III Risk Assessment.	*Benchmark*	*Result*	*Outside Benchmark*
a. Properly executed and notarized Jurat page			
b. Change(s) in officers, directors, or trustees since the previous Quarterly Financial Statement filing	= "#" after name	[Data]	[Data]
i. If "yes," from the review of the Biographical Affidavit(s) for any new officers, directors, or trustees indicated above. Assess any			

[i] The analyst should review and consider information from these data sources in conducting a risk-focused analysis. The review should be evidenced by sign-off and dating of the information source, procedure step or simplified checklist.

[ii] See footnote i

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areas of concern that would indicate further review is necessary (i.e., suitability and other governance-related concerns).			
ii. Assess any follow-up analysis or communication on any previously identified corporate governance issues.			
iii. Assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in its business culture or business plan.			
c. If the insurer has been a party to a merger or consolidation, note any observations or concerns, and ensure Form A or additional filings have been approved. [Quarterly Financial Statement, General Interrogatories, Part 1, #4.1 and #4.2]	=YES	[Data]	[Data]
d. Identify if any Certificates of Authority, licenses or registrations have been suspended or revoked. [Quarterly Financial Statement, General Interrogatories, Part 1, #7.1 and #7.2]	=YES	[Data]	[Data]

6. **Compliance Analysis:** Review and assess state-specific compliance or other analysis required by the state insurance department, and incorporate risks identified into Section III: Risk Assessment.
   a. Identify if the insurer is compliant with state statutes and regulations, including those that are new or revised (e.g., hazardous financial condition analysis, etc.).
   b. Assess if surplus meets the statutory minimum amount required by state law (varies by state and business type).
7. **Supplemental Filings:** If received since the last analysis, review and assess supplemental filings for compliance and identification of risks. Incorporate risks identified into Section III: Risk Assessment.
   a. Management Discussion & Analysis (MD&A) (April 1)[iii]
   b. Audited Financial Statement Report (June 1) [iv]
   c. For holding company groups, if performing the review of the group as the lead state, or receiving the lead state's group analysis summary, and assessing the impact of the group on the domestic insurer, incorporate risks identified related to the domestic insurer into Section III: Risk Assessment.
   d. For ORSA Summary Reports, if required, when receiving and performing the review of the ORSA Summary Report or receiving the lead state's review, incorporate risks identified that are related to the domestic insurer into Section III: Risk Assessment.
8. **Business Plan and Projections (If Available):** Incorporate risks identified and assessed into Section III: Risk Assessment.
   a. Identify and assess any material variances between actual financial results compared to the most recent business plan and financial projections.
   b. Identify and assess any material changes in the business strategy.

[iii] See footnote i
[iv] See footnote i

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9. **Analyst Notes of Current Period Results (Optional):** Include any analytical notes of material information.

Source	Notes	Risk Category

Section III: Risk Assessment

Risk Assessment Instructions

Risk Assessment entails gathering information from the aforementioned sections, as well as analyzing the data provided in the quarterly financial profile and the procedures provided in each of the nine branded risk assessments. Analysts should review and use all relevant and necessary data to focus on specific risks to complete the analysis, which may include data from other financial analysis tools. The depth of review will depend on the complexity, financial strengths and weaknesses, and known risks of the insurer.

Analysts should not rely solely on the risk assessment chapters for identification of all risks (or risk metrics) as they are not analysis checklists and do not represent a complete list of possible risks for every analysis. Analysts should customize their analysis to include risks unique to the insurer and utilize risk metrics (whether quantitative or qualitative) that are best suited for measuring the insurer's exposure to those risks. Note that procedures included in each of the risk assessment chapters are "best fit" as some procedures may identify risks that could be categorized in more than one branded risk category. Analysts should use their knowledge of the insurer and analytical skills to exercise discretion in re-categorizing risks as needed to document the details of the analysis and to update the IPS. Analysts are not expected to respond separately to procedures or benchmark results in the risk assessment chapters that fall outside the industry benchmarks, rather, analysts should use their expertise and knowledge of the insurer to tailor the analysis to address those risks deemed material or that warrant further investigation.

Complete the following to identify, document and explain each of the nine branded risks below. Refer to the risk assessment chapter for further guidance. Documentation of the analysis should contain sufficient detail to adequately explain the risks identified, the metrics/benchmarks used to assess the insurer's exposure to the identified risks, and the results of the risk assessment (i.e., the level and trend of the insurer's risk exposure).

Quarterly analysis should reflect material changes in the risks from the previous analysis period, identify any new risks in the current period, and reflect changes in the strengths and weaknesses of the insurer. When quarterly changes are not material, analysts may consider including an overall comment as such.

1. **Credit Risk Assessment:** Amounts actually collected or collectible are less than those contractually due, or payments are not remitted on a timely basis. Document the analysis of Credit risk.

Detail of Analysis	Assessment	Trend	IPS - Y/N
#1		↑	
#2		↔	
#3		↓	

2. **Legal Risk Assessment:** Non-conformance with laws, rules, regulations, prescribed practices or ethical standards (in any jurisdiction in which the entity operates) will result in a disruption in business and financial loss. Document the analysis of Legal risk.

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Detail of Analysis	Assessment	Trend	IPS - Y/N
#1		↑	
#2		↔	
#3		↓	

3. **Liquidity Risk Assessment:** Inability to meet contractual obligations as they become due because of an inability to liquidate assets and/or obtain adequate funding without incurring unacceptable losses. Document the analysis of Liquidity risk.

Detail of Analysis	Assessment	Trend	IPS - Y/N
#1		↑	
#2		↔	
#3		↓	

4. **Market Risk Assessment:** Movement in market rates or prices (such as interest rates, foreign exchange rates or equity prices) adversely affects the reported and/or market value of investments. Document the analysis of Market risk.

Detail of Analysis	Assessment	Trend	IPS - Y/N
#1		↑	
#2		↔	
#3		↓	

5. **Operational Risk Assessment:** The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events. Document the analysis of Operational risk.

Detail of Analysis	Assessment	Trend	IPS - Y/N
#1		↑	
#2		↔	
#3		↓	

6. **Pricing/Underwriting Risk Assessment:** Pricing and underwriting practices are inadequate to provide for risks assumed. Document the analysis of Pricing/Underwriting risk.

Detail of Analysis	Assessment	Trend	IPS - Y/N
#1		↑	
#2		↔	
#3		↓	

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7. **Reputation Risk Assessment:** Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions. Document the analysis of Reputational risk.

Detail of Analysis	Assessment	Trend	IPS - Y/N
#1		↑	
#2		↔	
#3		↓	

8. **Reserving Risk Assessment:** Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated. Document the analysis of Reserving risk.

Detail of Analysis	Assessment	Trend	IPS - Y/N
#1		↑	
#2		↔	
#3		↓	

9. **Strategic Risk Assessment:** Inability to implement appropriate business plans, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition. Document the analysis of Strategic risk.

Detail of Analysis	Assessment	Trend	IPS - Y/N
#1		↑	
#2		↔	
#3		↓	

Section IV: Update Insurer Profile Summary (IPS)

Prioritization: Consider any recommendation for a change in the priority designation of the insurer, including justification. Document it by updating the IPS.

PRIOR PERIOD PRIORITY DESIGNATION=	[Analyst Input]
CURRENT PERIOD PRIORITY DESIGNATION=	[Analyst Input]
	Current Quarter
i. Scoring System Result	[Data]
ii. Net Income (Loss)	[Data]
iii. Capital and Surplus	[Data]
iv. Hazardous Financial Condition Regulation	[Analyst Input]
v. [Insert Other State-Specific Prioritization Criteria]	[Analyst Input]
Rationale for Change:	

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Summary and Conclusion: Develop an overall summary and conclusion based on the completion of the risk-focused analysis performed, and document it by updating the IPS, including the Supervisory Plan, if applicable, for the following. **Updates to the IPS may be limited when only material changes exist from the previous analysis.**

1. Summary of the above risk-focused analysis results by risk classification
2. Prospective risks of the insurer in current analysis, as well as to identify future areas for analysis
3. Impact of the holding company on the insurer, if received since the last analysis
4. Completed or in-progress communication or other follow-up with the insurer, other areas of the Department of Insurance (DOI), financial examiners and other state insurance regulators
5. Additional analysis yet to be performed
6. Regulatory actions
7. Any other factors or information that, in the analyst's judgment, are relevant to evaluating the insurer's overall financial condition

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Quantitative Risk Assessment

A. Non-troubled insurers will receive the following automated review each quarter. Troubled insurers will receive a full risk assessment analysis each quarter.

Each quarter, non-troubled insurers should be assessed based on the results of the following automated system. Based on the results of the automated system, you may need to proceed with a full risk assessment analysis. **Also consider any other information that may not be reflected in the quarterly statement but may be known or noted in the analysis file or Insurer Profile Summary (IPS), which could impact the company on a prospective basis prior to relying solely on an automated review.**

B. If any of the following criteria is met, the insurer may be assigned a full quarterly risk assessment analysis:

1. The insurer is a troubled insurer
2. Prior year risk-based capital (RBC) is less than 250% (ST)
3. Prior year triggered the RBC Trend Test (ST)
4. Scoring System result greater than or equal to:
   - 450 for property/casualty (P/C) insurers
   - 250 for life insurers
   - 200 for accidental and health (A&H) insurers
   - 325 for health entities

C. Based on the results of the automated system calculations, a full quarterly risk assessment analysis may be completed if the insurer has the following number of "yes" responses from the automated calculations:

1. Four or more for P/C insurers, title insurers and health entities or
2. Three or more for life/A&H/fraternal insurers

Special Notes: Any automated results in D where the denominator is 0 return a "yes" response.

A default "no" response will be returned for insurers with no net retention for automated results #8 and #9.

For companies that have not filed a prior year-end or quarterly statement (e.g., either a new start-up insurer or exempt from filing), all responses in section D will default to a "yes." In this scenario, it is recommended the analyst perform a full quarterly risk assessment analysis.

D. Automated system calculations:

1. Are unassigned funds negative? (ST)
2. Has surplus/capital and surplus (based on business type) increased ≥ 12.5% (for first quarter), 25% (for second quarter), or 37.5% (for third quarter)? (ST)
3. Has surplus/capital and surplus (based on business type) decreased ≥ 5% (for first quarter), 10% (for second quarter), or 15% (for third quarter)? (ST)
4. Has any individual asset category that is greater than 5% of surplus/capital and surplus (based on business type) changed by more than +/- 10% from the prior year-end? (CR, MK, LQ)
5. Has any individual liability category that is greater than 5% of surplus/capital and surplus (based on business type) changed by more than +/-10% from the prior year-end? (RV, OP, ST)
6. Are affiliated investments greater than or equal to 75% of surplus/capital and surplus (based on business type), OR unrealized capital loss more than -15% of prior year-end surplus/capital and surplus (based on business type)? (CR, LQ)

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7. Does the net loss exceed 20% of surplus/capital and surplus (based on business type)? (OP)
8. For property/casualty insurers, title insurers and health entities, is the combined ratio greater than or equal to 100%? (PR/UW, OP)
9. Has net premiums written changed by more than +/- 5% (for first quarter), +/- 10% (for second quarter), or +/- 15% (for third quarter) from the prior year-to-date? (PR/UW)

Follow-up Analysis

If any of the following supplemental filings, information or analyses are received during the quarter, review and assess any risks, and document material risks in the IPS.

- Management Discussion & Analysis (MD&A)
- Audited Financial Statement Report
- Impact of the group on the domestic insurer from the analysis of the Holding Company Analysis (as completed by or received from the lead state)
- Risks related to the insurer from the analysis of the ORSA Summary Report Analysis (as completed by or received form the lead state)
- Business Plan and Projections
- Communications from the insurer, other departments or other regulators

Recommendation for Further Analysis

Does the automated system indicate a full quarterly risk assessment analysis should be performed?

- If “yes,” complete a full risk assessment analysis, or if a full risk assessment analysis was not completed, justify and document the reason(s) on the Quarterly Procedures for Non-Troubled Insurers.
- If “no,” no further actions are required.

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RISK ASSESSMENT – FINANCIAL ANALYSIS

The objective of Risk Assessment is for financial analysts to perform a sufficient level of analysis on all domestic insurers in order to derive an overall assessment that explains the risks of the insurer (including mitigating factors and prospective risks) and summarizes its strengths and weaknesses. Refer to II. Risk-Focused Financial Analysis Framework for further guidance on the risk-focused surveillance process.

Branded Risk Categories

Analysts should have a firm understanding of the branded risk classifications to support the risk assessment process. These risks are discussed in greater detail in each of the nine branded risk chapters but generally are defined as:

- **Credit (CR)—**Amounts actually collected or collectible are less than those contractually due or payments are not remitted on a timely basis.
- **Legal (LG)—**Non-conformance with laws, rules, regulations, prescribed practices or ethical standards (in any jurisdiction in which the entity operates) will result in a disruption in business and financial loss.
- **Liquidity (LQ)—**Inability to meet contractual obligations as they become due because of an inability to liquidate assets and/or obtain adequate funding without incurring unacceptable losses.
- **Market (MK)—**Movement in market rates or prices (such as interest rates, foreign exchange rates or equity prices) adversely affects the reported and/or market value of investments.
- **Operational (OP)—**The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events.
- **Pricing/Underwriting (PR/UW)—**Pricing and underwriting practices are inadequate to provide for risks assumed.
- **Reputational (RP)—**Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.
- **Reserving (RV)—**Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
- **Strategic (ST)—**Inability to implement appropriate business plans, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

Corporate Governance

As part of the risk-focused surveillance approach, analysts should work with the examination staff to assess the quality and reliability of corporate governance in order to identify, assess and manage the risk environment facing the insurer. This assessment will assist in identifying current or prospective solvency risk areas. Corporate Governance Disclosures will assist in assessing corporate governance of the insurer or the insurer group. (See section VI.D. Corporate Governance Disclosure Procedures) By understanding the corporate governance structure and assessing the "tone at the top," analysts will obtain information on the quality of guidance and oversight provided by the board of directors and the effectiveness of management, including the code of conduct established in cooperation with the board. To assist in this assessment, analysts may utilize:

- Board and audit committee minutes
- List of critical management and operating committees, the members and meeting frequencies
- Examination findings related to the insurer's risk assessment and risk management activities
- Sarbanes-Oxley filings and similar filings through the NAIC Model Audit Rule, as applicable

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Prospective Risks

A prospective risk is a residual risk that impacts future operations of an insurer. These anticipated risks arise due to assessments of company management and/or operations or risks associated with future business plans. The analyst's understanding of the above nine branded risk classifications includes an assessment of the level of that risk and the ability of the insurer to appropriately manage the risk during the current period and prospectively. These prospective risks require assessment and identification of how they may evolve related to the insurer's overall risk profile. Understanding how risks that may or may not appear urgent now will potentially impact future operations and how management plans to address those risks is key to prospective risk analysis. All insurers have prospective risks. It is highly unlikely that an insurer would be identified as having no prospective risks. The assessment of these nine branded risk classifications both currently and prospectively should be part of the quantitative and qualitative analysis completed within the Risk Assessment Procedures.

Insurer Profile Summary

An Insurer Profile Summary (IPS) should be developed by the domestic state insurance regulator for each domestic insurer. The IPS should be updated each year through the annual risk-focused analysis process, updated after the conclusion of onsite examination activities at the insurer (full-scope or limited scope) and updated as significant information impacting the insurer is identified throughout the year (e.g., quarterly risk-focused analysis or other interim information received). The IPS is intended to provide a high-level overview of the current and prospective solvency of the insurer as well as the ongoing regulatory plan to ensure effective supervision. A separate Supervisory Plan may also be utilized to outline steps to ensure effective supervision for high-priority or potentially troubled insurers.

The IPS should be concise and should contain information related to each of the five elements of the regulatory Risk-Focused Surveillance Cycle:

- Financial Analysis
- Financial Examination
- Internal/External Changes
- Priority System
- Supervisory Plan

In addition, the IPS should provide an assessment of the insurer's prospective exposure to each of the nine branded risk classifications. This assessment is intended to foster improved communication regarding risk exposures between functions (e.g., financial analysis, financial exam, etc.) and across states.

A template that can be used in developing an IPS, including example company information, is provided below; however, the actual form and content should be determined by each respective state as the only required elements of an IPS are those listed above. In addition, each state should determine how it will allocate its resources to create and maintain the IPS. Regardless of who creates and maintains the document, a current version should be available for review and use by assigned financial analysts and financial examiners as well as individuals from other relevant internal departments with a need to access the information (e.g., licensing, rates and forms, legal) upon request. In addition, the IPS should be made available to other relevant states, upon written request, in accordance with the "Insurer Profile Summary Sharing Best Practices Guide" posted on iSite+.

At the end of this chapter is an example of the template of an IPS. (*The interactive template of the IPS and heat map are located in iSite+ below the Risk Assessment Procedures link)*

Continual Review Process

A continual review process is necessary to address ongoing and emerging issues that arise in the solvency monitoring of insurers. For example, to the extent that an analyst completes the Risk Assessment procedures for

an insurer and has concerns with an identified risk, this analysis may result in questions posed to the insurer and additional information being supplied to the analyst. In some cases, the state may choose to perform a more in-depth analysis of the identified risk, or it may consider a targeted examination, if warranted. These are a few of many recommendations that could result from the ongoing analysis of an insurer. Other recommendations include:

- Requesting additional information from the insurer
- Obtaining the insurer's business plan
- Requesting additional interim reporting
- Engaging an independent expert
- Meeting with the insurer's management
- Obtaining a corrective action plan from the insurer

Regardless of the final outcome, the results of ongoing analysis should be documented in the IPS.

FINANCIAL EXAMINATION ASSESSMENT

In performing the procedures related to financial examinations, analysts should review information received from the examination function via the Summary Review Memorandum (SRM) and, to the extent necessary, review other key documents as identified by the examiners (e.g., examination report, management letter, etc.). Following the review of the SRM, analysts should be able to update the Supervisory Plan and IPS as appropriate for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other internal departments (or other areas within the state insurance department) is crucial during the consideration of these procedures. (See discussion below.) Analysts should also consider the insurer's corporate governance, which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors, and the effectiveness of management, including the code of conduct established by the board.

Summary Review Memorandum (SRM)

The SRM is a memorandum prepared by examiners at the conclusion of an examination. The SRM includes discussion of the insurer's governance and risk management practices, and a summary, by branded risk classification, of significant exam findings and/or concerns warranting communication. These findings may include overarching solvency concerns, examination adjustments, other examination findings, management letter comments, subsequent events and other residual risks or concerns the examiner may want to communicate to department personnel. The final sections, prioritization level and changes to the supervisory plan provide discussion of the examiner's overall conclusions regarding ongoing monitoring, including specific follow-up recommended for analysts. After reviewing the SRM, analysts may determine that he or she needs to review further documentation to understand the implications for ongoing solvency monitoring.

Financial Condition Examination Report

The fundamental purposes of a full-scope financial condition examination report are: (1) to assess the financial condition of the company; and (2) to set forth findings of fact (together with citations of pertinent laws, regulations and rules) with regard to any material adverse findings disclosed by the examination. The report on examination should be structured and written to communicate to regulatory official's examination findings of regulatory importance.

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Management Letter

Management letter comments are considered to be examination workpapers and can be used to present results and observations noted during the examination. These comments are similar to management letter comments frequently made by CPA firms as a result of an audit. Many insolvencies have been caused by mismanagement. When examiners identify systems, or operational or management problems that exist, management letter comments are an opportunity to alert management and other readers of the financial examination report to problems that, if left uncorrected, could ultimately lead to insolvency.

Management letter comments generally contain the following information:

- A concise statement of the problem found
- The factors that caused or created the problem
- The materiality of the problem and its effect on the financial statements
- The financial condition of the insurer or the insurer's operations
- The examiner's recommendation to the insurer regarding what should be done to correct the problem

Examination Follow-Up Procedures

The effectiveness of the financial examination process is enhanced if effective follow-up procedures have been established by the domiciliary state insurance department. Periodically, after a financial examination report has been issued, inquiries should be made to the insurer to determine the extent to which corrective actions have been taken on reported recommendations and findings. Because the examiners have usually moved on to another examination, many states utilize financial analysts to perform this function. A lack of satisfactory corrective action by the insurer may be cause for further regulatory action.

RISK-FOCUSED EXAMINATIONS

The concept of risk in the risk-focused examination encompasses not only risk as of the examination date, but also risks that extend or commence during the time in which the examination was conducted, and risks that are anticipated to arise or extend past the point of completion of the examination. Risk reviewed as part of the examination process include other than financial reporting (operating) and financial reporting type risks. The risks determined to be relevant for ongoing solvency monitoring should be identified as prospective risks on the SRM and, therefore, communicated to the financial analyst.

Certain information including examination reports is included in the Financial Exam Electronic Tracking System (FEETS) on iSite+. The NAIC requires the full use of FEETS when calling examinations on multistate insurers and recommends the use of FEETS for all examinations.

Phases of Risk-Focused Examinations

The risk-focused examination anticipates that risk assessment may extend through all seven phases of the examination.

- Phase 1 – Understand the Company and Identify Key Functional Activities to be Reviewed: Researching key business processes and business units.
- Phase 2 – Identify and Assess Inherent Risk in Activities: These risks include those previously identified by the department's financial analyst related to the branded risk categories.
- Phase 3 – Identify and Evaluate Risk Mitigation Strategies/Controls: These strategies/controls include management oversight, policies and procedures, risk measurement, control monitoring, and compliance with laws.

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- Phase 4 – Determine Residual Risk: Once this risk is determined, the examiner can determine where to focus resources most effectively.
- Phase 5 – Establish/Conduct Detail Examination Procedures: Upon completion of risk assessment, determine the nature and the extent of detailed examination procedures to be performed.
- Phase 6 – Update Prioritization and Supervisory Plan: Incorporate the material findings of the risk assessment and examination in the determination of the prioritization and supervisory plan.
- Phase 7 – Draft Examination Report and Management Letter: Incorporate into the examination report, management letter, and SRM the results and observations noted during the examination.

Goals of Risk-Focused Examinations

- Evaluate an insurer's business processes and controls, including the quality and reliability of corporate governance to identify, assess and manage the risk environment facing the insurer in order to identify current or prospective solvency risk areas.
- Assess the risks that a company's surplus is materially misstated.

Role of the Analyst in Risk-Focused Examinations

The role of the financial analyst in risk-focused examinations should be to assist in the planning and scope of the examination including: (1) provide information from recent analysis performed that identifies current and prospective risks; and (2) provide information to assist examiners in understanding the company (e.g., structure, management, functional areas and business segments, affiliated agreements, etc.).

Communication Between Analysts and Examiners Before and After Examinations

In preparation for an examination, communication between analysts and examiners should include a thorough discussion of key risks (current and prospective) highlighted in the IPS, as well as the company's financial condition and operating results since the last examination. Analysts should be prepared to explain during this discussion the reasons for any unusual trends, abnormal ratios and transactions that are not easily discernible. This discussion should occur through a meeting (in-person or via conference call), rather than only through e-mail exchanges, which are not deemed sufficient to achieve the expectation of a planning meeting with the examiner. During the course of this discussion, analysts should communicate and provide access to relevant information that has already been obtained by the analyst function and is available to the department. It may be specifically helpful for analysts to review the Exhibit B questionnaire and note specific items that have already been accumulated and available to the examiner. Contained in III.A.6 Exam Planning Agenda is an optional tool highlighting agenda items that may be discussed during a planning meeting with the assigned financial examiner in support of the financial exam planning process. The information provided to examiners is also used as input for scheduling and staffing of examinations. Follow-up meetings/calls to discuss analysis of subsequent filings may also be helpful to the examination process.

During the course of the exam, analysts may also be asked to participate in exam interviews in the planning portion of the exam as this would allow analysts to add their insights during the course of the interview process and gain meaningful information as part of this assignment. Examiners should also provide analysts with regular updates on the exam fieldwork to permit the department analyst to incorporate relevant updates in a timely manner.

As the examiners conduct the financial examinations, they should inform analysts of any significant examination findings. At the conclusion of the on-site examination, the examiners and analysts should work together to determine the company's priority score. The development of the management letter to the company should include contributions from the examiners and should be shared with the analyst. Additionally, analysts may have input into the letter. It is strongly recommended that analysts be responsible for evaluating and following up with the company responses to any examination management letter comments, as after the

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report of the examination has been issued, the analysts will be the primary regulatory contact with the company until the next examination. Analysts should have a good understanding of any material examination findings that in turn may help analysts to focus on their next review.

At the end of the exam, examiners should provide analysts with an SRM that is organized using the branded risk categories. This SRM should comment on the results of the examination and the resulting implications on each of the branded risk categories. Examiners may use the SRM to suggest changes to the branded risk assessments (e.g., if the analyst assessed credit risk as moderate risk with no trend, the examiner may suggest that the category be assessed as high and/or have an increasing trend based on the results of the examination.). Examiners may suggest additional concerns within each branded risk assessment that analysts should consider when updating the IPS. Lastly, the SRM will contain insights into issues of non-compliance, prioritization and ongoing monitoring, and proposed changes to the supervisory plan.

RISK ASSESSMENT LEVELS AND TRENDS

The financial analysis process assigns each risk component within the branded risk classification an assessment level commensurate with the nature, complexity and severity of the risk of either Minimal, Moderate or Significant. Additionally, analysts also assign a trend level to indicate the direction the risk is moving, either decreasing, static or increasing. Although risk assessment levels and trends are based on the judgement of the analyst and supervisor, they should factor in both quantitative and qualitative elements, as well as both current and prospective considerations. Note that within each of the three assessment levels, there may be appropriate grading of the severity of the risk.

With regard to setting individual risk assessments, the level of concern and trend of a risk is not defined relative to other risks facing the insurer. Risks should be assessed individually on each's factors and circumstances. Analysts should not automatically assess the "top" risks of an insurer as Significant, Moderate, or Increasing, if the factors don't meet the criteria for those assessment levels and trend. An insurer may have none, one, or multiple Significant risks, depending upon individual facts and circumstances. Failing to follow this guidance may result in an inappropriately high-risk assessment for the individual risk component, but also for the branded risk category and the overall assessment of the insurer.

Factors that may be given consideration include, but are not limited to, the following:

- **Significant:** The highest level of severity of risk from a solvency perspective. Risks assessed at this level require an elevated level of ongoing monitoring and/or regulatory actions.
    - A risk that has the potential to result in the future insolvency of the insurer, independently or in combination with other significant risks
    - A risk that impacts the going concern of the insurer or a major line of business of the insurer
    - A risk that represents a trend that if continued may result in a prospective necessity for the insurer to make significant changes in its business strategies or operations
    - A risk that represents a potential for material financial loss (i.e., earnings, surplus, asset value decline, etc.)
    - A risk identified by the insurer as high/critical/significant (i.e., through Own Risk and Solvency Assessment (ORSA) or communication with the insurer)
    - A risk that has rapidly escalated in severity due to known or unforeseen circumstances (e.g., economic impacts that result in significant decline in market value of assets)
    - A material risk for which the insurer has no mitigation strategy

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- A risk of an affiliate that could have a materially adverse impact on the insurer due to interdependencies (e.g., financial losses/strain at a subsidiary for which the insurer is the parental capital support, operational or strategic changes at the holding company that negatively impact or increase the risks of the insurer, financial solvency concerns of the parent, etc.)
- A risk identified as a high risk during a recent financial condition examination
- A risk related to a business activity that is significant and/or transactions are large in relation to the company's financial strength. Complexity and volatility are higher than normal.
- A risk that is occurring frequently
- A risk/event that results in a material rating agency downgrade
- A risk/event that requires board of director or senior management attention to address the issue
- A risk that impacts shareholder value or reputation currently

- **Moderate:** The medium level of severity of risk from a solvency perspective. Risks assessed at this level require routine ongoing regulatory monitoring and oversight and/or regulatory action.
  - A risk that represents a potential for some financial loss (i.e., earnings, surplus, asset value decline, etc.)
  - A risk identified by the insurer as a moderate risk (i.e., through ORSA or communication with the insurer)
  - A material risk for which the insurer has a mitigation strategy but that does not fully mitigate the risk
  - A moderate risk of an affiliate that could have some negative impact on the insurer due to interdependencies (e.g., financial losses/strain at a subsidiary for which the insurer is the parental capital support, operational or strategic changes at the holding company that negatively impact or increase the risks of the insurer, financial solvency concerns of the parent, etc.)
  - A risk that continues to worsen, though not rapidly, and for which no improvement in the risk is expected
  - The risk poses a prospective threat to financial solvency
  - A risk identified as a moderate risk during a recent financial condition examination
  - A risk related to a business activity that is significant, but transactions are moderate in size in relation to the company's financial strength. Complexity and volatility are easily managed.
  - A risk/event that requires senior or middle management attention to address the issue
  - A risk where the shareholder value or reputation could be impacted prospectively in the short term
- **Minimal:** The lowest level of severity of risk from a solvency perspective. Risks assessed at this level do not currently indicate a need for additional monitoring or regulatory actions.
  - A risk determined to be minimal due to the adequacy of mitigating strategies
  - A risk that does not pose a financial solvency concern
  - A risk with limited materiality
  - A risk that has improved from a moderate assessment but are not yet diminished to the point of being excluded
  - A risk related to a business activity or transactions that is remote or would have an insignificant impact to the company's financial strength
  - A risk/event that is handled by junior management to address the issue

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- A risk that has no impact on shareholder value or reputation

Factors that may be given consideration when assigning a trend include, but are not limited to the following:

- **General Considerations:**
  - Consider trending within quantitative metrics to assist in determining the trend assessment
  - Consider qualitative factors such as the insurer's planned business strategies to address the risk
  - Consider both historical/current and prospective/planned trends in exposure.
- **Increasing Trend:**
  - The risk has historically increased year-over-year and continues to increase
  - The risk has the potential to increase prospectively if not addressed
  - The risk is expected to increase prospectively as outlined in the company's business plan and projections
  - The risk has escalated rapidly and materially from the prior analysis period but may have been static in the prior years
- **Static Trend**:
  - The risk has historically remained consistent year-over-year with only minor fluctuations
  - The risk is being addressed and no further fluctuation is expected in the near future
  - The company's business plans and projections don't show any significant movement in risk exposure
  - The risk is not likely to change materially in the future
- **Decreasing Trend:**
  - The risk has been on a historically declining trend year-over-year and continues to decrease
  - The risk is being addressed and is expected to decline in the near future
  - The risk is expected to decrease prospectively as outlined in the company's business plan and projections
  - The risk has declined materially from the prior analysis period

Developing an Overall Assessment

Risk assessment, either for an individual risk component or for the overall branded risk classification reflected in the heat map of the IPS, should be based on the ultimate overall assessment of the risk to the insurer, which should take into account any known positive attributes including risk-mitigation strategies and internal controls established by the insurer to ensure management's business objectives are being followed. Risk-mitigation strategies and internal controls are assessed during examinations; however, they may not all be apparent or known to analysts during interim analysis periods. To the extent known either through current analysis, recent examination results or communication with the insurer, analysts should factor risk-mitigation strategies and internal controls into the overall assessment of the risk. Analysts should also consider that changes in risk-mitigation strategies and internal controls may occur between examinations, which will affect the overall risk assessment process. Therefore, the overall assessment reflects the ultimate impact of risks on the insurer after consideration of mitigation strategies and controls.

Examples of risk-mitigation strategies that may be considered positive attributes during the analysis may include (but are not limited to):

- reinsurance programs intended to mitigate underwriting & strategic risks

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- derivatives hedging programs intended to mitigate market risks
- strong enterprise management controls over IT systems to mitigate operational risks
- regular auditing and strong oversight of MGAs & TPAs to mitigate underwriting and operational risks
- strong corporate governance and enterprise risk management that mitigate various risk components
- capital maintenance agreements with a financially strong parent holding company that ensure payment of claims and/or maintenance of capital above certain thresholds to mitigate strategic risk

DISCUSSION OF ANNUAL PROCEDURES

The Risk Assessment annual procedures are designed to identify and assess potential areas of concern, including prospective risks. The Risk Assessment procedures are comprised of the following four sections, which collectively represent a complete analysis of an insurer: (1) Background Analysis; (2) Current Period Analysis; (3) Risk Assessment; and (4) Update the IPS.

The department should generally follow the risk-focused financial analysis process outlined in this Handbook to ensure that appropriate analysis procedures are performed on each domestic insurer. The documentation must be prepared in sufficient detail to provide a clear understanding of the work performed and conclusions reached.

Section I: Background Analysis

The background analysis is intended to assist analysts in "pre-analysis" procedures, including identifying current prioritization of the analysis of the insurer, current and prospective risks identified in the prior analysis, and new information provided by other inter-state departments. **The procedures outline a thought process for analysis; however, there is no documentation requirement in this section.**

Any comments or notes on key issues analysts chooses to include in this section to assist in developing the scope of the analysis should be concise and may include links to source documents but should avoid lengthy restatements of narratives from prior period work papers.

PRIOR PERIOD ANALYSIS AND PRIORITIZATION PROCEDURE #1 provides guidance to analysts in determining if any conclusions reached in prior period(s) analysis (annual and/or quarterly) of the insurer should be considered in the work to be completed for the current year. Areas of concern noted in the prior period and/or insurers who were classified as priority companies in the prior period should be reviewed carefully in the current year. Analysts should use their state's definition/criteria for determining the hazardous financial condition of an insurer. Analysts should review the IPS (including the Supervisory Plan, if applicable), for any concerns or risks that may require additional attention during the current analysis. While analysts may choose to highlight a few material issues that should be carried forward to the current analysis, it is not expected that analysts restate the prior period IPS. Material information and risks in the current period analysis should be documented in Section III: Risk Assessment.

PRELIMINARY ANALYSIS: States have the option to conduct a preliminary analysis of non-priority companies. If a preliminary analysis indicates no immediate concerns, then analysis of non-priority insurers should be completed by analysts and reviewed by supervisors by the end of July. This provides an extension of the non-priority deadline, which is normally the end of June. Preliminary analysis performed and relied upon for analysis completion dates should be completed within two weeks from receipt of filing.

- Determination of "no immediate concerns" should be based on sound judgement and knowledge of the insurer.
- The following considerations are recommended to be included in preliminary analysis:

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- Has the minimum capital and surplus requirements been met?
- Did the insurer report a decline in capital and surplus of greater than 10% from the prior year-end?
  - If yes, was the decline due to an ordinary or approved extraordinary dividend, approved reinsurance or other transaction, or has the cause been previously adequately addressed by the insurer?
- What is the RBC?
- Did the RBC trigger the RBC Trend Test?
- Did the insurer report a net loss?
  - If "yes," did the insurer trigger Hazardous Financial Condition?
- Did the insurer trigger Hazardous Financial Condition from any other criteria?

COMMUNICATION PROCEDURE #2 alerts analysts to review recent inter-departmental communication, as well as communication with other state insurance departments and the insurer that may not be included in the prior-period risk assessment or IPS. Internal communication may include departments such as examination, licensing and admissions, consumer affairs, rate filings, policy/forms analysis, agents' licensing, legal, and market conduct. It may be necessary to communicate with other state departments if a multi-state domestic insurer writes a significant amount of business in other states. Additional communication with the insurer throughout the year should be reviewed to identify any items or areas that may require special attention during the analysis process. Refer to the introductory chapters for further discussion on internal and external communication.

EXAMINATION PROCEDURES #3 AND #4 are intended to assist analysts in determining if information from a recent examination is available and analyst follow-ups are outstanding OR if a new examination is in the planning phases or soon to be in a planning phase so that analysts can perform necessary analysis and communication with the examiners to assist in the risk-focused examination process. Information collected from this procedure should be included in the related branded risk assessment of the insurer.

***NOTE*: If no exam is being planned, then #3 is not applicable. If the findings and follow-up analysis from the most recent exam have been completed and documented in a prior period analysis, with no further follow-up required, then #4 is not applicable.**

Procedure #3 assists analysts in participation in the planning of upcoming examination activities and gathering specific information related to the insurer's most recently completed financial examination. As stated above, communication between the analyst and the examiner in preparation of an examination should include a thorough discussion of key risks and concerns highlighted in the IPS, as well as additional information from the risk assessment on the company's financial condition and operating results since the last examination.

Procedure #4 assists analysts in assessing results of the latest examination. In following up on completed examinations, analysts should identify any items or areas that indicate further review is necessary. This might include such things as internal control issues, risk management, information technology, or other issues that could impact the insurer's priority. Analysts should review the SRM and to the extent considered necessary, the Examination Report and management letter comments, which may include risks or progress on issues that the analyst should give attention to while the current analysis is being performed. Analysts should consider the impact of the examination findings on the conclusions reached as a result of the current analysis and the need to perform detailed analysis on identified risks. Effective communication between the analyst and the examination staff is important in developing a good understanding of the insurer's management and financial position. As an example, the examination staff may have specific information on the reliability of the insurer's financial reporting.

Section II: Current Period Analysis

Comments or notes on key issues analysts chooses to include in this section to assist in developing the scope of the analysis should be concise and may include links to source documents but should avoid lengthy narratives that duplicate the documentation in Section III: Risk Assessment. Large variances noted in the current period

review that do not warrant inclusion in Section III or the IPS may be documented in this section. However, avoid lengthy documentation or investigation of small or immaterial variances.

FINANCIAL REPORTING AND DATA APPLICATION PROCEDURE #5*:* The intent of the current period analysis section of the Risk Assessment procedures is analysts to perform a review of current results that may identify a change from the prior period or a new risk that should either be updated or further analyzed and documented in the Section III: Risk Assessment. Analysts should use their knowledge, expertise and professional judgement to complete a thorough analysis of the current period financial results.

Analysts should review and consider information from data sources including the Annual Financial Statement, Actuarial Filings, Financial Ratios and Financial Analysis Solvency Tools, MD&A and the Audited Report in conducting a risk-focused analysis. The review should be evidenced by sign-off and dating of the information source, a procedure step (i.e., within TeamMate TeamStores), a simplified checklist developed by the department, or within Section II #5. Note that signoff of the completed risk assessment would not be considered a signoff of the review of source information.

MANAGEMENT ASSESSMENT PROCEDURES #6A AND #6B assist analysts in determining if changes in the insurer's management or board of directors have occurred. Changes such as these can have a significant impact on the ongoing operations of the insurer and management philosophy. Changes in the board of directors may also indicate changes in the audit committee. When assessing management, analysts should take into consideration not only the changes in management, but also the analyst's and examiner's knowledge about the current management team and any concerns that may exist regarding management. While management changes alone may not indicate a problem, knowledge of these changes may help analysts understand other potential problems. Information and risks identified from this assessment should be documented in the related branded risk classifications in Section III: Risk Assessment.

With regard to corporate governance, there are many aspects that require consideration, such as: adequate competency; independent and adequate involvement of the board of directors; multiple channels of communication; code of conduct between the board and management; sound strategic and financial objectives; support from relevant business planning; reliable risk management processes; sound principles of conduct; reporting of findings to the board; adoption of Sarbanes-Oxley provisions; and board oversight and approval of executive compensation and performance evaluations.

Analysts should review the biographical affidavits for any new officers, directors, or trustees; follow up on any previously identified unusual corporate governance items or areas of concern; and consider whether changes identified will alter management philosophy. Analysts should pay close attention to responses regarding any suspensions, revocations or non-approval of licenses, conflicts of interest, civil actions, or criminal violations and follow up on any areas of concern. In performing such review, analysts should also consider on a regular basis whether officers, directors and trustees are suitable for the positions they hold within an insurer. Suitability includes considering whether the individual has the appropriate background and experience to perform the duties expected of his or her position. Communication with other state insurance departments (and also possibly with international regulators) may be necessary if the officer previously worked for an insurer domiciled in another state.

MANAGEMENT ASSESSMENT PROCEDURE #6C directs analysts to determine whether the insurer was a party to a merger or consolidation, which can have a significant impact on the ongoing operations of the insurer. This procedure also directs analysts to determine if significant changes in the organizational structure or management have taken place. While organizational changes alone may not indicate a problem, knowledge of the change may help analysts understand the insurer's future plans and goals. Additionally, analysts should verify that Form A or additional filings have been approved.

MANAGEMENT ASSESSMENT PROCEDURE #6D requires analysts to review the Annual Financial Statement, General Interrogatories, Part 1, #7.1 and #7.2, to determine whether the insurer had any Certificates of Authority, licenses or registrations (including corporate registration if applicable) suspended or revoked by any governmental entity during the reporting period and investigate the reason(s) for the action(s).

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COMPLIANCE ANALYSIS PROCEDURE #7: States generally have specific compliance analysis that is performed (e.g., compliance with hazardous financial condition and investment limitation laws, or compliance with state statutes on minimum capital and surplus standards). The procedure directs analysts to identify if the insurer is in compliance with the state's statutes and regulations that could have an impact on the insurer's financial position or reporting. To the extent that information is available regarding a new or revised statute or regulation, analysts should determine if the insurer has failed to comply with the new state statutes and/or regulations that have been enacted during the period. Analysts may choose to include a link to other work papers, but generally it is not expected that compliance also be documented here. Information and risks gathered from these analyses should be considered and documented in the review of related branded risk classifications in Section III: Risk Assessment.

SUPPLEMENTAL FILINGS PROCEDURE #8 requires analysts to review supplemental filings and other state compliance analysis, including a review of filings such as the MD&A, the Audited Financial Statement, Holding Company Analysis and the ORSA Summary Report (if applicable), to determine if any information is provided in these filings that helps identify or explain risks (current and prospective), trends or other information that can be used in the assessment of specific risks within each branded risk classification. If received prior to the completion of the annual analysis, any issues or risks identified and investigated as a result of the review of the filing should be documented in the related branded risk classifications in Section III: Risk Assessment. Risks identified and assessed in filings received after the completion of the annual analysis should be documented in the subsequent quarterly analysis and, if warranted, the IPS.

The review should be evidenced by sign-off and dating of the information source.

BUSINESS PLAN AND PROJECTIONS PROCEDURE #9 directs analysts to review the business plan of the insurer if it is available from recent surveillance activity, such as in follow-up to a previous analysis or examinations, and if a review of the business plan is considered necessary based on the insurer's priority designation and financial condition. If reviewed, analysts should assess if the plan is consistent with current operations and expectations of projected results. For example, consider if the insurer is writing more or less premium or different lines of business outlined in the plan. Consider if the plan is consistent with changes in the markets or geographical areas where business is being written, or new licenses obtained to write business. Analysts should assess significant variances in the business plan through review of the plan and/or through communication with the insurer. If a business plan is not available or current and, based on the analysis performed, the analyst feels it is necessary to request a business plan and recommend further analysis in this area, the analyst should consider requesting a new business plan as part of any analysis follow-up with the insurer. If received prior to the completion of the annual analysis, any issues or risks identified and investigated as a result of the review of the filing should be documented in the related branded risk classifications in Section III: Risk Assessment. Risks identified and assessed in filings received after the completion of the annual analysis should be documented in the subsequent quarterly analysis and, if warranted, the IPS.

REQUESTING BUSINESS PLANS AND PROJECTIONS – The following are examples of scenarios when it may be appropriate to request business plans and multi-year pro-forma financial projections as part of risk-focused analysis and assessment of prospective risks for both legal entities and holding company groups, by the domestic or lead state (in the case of groups). Note this list is not all-inclusive as other situations may occur where requesting a business plan and projections may be appropriate.

- For non-troubled insurers, it may be sufficient to receive updated business plans and projections less frequently than every year.
- For non-troubled insurers that have indications of material changes occurring or expected, for example through communication between the insurer and the state insurance regulator, or reflected in financial results, it may be appropriate to request updated business plans and projections more frequently, such as annually.
- For troubled insurers, it may be appropriate to request updated business plans and projections annually.

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- When concerns are noted during risk-focused analysis, holding company analysis and/or when actual results vary materially from previously provided projections, requesting an updated business plan and projections may be an appropriate action along with communication with the insurer/group for explanations of the concerns.
- As noted below in #11-Information Request, it may be necessary to request a business plan and projections to assess the insurer's strategy, which impacts various risk categories primarily, operational and strategic risks.
- As a result of financial examination findings, monitoring of certain risks may require a request for a business plan and projections.
- If the insurer submits an application for Certificate of Authority to write business in the state, it may be appropriate to request additional information including a business plan and projections.
- For insurers undergoing a merger or acquisition, business plans and projections are generally included in the Form A application and approval process (see V.B. Form A Procedures). Upon completion of the Form A, it may be appropriate to request updated plans and projections after a year or more to determine if any concerns exist regarding the insurer's actual results subsequent to acquisition.

ANALYST NOTES #10 (OPTIONAL): This optional section may be used as a tool for notating any material information from above that, for example, is not specific to assessment of risks in Section III: Risk Assessment; or short notations regarding the analyst's completion of their review. Comments or notes on key issues analysts chooses to include in this section to assist in developing the scope of the analysis should be concise and may include links to source documents. It may also be beneficial to provide a reference to where the issues are addressed within Section III: Risk Assessment. However, to avoid inefficiencies, analysts should avoid the creation of notes that are lengthy narratives that duplicate or replace the documentation in Section III: Risk Assessment. Instead, the detailed discussion of risks and results of analysis should be documented in Section III: Risk Assessment.

INFORMATION REQUEST PROCEDURE #11*:* In order to effectively enhance risk-focused financial analysis, state insurance regulators may need to gain a greater understanding of the insurer's strategies, risk exposures and business operations. While a general understanding of the insurer can be obtained through a review of regulatory filings and publicly available information, additional information may be needed on certain strategies, risk exposures and business operations before the insurer can be fully understood and evaluated.

State insurance regulators should first review existing sources of information available to the department (e.g., annual and quarterly statement Notes to Financial Statements and General Interrogatories, MD&A, filed business plans, recent examination results, etc.). Additionally, if the insurer is part of a holding company group and the department is not the lead state, if not already provided by the lead state, the non-lead state should contact the lead state to obtain analysis already prepared by the lead state for additional holding company group information (i.e., the Group Profile Summary). For Corporate Governance Annual Disclosure (CGAD) filed on a group basis and the Enterprise Risk Report (Form F), the non-lead states should rely on the information provided in the GPS, or other information provided by the lead state on material risks relevant to the insurance entity. Contacting the lead state first will help eliminate the duplicate requests for holding company group level information.

If it is determined that additional information is still needed, state insurance regulators may choose to conduct in-person meetings with the insurer, hold conference calls, submit written information requests or take other steps necessary to obtain a sufficient understanding of the insurer. If meetings or conference calls are scheduled with the insurer to gather additional information, state insurance regulators should give consideration to the level at which the meetings should be conducted (i.e., legal entity, intermediate holding company, or ultimate controlling parent) and involve the lead state and other affected state insurance regulators in the process as appropriate. If a meeting is conducted at the group level, lead states may also wish to consider topics and questions outlined in V.H. Periodic Meeting with Group.

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The following table highlights topics where the information available through regulatory filings may not be sufficient to provide an adequate understanding of the insurer.

General Topic and Description (The suggested areas of understanding within each general topic below are not meant to be an all-inclusive list.)	**Primary Branded Risks**
Underwriting Strategy – Understand the insurer's overall underwriting strategy and goals, including its target market(s), geographic locations, products/lines of business, profitability challenges and distribution channels.	PR/UW, RV
Reinsurance Strategy – Understand the insurer's overall reinsurance strategy, including its identification and modeling of risk exposure and concentrations, reinsurance program structure (affiliated and non-affiliated), reinsurer selection, and quality.	CR, PR/UW, LQ, ST
Investment Strategy – Understand the insurer's investment strategy and goals, including its policies and guidelines that specify the type, credit quality and maturity of investments to be held. In addition, understand roles and responsibilities related to investment decision-making, oversight and reporting.	CR, MK, LQ, ST
Legal and Regulatory Issues – Understand significant legal, ethical and regulatory issues affecting the insurer's current and prospective solvency, including the status or results of ongoing/recent regulatory investigations, pending/upcoming regulatory filings (e.g., rate filings, Form Ds, etc.), material ongoing litigation, and violations of the insurer's code of ethics.	LG, RP
IT Systems – Understand significant changes made to IT systems since the last examination, including related implementation and transition plans, cybersecurity measures, etc.	OP, LG
Outsourcing of Functions – Understand the significant functions outsourced by the insurer to third parties, including the insurer's use and oversight of MGAs/TPAs, investment advisers, producers, custodians, and affiliated service providers.	OP, RP, LG
Risk Management (for non-ORSA filers) – Understand the overall risk management practices in place at the insurer, including how material and relevant risks are identified, assessed, monitored, managed, and reported.	ST, OP
Business Plans – Understand the insurer's overall business plans, including its historical performance against projections, as well as current/future goals and initiatives.	ST, OP
Overall Strengths and Weaknesses – Understand the insurer's view of its overall strengths and weaknesses, including market position, financial resources, reputation and competition.	ST, OP, RP

Once state insurance regulators have a sufficient understanding of the insurer in relation to all identified areas of importance, as determined by the analyst's judgment, such an understanding should be updated through the IPS and/or the Risk Assessment Analysis or other analysis documentation to facilitate effective and efficient analysis processes. In years where the insurer is currently undergoing or preparing for a financial condition examination, such an understanding should be maintained, communicated and updated through participation in the examination process. In other years, the steps highlighted above (e.g., meetings with the insurer, conference calls or written information requests) may be necessary to supplement or update the state insurance regulator's understanding. However, once the initial understanding is obtained, such steps should focus on changes in strategies, risk exposures and business operations in an effort to promote efficiency.

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Section III: Risk Assessment

Risk assessment entails gathering information from Section I and Section II, along with analyzing the data and benchmarks for each of the nine branded risks included in the annual financial profile report and procedures provided in each of the nine branded risk assessment chapters to develop and document a risk assessment of each relevant material risk of the insurer.

Depth of review and level of documentation:

- The depth of review and level of documentation should be commensurate with the nature, complexity, financial strengths and weaknesses, and known risks of the insurer. New risks and significant changes in exposures will require more investigation than risks that the insurer has routinely been exposed to and that don't change materially year-over-year.
- Other factors, such as the insurer's past regulatory history, accuracy of filing, age of insurer, stability of business plan, and knowledge of the insurer's operations, materiality of the concerns etc., may affect the scope and depth of analysis. The flexibility to customize the scope and depth of the analysis is determined at the state insurance department's discretion, should include analyst and supervisor input and may vary between analyses. Therefore, the state insurance department should tailor the data and procedures used and the level of documentation to sufficiently address the specific risks of the insurer. It is expected that the risk assessment documentation will be at a level that is more detailed than the IPS.
- In certain situations, it may be appropriate to reference documentation located in another area of the analysis file (e.g., Form D review, ORSA review template) as opposed to duplicating the documentation here. However, in such situations, the risk component title should still be presented, along with a conclusion on the current level of concern/trend in Section III, with a cross-reference to supporting documentation provided in other areas of the file. When doing this, the analyst should carefully consider whether the risk exposure has shifted since it was assessed in another area of the file and whether the level of concern/trend conclusion is adequately supported by the cross-referenced work.

Branded Risk Assessment Chapters:

- **Analysts should not rely solely on the risk assessment chapters for identification of risks as they do not represent a complete list of possible risks. Analysts should customize their analysis to identify and assess risks unique to the insurer.**
- It is not necessary and may be inefficient and unproductive to include every risk component from the risk assessment chapters in the analysis if it is not applicable to the insurer.
- The risk assessment chapters are a tool for helping identify and investigate risks; however, there is no documentation requirement within the chapters themselves.
- Analysts are not expected to respond separately to procedures or benchmark results in the risk assessment chapters or the annual financial profile that fall outside the benchmarks, rather, analysts should use their expertise and knowledge of the insurer to tailor the analysis to address those risks they deem material or that warrant further investigation.
- Analysts may choose to use the risk assessment chapters as a starting point for analysis; however, alternatively for analysts that have a good understanding of their assigned insurers' risks, the analyst might consider using the chapters as a completeness check at the end of their review to ensure they have not overlooked any material issues.
- Note that procedures included in the risk assessment chapters are "best fit" as some procedures may identify risks that could be categorized in more than one branded risk category. Analysts should use his or her knowledge of the insurer and critical thinking skills to exercise discretion in re-categorizing risks as needed to document the details of the analysis and to update the IPS.

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- Analysis results from the risk assessment chapters should be documented in Section III: Risk Assessment section of the worksheet.

For reserving risk: Analysts should also consider the risk assessment chapters for review of the Statement of Actuarial Opinion and other related actuarial filings. For property/casualty (P/C) insurers, this includes completion of the Actuarial Opinion Summary procedures. For life/health and fraternal insurers, this includes completion of the procedures for the Regulatory Asset Adequacy Issues Summary (RAAIS).

For Title insurers: Analysts should first utilize the III.C.3 Title Insurer Worksheet to develop the risk assessment and then reference the applicable risk assessment chapters as needed.

Inclusion in the IPS: The Risk Assessment worksheet provides for consideration of whether the risk warrants inclusion in the IPS, the assessment level (minimal, moderate, or significant) and the trend (static, decreasing or increasing). Not all issues analyzed will warrant inclusion on the IPS due to materiality or other reasons.

Refer to the Analyst Reference Guide branded risk chapters for explanation of the risk category and of the data, benchmarks and procedures provided for each.

Section IV: Update Insurer Profile Summary

At the conclusion of the analysis, analysts should also assess the priority level based on the results of the current analysis. While summary documentation of the rationale for the insurer's priority may be included in the IPS, detailed documentation of the rationale for a change in priority should be included in the risk assessment worksheet.

At the conclusion of the Risk Assessment procedures, analysts are asked to develop and document an overall summary and conclusion based on the results of the risk-focused analysis performed, prospective risks of the insurer, follow-up analysis or regulatory actions, impact of the holding company on the insurer, and any correspondence. Analysts should update the IPS (and supervisory plan, if applicable). **Note that an analyst's documentation of the Section III: Risk Assessment and other cross-referenced work represents the *detail* of the analysis of risks, which should be more in-depth for certain material risks or complex insurers, whereas the IPS represents a *summary* of the risks of the insurer for purposes of communication to other state insurance regulators and departments.**

Ensure that all nine branded risk classifications are addressed in the IPS, even if documentation is limited to *"Assessment of this risk classification was performed, and no material risks were identified for this risk."* Where no individual risk components were identified within a branded risk classification, it is acceptable to include a statement, such as the above, in the narrative of the branded risk classification and list no risk components in the table, so as to avoid listing items that do not represent a risk to the insurer (i.e., generic or positive attributes). Positive attributes may be included in the narrative or other areas of the IPS as appropriate (e.g., background, strengths and weaknesses).

Because some items, such as the Audited Financial Report and the various holding company filings are not required to be filed until after most of the annual review is completed, analysts will document a conclusion based on the current analysis of the insurer. The Audited Financial Report should be reviewed upon receipt, and if additional concerns are noted, the conclusion or the quarterly conclusion should be revised to reflect the most recent information.

While analysts may consider a cursory review of holding company filings when received to identify any material or urgent solvency concerns, the review of holding company filings is required to be completed by October 31st for analysis conducted by the lead state or by December 31st for analysis conducted by the domestic state.

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DISCUSSION OF QUARTERLY PROCEDURES

The Quarterly Risk Assessment Procedures are designed to help analysts perform a general review of the insurer with the quarterly filings. The quarterly procedures are similar to the risk-focused annual procedures. However, the quarterly procedures include a review that focuses primarily on changes from the prior year that may identify new or changing risks and leveraging the existing analysis documentation that is still relevant. Quarterly analysis should also include assessment of any risks identified in supplemental filings or correspondence received after the annual analysis has been completed. In updating analysis work on a quarterly basis, analysts should:

- Clearly document those risk assessments or sections of the IPS that have been updated in order to avoid confusion when sharing the most current analysis.
- Avoid performing detailed and time-consuming or duplicative analysis work and documentation from year-end if the insurer's exposure has not significantly changed from the prior year.
- Consider limiting quarterly documentation to only those risk components that are new or that have changed significantly from the prior year. If there are no changes in a risk component from the prior year, analysts may consider simply referring to the prior year analysis and commenting in the narrative that no material changes in the risk component have occurred.
- Given the limited data available in the quarterly filings, not all risks may be assessable on a quarterly basis. Therefore, no additional analysis documentation would be expected for these risks.

At the conclusion of the Quarterly Risk Assessment procedures, analysts are asked to develop and document an overall summary and conclusion based on the results of the risk-focused analysis performed, prospective risks of the insurer, follow-up analysis or regulatory actions, and any correspondence. As with the annual review, the Summary and Conclusion should be reviewed and revised as necessary when subsequent procedures and follow-up with the insurer are completed. Analysts should update the IPS (including the Supervisory Plan, if applicable). Note, however, that updates to the IPS may be limited to material changes from the previous analysis.

DISCUSSION OF THE QUARTERLY QUANTITATIVE ASSESSMENT OF NON-TROUBLED INSURERS

The Quarterly Quantitative Assessment of Non-Troubled Insurers is designed to assist analysts in conducting a quantitative review of the insurer and its operations. To determine whether an insurer is non-troubled for procedure B.1, analysts should use their state's guidelines and policy. The non-troubled quarterly assessment includes key broad-based questions and questions that focus primarily on changes from the prior year.

Updates/New Information:

- Although not required, analysts may consider updating the risk assessment for non-troubled insurers on a quarterly basis if new information or trends regarding various risk exposures or components are identified.
- If the department receives new information to update the IPS with this information, the quarterly risk assessment may not need to be completed since the IPS will be updated for the quarter.
- Analysts can choose to only update the IPS as needed as the risk assessment would be updated during the next annual review so long as the information does not impact whether the insurer would be considered non-troubled.
- If appropriate, analysts may consider including a brief narrative regarding the information received at the bottom of the non-troubled checklist under "Follow-Up Analysis".

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Special note for new or previously exempt filers: For companies that have not filed a prior year-end or quarterly statement (e.g., either a new start-up insurer or exempt from filing), all responses in section D will default to a "yes." In this scenario, it is recommended analysts perform a full risk-focused review.

DISCUSSION OF ANALYSIS FOR INTERCOMPANY POOLING ARRANGEMENTS

Intercompany pooling arrangements involve the establishment of a quota share reinsurance agreement under which pooled business is ceded to a lead entity and then retroceded back to pool participants in accordance with stipulated shares (if any). This generally results in pool participants sharing exposure to the various insurance risks ceded into the pool. Because of this structure, financial analysts may be able to gain efficiencies by conducting and documenting the analysis of insurance risks associated with the pooled business on a combined basis and then leveraging the results of that work to complete legal entity analysis. For example, in situations where the majority of the group's writings are ceded into the intercompany pool and there are few unique legal entity risks, analysts may choose to create and maintain a combined risk assessment and/or IPS for all of the legal entities participating in the pool (if domiciled in the same state). In other situations, it may be more appropriate to maintain separate risk assessment worksheets and/or IPSs for each legal entity, but to reference work completed in the pool lead's documentation or include substantially similar information in each legal entity's risk assessment worksheet and IPS.

While insurers participating in intercompany pooling arrangements often share exposure to pooled insurance risks, differences in the overall risk exposure of participants may arise due to a number of factors including, but not limited to, the following:

- Surplus/RBC levels
- Balance sheet composition
- Pool participation percentages
- The timing of pool participation
- Premiums not ceded to the pool
- Reinsurance arrangements outside of the pool (e.g., facultative placement prior to cessions to the pool lead)
- Current or legacy risks (e.g., asbestos exposure) disclosed within the financial statement

Regardless of the method utilized to assess and document the analysis of the pool, the financial analyst should ensure that all significant, unique exposures of each pool participant are separately assessed and addressed within analysis documentation.

If pool participants are domiciled in various states, communication and coordination across states is needed to achieve efficiencies in analysis. For example, the domestic state of the pool lead would generally be expected to indicate to the analysts of the other insurers in the pool if it intends to complete a combined risk assessment and IPS and specifically when both will be provided to the other domestic states for their review. This will enable other states with domestics in the pool to leverage the completed work. To allow sufficient time for this coordination to take place, domestic states that intend to place reliance on the work of the pool lead state will have 30-days from the receipt of completed analysis work from the pool lead to complete the analysis of their legal entity or until the end of the prescribed analysis timeline, if longer. During this 30-day review period, prior to accepting the risk assessment and the IPS from the pool lead as satisfying all legal entity analysis requirements, each domestic state should consider and document the following:

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- The extent to which they are satisfied with the quality of work performed by the pool lead state and willing to be judged on that work from an NAIC Accreditation perspective (if relevant);
- The extent to which the work performed by the pool lead addresses all relevant and material solvency risks of the individual legal entity, including common differences in the risk exposure of pool participants noted above; and
- The completion of any supplemental, state specific analysis procedures (compliance or otherwise) that are necessary to finalize the legal entity analysis.

In situations where an insurer cedes business to an intercompany pool but does not participate in retrocession, the analysis of the pooled business should be obtained/reviewed to evaluate reinsurance credit risk. If the pool is troubled or potentially troubled, this may require more in-depth analysis to evaluate the potential impact of claims associated with the insurer's direct writings not being covered by the pool.

DISCUSSION OF NON-ROUTINE ANALYSIS

The Handbook contains procedures that assist an analyst in deriving an overall assessment of the insurer's financial condition; however, situations may exist when it is necessary to perform additional procedures and analysis not contained in the Handbook for one or more insurer.

On occasion, events or situations outside of the normal course of business occur that may have a material impact on the overall financial condition of an insurer. During these occasions, state insurance regulators may need to perform non-routine analysis, which may require additional reporting from a specific insurer or from a group of insurers. A few examples of these occasions may include significant financial events such as material investment defaults, credit market stress, or catastrophic events. Non-routine analysis may also be appropriate and necessary in situations impacting a single insurer, a group, or a small group of insurers. For example, when permitted practices are granted, there may be a need to perform follow-up analysis of the situation requiring the permitted practice (e.g., assessing the reliability of deferred tax assets). The state may conduct this analysis itself or enter into an agreed-upon procedures audit with a CPA firm to assist in the assessment and analysis of the projected future deferred tax assets and the impact to surplus.

The following are a few examples of types of non-routine analysis that may be appropriate in an economic downturn, investment defaults, and changes in the credit markets (Note that some or all of these may also be applicable in other non-market or investment related situations).

- Focused analysis on asset quality where insurers hold higher amounts of riskier assets. Analysts should not only consider exposure to individual default events, but also aggregate exposure. Additional review or explanation from the insurer may be requested when high amounts of other-than-temporary impairments, unrealized losses and/or large variances between book and market value are reported. Analysts should review the value of affiliated investments and assess indirect exposure to economic events that may result in the decline in the affiliated holdings. Analysts may consider other sources of analysis or information to assist in the review of investments. For example, an analyst may consider requesting assistance from the NAIC Capital Markets Bureau.
- Analysts should consider the impact of tightened short-term credit markets on insurers or groups that depend on commercial paper, overnight repos, dollar repos, etc. Another area that could be impacted by changes in credit markets is the insurer's ability to obtain letters of credit (LOCs) provided for XXX (life reserves) or other reinsurance reserves, and the costs of those LOCs for an insurer dependent on LOCs.
- If the insurer engages in securities lending, analysts may consider requesting detailed information about the program to review the types of assets (risk and duration match) within the program, gain an understanding of the structure and terms of the program, and, if material, monitor monthly changes in the program.
- Certain insurance products may be impacted more than others in an economic downturn. Analyst should consider the impact to an insurer that writes a material amount of products that are more likely to be

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accelerated (e.g., funding agreements, guaranteed interest contract (GICs) or where the liability can be accelerated (e.g., variable annuities, living benefit/death benefit on variable annuities).

- Analysts should consider the level of sensitivity of the insurer to ratings downgrades and the possible impact on the insurer or the group. For example, its ability to market new business or the impact of rating downgrades on any debt covenants. If an insurer is downgraded, analysts may consider monitoring surrenders, new business sales, and any changes in the insurer's business plans.
- Where liquidity is a concern, analysts may also consider requesting interim reporting from the insurer on areas of risk specific to that insurer. For example, surrender activity, high-risk investment exposures, GICs, capital and surplus, available liquidity, available credit facilities and capital losses.
- Where significant concerns exist, the state may consider requesting the insurer to perform stress testing on the possible future impacts of additional equity losses, defaults, or other areas relevant to the situation.

Examples of types of non-routine analysis that may be appropriate in catastrophic events:

- Implement disaster reporting requests to appropriate insurers and monitor claims exposure during future periods following the event
- Identify insurers and reinsurers with material exposure
- Implement appropriate procedures to identify fraudulent activities
- Perform an in-depth analysis of liquidity to ensure timely payment of claims
- Engage legal staff to ensure appropriate claims payment practices

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XX DEPARTMENT OF INSURANCE

INSURER PROFILE SUMMARY
COMPANY NAME
As of 12/31/20XX
Updated as of XX/XX/20XX

Insurer's Group Number
List here

Lead State/Groupwide Supervisor
List here

State Prioritization
List X out of X

RBC Ratio
List % here as calculated in the 5-year history by the Company

Insurer's Financial Strength/Credit Ratings
List here

Contact at Insurer
List name here
List phone here
List e-mail here

Key Personnel
List name here – CEO
List name here – CFO
List name here – CRO
List name here – Other

CPA Firm
List here

Appointed Actuary
List here

Analyst
List here

Date of Last Exam
List here

Examiner In Charge
List here

BUSINESS SUMMARY

Provide a summary of the business operations and lines of business of the insurer.

ABC is an independently owned property and casualty insurance organization based in state X that specializes primarily in auto and homeowners insurance with significant exposure in the southeastern states. As such, ABC carries significant reinsurance protection with highly rated reinsurers to mitigate catastrophe exposure. Through its subsidiaries, DEF Insurance Company, GHI Insurance Company, JKL Underwriters, and MNO Premium Finance Company, the group offers a variety of insurance related services including premium finance and claims processing.

Identify the ultimate controlling person (UCP) and provide a brief summary of the holding company system (e.g., business profile and key operations or segments, pooling arrangement). Refer to the Group Profile Summary to avoid unnecessary duplication of details that are not specific to the impact on the solvency the insurer.

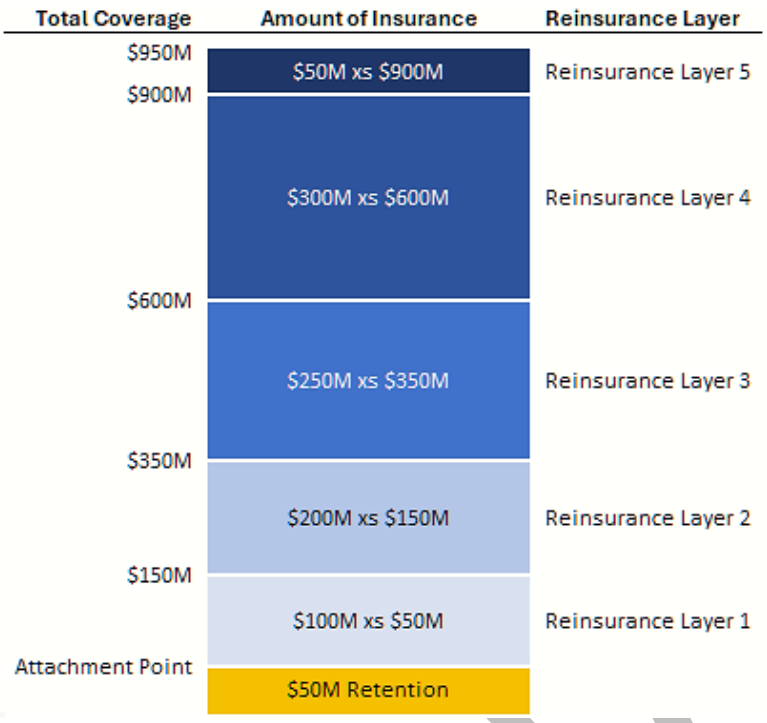
ABC is owned by PQR Holding Company, a mutual owned holding company that acts as the ultimate controlling person for the group. The group provides a wide range of financial products to its customers but operates under a fairly direct and simple organizational structure. The PQR Holding Company is divided into two business segments: insurance, and financial services/planning. The insurance segment makes up approximately 70% of the group's total revenue, which includes both property & casualty (55% of total revenue) and life insurance (15% of total revenue). Refer to the Group Profile Summary for PQR (file location) for further details.

The following is a description of the reinsurance program from the Interrogatory on Catastrophe Reinsurance Program PR027A:

ABC's catastrophe reinsurance program provides coverage for natural perils, including hurricanes, severe convective storms, wildfires, winter storms, and earthquakes. The program consists of an excess of loss treaty, effective from June 1 to the following May 31 each year. It is designed to protect the company up to a 1-in-250-year probable maximum loss, estimated at $950 million. The program is structured as a series of cascading layers of protection. Each layer provides coverage for a specific range of losses above the company's $50 million retention level, up to a total program limit of $950 million (representing $900 million in cumulative reinsurance protection). This is shown in the accompanying diagram. The program also includes one reinstatement of coverage limits per year.

Example

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REGULATORY ACTIONS

Discuss any significant actions taken against the company, permitted practices, issues of non-compliance, results from the most recent financial examination, etc.

In 20XX, ABC was required to file a corrective action plan with the department to address its breach of the RBC Company Action Level. Since that time, ABC received a capital infusion from its parent and has raised its RBC to an acceptable level. The company has been granted a permitted practice relating to its SCA investment in JKL Underwriters. The permitted practice allows ABC to admit its investment in JKL ($2 million at 12/31/XX) without requiring an independent financial statement audit.

FINANCIAL SNAPSHOT (SUMMARY DATA) – OPTIONAL

Assets and Liabilities		
Years Ended December 31 (Dollars in millions)	***20XX***	***20XY***
Total Invested Assets	*219*	*253*
Other Assets	*111*	*131*
TOTAL ASSETS	*330*	*384*
LIABILITIES		
Insurance reserves	*97*	*95*
Other liabilities	*169*	*193*
TOTAL LIABILITIES	*266*	*288*
Capital and Surplus	*64*	*96*
TOTAL LIABILITIES AND C&S	*330*	*384*
Operations	***20XX***	***20XY***
Premiums	*218*	*233*
Investment income (net of gains/losses)	*1*	*8*
Other income	*0*	*0*
Total revenues	*219*	*241*

Example

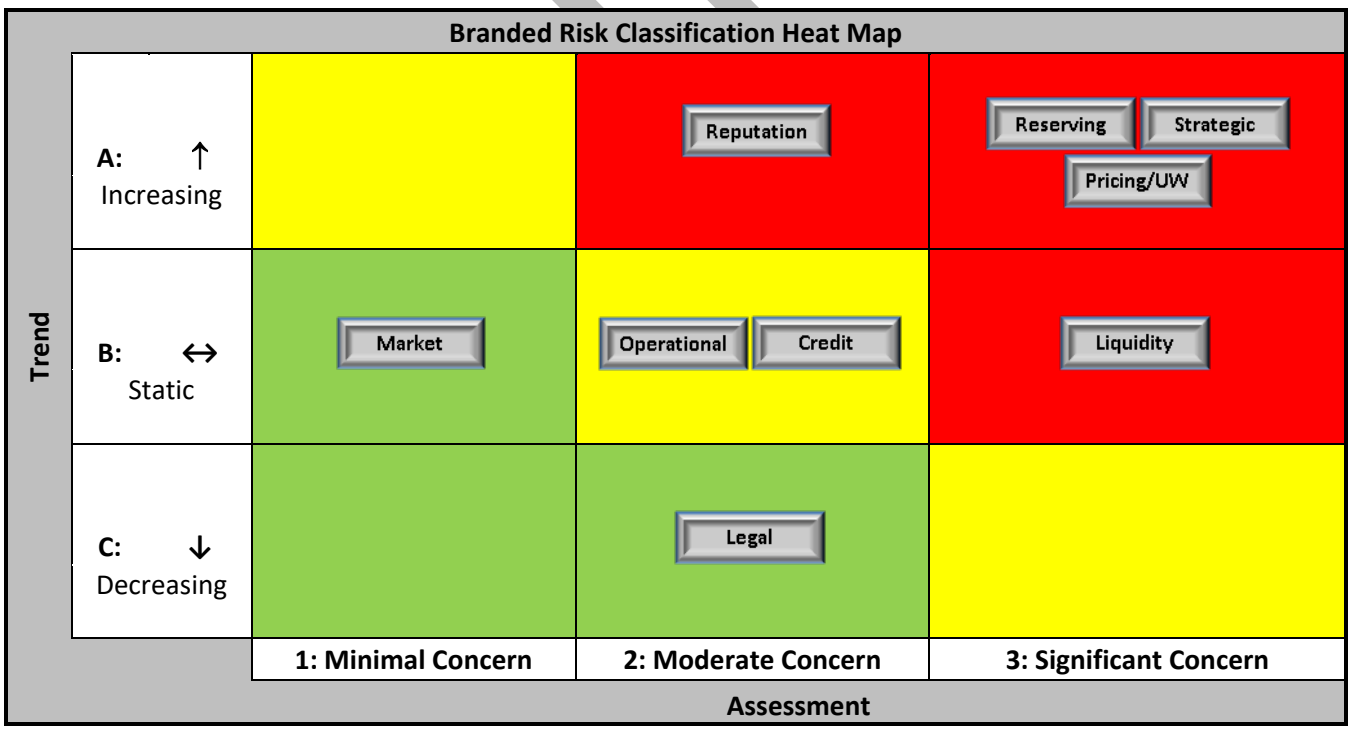
LOSSES, BENEFITS AND EXPENSES		
Policyholder Benefits	*177*	*157*
Expenses	*77*	*80*
Total losses, benefits and expenses	*254*	*237*
Other	*0*	*2*
NET INCOME	*(35)*	*2*

BRANDED RISK ASSESSMENTS

Summarize your assessment of the branded risk classifications for the insurer based upon both quantitative (e.g., 5-year trending of key ratios) and qualitative information. An assessment of each significant individual risk component (including prospective risks) relevant to the classification should be provided by indicating either "minimal concern," "moderate concern," or "significant concern" as well as the direction in which the risk is trending. If no individual risk components are identified for a branded risk classification, documentation should be provided to support this conclusion. Consider the materiality and/or significance of each individual risk component in aggregating the overall assessment and overall trend, including positive considerations and mitigating factors, for each branded risk classification. Update the Branded Risk Classification Heat Map to illustrate your conclusions.

The following is an interactive map. Click and drag the risk classification to the appropriate section of the risk classification heat map after assessing the trend in each individual category.





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Credit: *This risk is considered moderate, driven primarily by a fairly conservative investment mix (96.4% of bonds are NAIC 1 with 28% US government, 14% US states, most of the rest high quality corporates) and limited exposure to equities, offset by a relatively high amount of real estate ($33 million, 10% of assets), growing agent balances ($59 million) including past due amounts of $12 million and significant reinsurance recoverables (paid and unpaid) of $41 million. However, the reinsurance recoverables are diversified across a number of highly rated reinsurers.*

Overall: *the credit risk is assessed as moderate and increasing due to the material exposure to real estate and receivables, mitigated by a diverse reinsurance program and a conservative bond portfolio.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Real Estate-Home Office		↔
		Agent Balances and Uncoll Prem	↑
Overall Credit Assessment: Moderate Concern		**Overall Trend:**	↑

Legal:

Fee Schedule Lawsuits: *The Company has a vested interest in the outcome of the case of GEI v. Virtual Imaging which is before the State Supreme Court. This case pertains to a change in statutes, effective January 1, 20xx, that affected the manner in which insurers, including the Company, have paid claims. Subsequent to the statutory change, cases have been brought and trial courts have concurred that the statutes and resulting payments are ambiguities in the statutes. These cases are collectively known as the "Fee Schedule" matter. The Company began receiving lawsuits on this matter in May 20xx, some of which were closed at high cost. Since that time, the Company has modified its strategy for handling these cases and has received multiple trial victories from juries that ruled no further payments were owed to the plaintiffs. Exam results indicate that the Company's legal team tracks and monitors outstanding lawsuits and involves experienced external counsel in representing the Company in these matters.*

Overall: *Overall, legal risk is assessed as moderate with a declining trend as a ruling on the Fee Schedule matter is expected soon and the Company has taken measures to address the claim payments prospectively.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Fee Schedule lawsuits		↓
Overall Legal Assessment: Moderate Concern		**Overall Trend:**	↓

Liquidity:

Exposure to PIP Market: *The Company is subject to high liquidity risk due to the lines of business written and the corresponding need to meet short-term obligations. The Company's high exposure to the volatile PIP market and related losses has reversed the trend of improved liquidity in recent years due to a sharp increase in claim liabilities in the current year.*

Liquidity Position: *Trends in the Company's five-year liquidity ratio indicated improvements in the ratio before a negative shift in the current year.*

Overall: *The overall assessment for liquidity risk is moderate and static as the above noted risks are somewhat mitigated by an asset portfolio that is comprised of cash, and mostly investment grade bonds and highly liquid equities.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
		Exposure to PIP Market	↔
		Fluctuations in Liquidity Position	↔
Overall Liquidity Assessment: Moderate Concern		**Overall Trend:**	↔

Example

Market:

Equity Exposure and Changes in Credit Spreads*: Equity risks, changes in credit spreads, and also interest rate risks exist for this Company but are, mostly, not inherently significant due to its relatively conservative investment portfolio and relatively short-term policies (typically 6 months or 1 year), which allow the Company to reprice fairly easily to align with shifts in the market.*

Economic Volatility: *As reflected during the recent financial volatility in the last quarter, some of the Company's products are more sensitive to general economic volatility, which can impact the Company's performance.*

Overall: *As a result, the overall assessment is moderate and static.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Equity Exposure			↔
Changes in Credit Spreads			↔
	Economic Volatility		↑
Overall Market Assessment: Moderate Concern		**Overall Trend:**	↔

Operational:

Segregation of Duties: *Concerns were raised regarding segregation of duty issues related to the handling of claims and cash disbursements during the last exam.*

Agent Fraud: *In addition, a recent news report indicated that one of the Company's independent agents has been charged with committing fraudulent activities. Due to the Company's heavy reliance on independent agents to generate business and manage policyholder relations, even though the report might be an isolated incident it represents a moderate concern in this category.*

Compliance Issues*: The Company has consistently been out of compliance with one or more laws, regulations or requirements of the Department and other states.*

Incorrect Statutory Financial Statements: *The analyst and examiner have noted issues with certain amounts reported incorrectly within the statutory financial statements, affecting reported income statement results and supporting schedules. The Company has agreed to amend the most recent statement and implement changes within their accounting department processes/systems to address the Department's concerns.*

Overall: *The results of the last exam indicated that the Company has a reliable IT environment and effective internal controls in most areas. Cybersecurity risk was tested during the exam and controls were determined to be generally effective. Overall, the assessment is moderate and increasing following the recent exam and annual reporting. The analyst will continue to monitor the insurer's progress in implementing improvements to address the exam findings and concerns noted above.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Segregation of Duties		↔
	Agent Fraud		↑
	Compliance with Laws		↑
		Incorrect Statutory Financial Statements	↑
Overall Operational Assessment: Moderate Concern		**Overall Trend:**	↑

Pricing/Underwriting:

Rate Adequacy: *Although the Company is primarily engaged in short-term products (6 months or 1 year), it is subject to highly competitive price pressure and has shown historically weak underwriting results. Underwriting results have shown a negative trend over the past 6 periods as losses incurred continue to rise, a sign that pricing*

Example

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pressures are influencing the bottom line. The Company appears to be utilizing cash flow underwriting as a way to bolster earnings through investment income, which leads to a concern regarding the adequacy/ appropriateness of rates used by the Company.

***Lack of Underwriting Guidelines**: In addition, the last financial exam noted a lack of documented underwriting guidelines at the Company, which is in the process of being corrected. However, the lack of documented, detailed underwriting guidelines represents a moderate concern in this area.*

***Overall:** Overall, this risk category represents a moderate increasing concern for the Company.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Lack of Underwriting Guidelines		↔
		Rate Adequacy	↑
Overall Pricing/Underwriting Assessment: Moderate Concern		**Overall Trend:**	↑

Reputation:

***Agent Fraud:** The Company's business is not rating sensitive, but the Company is highly dependent upon business produced by agents. As noted in the Operational section, a recent concern has been identified regarding potential fraud committed by one of the Company's agents.*

***Market Conduct Findings/Violations**: In addition, the findings of a recent market conduct examination led to numerous violations. These violations related to claims handling issues, such as failure to comply with timely payments and denial of legitimate claims. Although the Company has disputed these findings, gross writings continue to suffer as several agents have stopped writing on behalf of the Company.*

***Overall**: As a result of these outstanding issues, the overall assessment is moderate and increasing.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Agent Fraud		↑
	Market Conduct Findings/Violations		↑
Overall Reputation Assessment: Moderate Concern		**Overall Trend:**	↑

Reserving:

***Long-tail Exposure**: The Company historically has been overly optimistic in the forecasting of future liabilities and reserving, where actual reported results have failed to meet projections for the long-tailed homeowners lines of business, which represent [x%] of overall reserves.*

***Adverse Development** The types of business written and geographic regions in which coverage is provided leave the Company vulnerable to high losses and a greater than industry average risk for adverse reserve development.*

	CY	***PY***	***PY1***	***PY2***	***PY3***
Two Year Develop	*53.4%*	*8.0%*	*-20.3%*	*25.7%*	*100.1%*
Loss & LAE/C&S	*204.1%*	*132.3%*	*168.0%*	*235.2%*	*496.9%*

***Loss Portfolio Transfer and Adverse Development Cover Agreement**: Effective [date], the Company entered into a loss portfolio transfer and adverse development cover agreement with 123 Reinsurance Co. This agreement substantially covers the outstanding reserves for the lines of business that have been driving unfavorable development, thereby mitigating some of the risk of future reserve deficiencies. As a result of this mitigating factor on prospective risk, the overall assessment for reserves is lowered to Moderate. The actual results of the reinsurance program's impact will be monitored in future reporting periods.*

Example

Overall: *The Company's reserving risk is moderate and increasing, driven primarily by the above reserve trend information, which is expected to be mitigated by the new loss portfolio transfer and adverse development cover agreement.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
		Long-tail Exposure	↔
		Adverse Development	↑
Overall Reserving Assessment: Moderate Concern		**Overall Trend:**	↔

Strategic: *The following issues have been identified relating to the Company's strategy:*

Profitability Impact on Capital Concerns*: As discussed above, the Company has experienced weak underwriting, which has resulted in material losses and material reductions in capital. Underwriting losses have been reported in each of the past five years. Consequently, profitability and capital are considered weak as investment activity has been used to prop up the bottom line, in addition to capital contributions from the Company's parent. The Company has not yet finalized and presented an updated business plan to demonstrate how it will address these strategic issues going forward.*

Expansion in New Jurisdictions*: The Group indicated in the Group's ORSA that it was changing its mix of business in states other than State X and Y. This could create a risk as the Company has only been writing in the other states for a few years; therefore, there is limited historical development available for these states. This should be considered in the context of the targeted examination.*

Catastrophe Reinsurance Program*: ABC's catastrophe reinsurance program covers natural perils including hurricanes, severe convective storms, wildfires, winter storms, and earthquakes. The program consists of an excess of loss treaty, effective from June 1 to the following May 31 each year and is designed to protect the company up to a 1-in-250 year probable maximum loss, estimated at $950 million. There is a series of cascading layers of protection. Each layer providing coverage for a specific range of losses above the company's $50 million retention level, up to a total program limit of $950 million (representing $900 million in cumulative reinsurance protection). The analyst considers the reinsurance program sufficient, however, given the Company's exposure to natural perils and the hardening reinsurance market, it is determined to be a moderate concern with an increasing trend. The analyst will continue to review the catastrophe reinsurance program for adequate cover in the near future.*

Overall*: The overall strategic risk assessment is significant and increasing as a result of the weak profitability, capital position, natural cat exposure and uncertainties in future business plans.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Expansion in New Jurisdictions		↑
		Profitability Impact on Capital Concerns	↑
	Catastrophe Reinsurance Program		↑
Overall Strategic Assessment: Significant Concern		**Overall Trend:**	↑

IMPACT OF HOLDING COMPANY ON INSURER

Summarize the evaluation of the impact of the holding company system on the domestic insurer. Utilize information provided in the Group Profile Summary prepared by the Lead State.

EXAMPLE:

The group is highly dependent upon cash flows from the various entities, including ABC, to make payments on the holding company debt used to help finance past transactions associated with the growth of the group. The group

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has sufficient liquidity to meet the necessary cash flows expected in the near term. Other risks from the non-insurers are not significant. See the Group Profile Summary for further discussion.

The holding company's UCP, has provided capital to the insurer when it has been required. The presence of many agreements involving the insurer and its affiliates indicate that the holding company is highly interconnected with entities being dependent on one another. The insurer provides services to, as well as receives services from affiliates. This is accomplished via a Risk Share Agreement which superseded previous agreements the insurers had with the affiliated entities. The insurer provides TPA services for certain members of the group.

Overall, the operations of the holding company are profitable and able to maintain the ability for the holding company to infuse capital into the three insurers when needed. The holding company has requested distributions from the insurer from time to time to help fund capital deficiencies in two affiliates, but there is no concern with the insurer's financial condition or independent ability to provide this support at the present time. In evaluating whether the holding company has the ability to provide necessary financial support to its insurers, it is noted that the holding company has equity of $X billion as of it most recent audited financial statements and has positive net operating income over the past several years. In addition, the holding company has bond ratings from Moody's of Aa3 and from Standard & Poors of AA. These strong ratings coupled with a strong balance sheet provide evidence that the holding company has the ability to continue to assist the insurer by means of capital infusions should the needs arise.

The [name of parent] has [issued or modified] a parental guarantee agreement [or capital support agreement] under which the Parent will be responsible for ensuring that the Company has sufficient capital and liquid assets to pay claims. The Parent will also maintain capital at a level that ensures a minimum RBC level of ##.#% ACL.

OVERALL CONCLUSION AND PRIORITY RATING

This section should include an overall conclusion as to the Company's financial condition, discuss strengths that potentially mitigate the risks assessed above, and highlight weaknesses and any concerns with the Company's operations going forward. Include any actions that may have been taken (e.g., significant holding company transactions, prior or planned meetings with management, and referrals to/from other divisions, etc.). Recommend the priority level that should be assigned to the Company and explain the rationale.

EXAMPLE:

Based on the branded risk assessments provided above as well as the Company's poor financial results reported in recent periods, the Company appears to be potentially troubled. The Company has triggered more than five of the department's prioritization criteria and is a multi-state insurer; therefore, the Company has been assigned our highest priority rating of 1, which is unchanged from the prior year. Some of the most significant issues facing the Company include rate adequacy, reserve sufficiency and overall cash flow and liquidity issues. However, these weaknesses are somewhat offset by Company strengths including a conservative investment portfolio, brand recognition and a strong historical reputation. The department has scheduled a meeting with senior management for the 3rd Quarter to discuss the Company's poor financial performance and ongoing business plan. During the meeting, the department plans to share its concerns and inform the Company of steps planned to monitor the company's operations more closely, as described below.

SUPERVISORY PLAN

List any specifically identified items that require further monitoring by the analyst or specific testing by the examiner. In addition, indicate if the Company is or should be subject to any enhanced monitoring, such as monthly reporting, a targeted examination, or a more frequent exam cycle.

If any Holding Company issues impact the insurer, include any monitoring or follow-up with the Lead State or the insurer. For example, include suggested follow-up procedures to address any potentially significant unresolved concerns with cost sharing or service agreements with affiliates or significant reliance on affiliates to provide services.

Example

EXAMPLE:

Analysis Follow Up

- *Obtain further detail regarding the impact of proposed rate increases and monitor through monthly financial reporting.*
- *Obtain further detail regarding the insurer's liquidity strategy.*
- *A new business plan has been requested. Assess the reasonableness of the Company's business plan as soon as it is received, given the inability to execute the most recent strategy. Consider requesting minutes of the board meetings to assess the concern regarding the future viability of the Company.*
- *Follow-up correspondence was sent regarding examination follow-ups (IT, and corporate governance over accounting & reporting and segregation of duties). Requested a response from the Company by [date].*

Examination Follow-Up

- *During the next regularly scheduled examination, audit the specific risks associated with the Company's agents' balances and uncollected premiums to determine if further concerns exist.*
- *Follow-up on segregation of duties issues noted in the last examination.*
- *Perform a targeted examination of the reserves, pricing and claims management. Consider in the reserve study any pricing review, information related to the changing legal environment, as well as the mix of business in states outside of X and Y.*

Example

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OVERVIEW

This template is intended as an optional tool highlighting items that may be discussed during a planning meeting between the assigned financial analyst and the financial examiner in support of the financial exam process. This meeting should ensure that the examiner both understands the company that will be examined and also receives details on work that has already been performed in supervising the company's operations. An effective exchange of information will promote efficiencies in the financial examination process by allowing the examiner to leverage the knowledge and work performed by the financial analyst. It may also prove useful to supplement this meeting with a discussion of the Exam Planning Questionnaire (Exhibit B) so that the analyst can review during the discussion to highlight or indicate if a document being requested has been obtained and/or reviewed by the insurance department. Although this template focuses on discussions between the assigned financial analyst and the financial examiner, the examiner may also consider incorporating this discussion into a broader planning meeting with members of department management and representatives from other areas of the department. However, if such an approach is taken, it should not reduce or diminish the level of discussion between the analyst and the examiner.

Given the importance of the Insurer Profile Summary (IPS) in communicating the results of the department's financial analyst's review of the company's operations, the planning meeting with the analyst is intended to generally follow the format of the IPS template.

Depending on the significance of operations at the group level, the examiner should consider whether additional agenda items should be added to focus on risks posed and discussed on the Group Profile Summary that are relevant for consideration during the examination.

NOTE: The exhibit was prepared to assist examiners in obtaining a general knowledge of the company through the meeting with the analyst. The examiner leading the discussion should not rely exclusively on these topics and should tailor agenda items based on knowledge of the company and based on knowledge of work that has been performed by the department. In situations where the exam is being led by an independent contractor, the department may consider having the insurance department's designee to lead the discussion of certain agenda items such as the role of the financial analyst in the examination.

PLANNING MEETING BETWEEN THE FINANCIAL ANALYST AND FINANCIAL EXAMINER – AGENDA ITEMS

1. **Business Summary** – Discuss a summary of the business operations and lines of business of the insurer.
    a. Discuss whether the department has received a recent business plan from the company and has identified any significant changes in strategy/operations.
    b. Discuss any recent meetings with the company and their potential impact on the examination.
    c. Discuss the corporate governance in place at the company and any recent changes or concerns identified.
2. **Regulatory Actions** – Discuss any significant recent steps taken in supervising the company, including, but not limited to:
    a. Granting of permitted practices
    b. Identification of issues of non-compliance
    c. Follow-up on items from the last financial examination
    d. Review of items filed with the department for approval

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3. **Financial Snapshot/Overview of Financial Position** – Discuss the company's recent financial results, including, but not limited to:
    a. Changes in profitability trends.
    b. Deterioration in asset quality, liquidity or capital adequacy.
    c. Changes in investment holdings and strategy.
    d. Changes in key annual statement balances.
    e. Changes in reinsurance balances and program structure.
    f. Significant results noted in financial analysis solvency tools.
4. **Branded Risk Assessments** – Discuss individual branded risk assessments with a focus on moderate and significant areas of concern. For example:
    a. Discuss a summary of detailed analysis work performed to address key issues.
    b. Discuss the status of any outstanding inquiries or requests for the company.
    c. Discuss any management representations to the department that should be verified or corroborated during the exam.
    d. Discuss any recommended exam procedures and/or follow-up on key issues.
5. **Impact of Holding Company on Insurer** – Discuss the impact of the holding company system on the domestic insurer. For example:
    a. Discuss and obtain the Group Profile Summary and non-lead state holding company analysis work as necessary.
    b. If the lead state, discuss whether the analyst's review of the group's Corporate Governance Annual Disclosure (CGAD), if applicable, Own Risk and Solvency Assessment (ORSA) Summary Report and/or Form F reporting indicate a need for additional follow-up and review during the exam.
    c. If not the lead state, discuss whether your state's review of the following indicates a need for additional follow-up and review during the exam.
        i. As applicable, either the insurance entity CGAD, or the lead state's review of the group's CGAD provided in the GPS and other information provided by the lead state
        ii. The lead state's analysis of the ORSA Summary Report
        iii. The lead state's analysis of the Form F provided in the GPS or other information provided by the lead state
    d. Discuss any developments or follow-up items resulting from recent supervisory college sessions.
6. **Overall Conclusion and Priority Rating** – Discuss the analyst's overall conclusion on the company's financial condition, strengths, weaknesses, and priority rating assigned to the company.
7. **Supervisory Plan** – Discuss the analyst's plans for the ongoing supervision of the company, including any specific examination procedures identified.
8. **Access to Work Papers and Company Documents** – Discuss the best way that the analyst's work can be reviewed/obtained. As the number of files that examiners wish to review and obtain increases, they may consider obtaining access to the analyst's workpapers and receiving specific locations (i.e., workpaper references) for all requested documents.

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9. **Input from Other Areas of the Department** – Discuss whether the analyst has received recent communications from other areas of the insurance department regarding issues that could affect the financial examination including, but not limited to, units in charge of:
    a. Approving rates and forms filings
    b. Legal and administrative matters
    c. Market conduct examinations/filings
10. **General Observations** – Depending on the information already provided, determine whether there are any additional topics relevant for discussion, such as:
    a. If you were going on-site to examine this company, where would you focus your time?
    b. What are your biggest concerns in terms of things that could go wrong at this company to result in a solvency concern?
    c. Are you aware of any fraud allegations or concerns at the company? Are there any fraud risk factors that the exam team should be aware of?
11. **Communication/Coordination Throughout Exam** – Discuss the role of the financial analyst in the examination, including the following:
    a. Participation in examination activities (e.g., Meetings with the company, C-Level interviews)
    b. Ongoing monitoring of exam status and findings; and
    c. Responsibility to communicate new information about the company (e.g., Form D filings, quarterly analysis results/updated Insurer Profile Summary) to the examination team timely throughout the course of the exam.

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USE OF BRANDED RISK ASSESSMENT GENERAL GUIDANCE

To assess a branded risk category, consider the procedures, data elements, metrics and benchmarks in this chapter. The placement of procedures, metrics and data within each branded risk category is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting financial determinations of the analysis. For example, key insurance operations or lines of business may have related risks addressed in different risk categories. Therefore, analysts may need to review risks in conjunction with multiple branded risk categories.

Analysts are not expected to document every procedure, data or benchmark result. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document the applicable details within the analysis. Results of risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.

Just as the analysis is customized to the individual insurer, analysts are strongly encouraged to customize the risk component names (i.e., an individual risk exposure or element that contributes to the broader branded risk category assessment) used within analysis documentation (including within TeamMate+) and the Insurer Profile Summary (IPS), rather than relying solely on titles of risks from the Handbook guidance. Clearly labeled risk component names benefit the understanding of the risk assessment for the reviewer and other readers of the IPS.

In conducting your analysis, utilize available tools in iSite+ such as financial profile reports, dashboards, investment snapshot, jumpstart reports, and other industry aggregated analysis. Consider also external tools such as rating agency reports, industry reports, and publicly available insurer information.

Analysts should complete their risk assessment in conjunction with:

- A review of the Supervisory Plan and IPS and the prior period analysis.
- Communication with the company.
- Communication and/or coordination with other internal departments.
- The insurer's corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board.

The Handbook's guidance by branded risk is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

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CREDIT RISK: Amounts actually collected or collectible are less than those contractually due or payments are not remitted on a timely basis.

The credit risk assessment is focused primarily on exposure to credit risk of investments and reinsurance receivables. In analyzing credit risk, analysts may analyze specific types of investments and receivables held by insurers. Analysts' risk-focused assessment of credit risk should take into consideration the following areas (but not be limited to):

- Concentrations of investments in type and sector (i.e., diversification).
- Materiality of high-risk or low-quality investments.
- Credit quality of affiliates and subsidiaries.
- Extensive use of reinsurance.
- Credit quality of reinsurers.
- Collectability of reinsurance receivables.
- Quality of collateral held on unauthorized or overdue authorized reinsurance.
- Collectability of other receivables (e.g., intercompany receivables).
- Collectability of uncollected premium and agents' balances.
- Strategies for mitigating credit risk (i.e., counterparty risk with derivatives and off-balance sheet transactions).

Principles-Based Bond Definition (PBBD)

Beginning in 2025, investment schedules and certain other Notes to the Financial, General Interrogatories, 5-Year History, and related pages of the quarterly and annual financial statement were amended for the implementation of the statutory accounting principles-based bond definition (PBBD) revisions.

Analysts should be aware that in some cases, changes between amounts reported on investment schedules and certain lines of the schedules may not be comparable to the prior year (2025 to 2024) or may vary from the prior year due to the bond definition change, in which an insurer may hold some securities that no longer meet the definition of a bond (or vice versa), as well as revisions to investment schedule reporting categories.

The PBBD project revised the definition of a bond to "a security structure representing a creditor relationship with a fixed payment schedule." A creditor relationship requires the evaluation of substance rather than solely the legal form. In assessing credit, market and liquidity risks for bonds, the analyst should have a clear understanding of what securities are reported as bonds and the related reporting requirements.

Debt secuities that do not quality as bonds are in scope of SSAP No. 21 and would be reported on Schedule BA. Under PBBD, there are three reasons why a debt security would not qualify as a bond: 1) the debt security does not reflect a creditor relationship (applies to Issure Credit Obligations—ICO and Asset-Basked Securities—ABS); 2) the debt security has a lack of substantive credit enhancement (applies to ABS); and 3) the debt security lacks meaningful cash flows (applies to non-financial ABS).

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The PBBD modified Schedule D reporting to differentiate more fully between Issuer Credit Obligations (ICO), reported on Schedule D, Part 1, Section 1, and Asset-Backed Securities (ABS) reported on Schedule D Part 1, Section 2, which are defined as follows.

ICOs are issued by operating entities. For an ICO, the repayment of the instrument is supported primarily by the general creditworthiness of an operating entity or entities. ICOs are reported on Schedule D, Part 1, Section 1, which only includes securities in scope of SSAP No. 26. Investments in orange italics are not bonds but are explicit inclusions within the scope of SSAP No. 26.

- U.S. Government Obligations
- Other U.S. Government Obligations
- Non-U.S. Sovereign Jurisdiction Securities
- Municipal Bonds – General Obligations
- Municipal Bonds – Special Revenue
- Project Finance Bonds Issued by Operating Entities (Unaffiliated / Affiliated)
- Corporate Bonds (Unaffiliated / Affiliated)
- Mandatory Convertible Bonds (Unaffiliated / Affiliated)
- Single Entity Back Obligations (Unaffiliated / Affiliated)
- *SVO–Identified Bond Exchange Traded Funds–Fair Value*
- *SVO–Identified Bond Exchange Traded Funds–Systemic Value*
- Bonds Issued by Funds Representing Operating Entities (Unaffiliated / Affiliated)
- *Bank Loans–Issued* (Unaffiliated / Affiliated)
- *Bank Loans–Acquired* (Unaffiliated / Affiliated)
- *Mortgage Loans that Qualify As SVO-Identified Credit Tenant Loans* (Unaffiliated / Affiliated)
- *Certificates of Deposit*
- Other Issuer Credit Obligations (Unaffiliated / Affiliated)

ABSs are bonds created for the primary purpose of raising debt capital backed by financial assets or cash-generating non-financial assets owned by the ABS issuer, where repayment is primarily derived from the cash flows associated with the underlying defined collateral other than the issuing entity's operating cash flows.

- Required Defining Characteristics:
    - Reporting entity holder of debt is in a different position than if the underlying collateral was held directly.
    - Collateral must be financial assets or cash-generating non-financial assets expected to generate a meaningful source of cash flows for bond repayment other than through sale or refinancing of the assets.

ABSs are reported on Schedule D, Part 1, Section 2, which only includes securities in scope of SSAP No. 43.

- Financial Asset-Backed Securities – Self-Liquidating [i.e., RMBS, CMBS, CLOs]
    - Agency Residential / Commercial Mortgage-Backed Securities – Guaranteed (Exempt from RBC)
    - Agency Residential / Commercial Mortgage-Backed Securities – Not/Partially Guaranteed (Not Exempt from RBC)

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  - Non-Agency Residential / Commercial Mortgage-Backed Securities (Unaffiliated / Affiliated)
  - Non-Agency – CLOs/CBOs/CDOs (Unaffiliated / Affiliated)
  - Other Financial Asset-Backed Securities – Self-Liquidating (Unaffiliated / Affiliated)
- Financial Asset-Backed Securities – Not Self-Liquidating [i.e., CFOs, other equity-backed]
  - Equity Backed Securities (Unaffiliated / Affiliated)
  - Other Financial Asset-Backed Securities – Not Self-Liquidating (Unaffiliated / Affiliated)
- Non-Financial Asset-Backed Securities – Practical Expedient [i.e., Lease-backed with less than 50% cashflows from sale/refinance at maturity]
  - Lease-Backed Securities – Practical Expedient (Unaffiliated / Affiliated)
  - Other Non-Financial Asset-Backed Securities – Practical Expedient (Unaffiliated / Affiliated)
- Non-Financial Asset-Backed Securities – Full Analysis [i.e., Lease-backed / other ABS supported as bonds due to entities detailed analysis]
  - Lease-Backed Securities – Full Analysis (Unaffiliated / Affiliated)
  - Other Non-Financial Asset-Backed Securities – Full Analysis (Unaffiliated / Affiliated)

Further detailed guidance on the Principles Based Bond Definition, including what classifies as a bond and the related reporting changes can be found within:

- SSAP No. 21—Other Admitted Assets
- SSAP No. 26—Bonds
- SSAP No. 43—Asset-Backed Securities
- Statutory Issue Paper No. 169—Principles-Based Bond Definition
- 2025 annual and quarterly financial statement reporting blanks and instructions

ANNUAL CREDIT RISK ASSESSMENT

Significant Investment Concentration by Asset Class

Determine whether the insurer's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by asset type, duration or issuer.

Various types of investments to total net admitted assets (excluding separate accounts) are a measure of the diversity of the insurer's investment portfolio by type of investment. The results of these ratios may also provide some indication of the insurer's liquidity. Ratios are included for most types of investments except for government and agency bonds and cash and short-term investments, which are generally very liquid and have low credit risk. In addition, the ratio of the investment in any one issuer to total net admitted assets (excluding separate accounts) is a measure of the diversity of the insurer's investment portfolio by issuer.

Procedures / Data

- Consider evaluating the following assets classes that may have credit default risk in comparison to total net admitted assets to determine the level of concentration:
  - *Issuer Credit Obligations (Unaffiliated):*

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- *Project Finance Bonds Issued by Operating Entities*
- *Corporate Bonds (non-investment grade)*
- *Mandatory Convertible Bonds*
- *Single Entity Back Obligations*
- *Bonds Issued by Funds Representing Operating Entities*
- *Bank Loans–Issued or Acquired*
- *Mortgage Loans that Qualify as SVO-Identified Credit Tenant Loans*
- *Other Issuer Credit Obligations*

- *Financial and Non-Financial Asset-Backed Securities*
- *Preferred stocks*
- *Mortgage loans*
- *Other invested assets (Schedule BA)*
- *Derivative exposure to any single Exchange, Counterparty or Central Exchange*
- *Collateral Loans [Life/A&H Insurers]*
- *Aggregate write-ins for invested assets*
- *Investments in affiliates, subsidiaries, and parent*
- *Any single investment (by issuer) in bonds, preferred stock, mortgages, or BA assets (excluding federal issuers and affiliated investments)*

Additional Review Considerations

- Review the percentage distribution of assets for significant shifts in the mix of investments owned during the past five years.
- Compare the insurer's distribution of cash and invested assets to industry averages and peer averages on iSite+ to determine significant deviations from the industry and peer averages. The comparison should focus on an appropriate peer group based on insurer type and asset size.
- Review of the Annual Supplemental Investment Risks Interrogatories to identify any unusual items or areas and determine whether the insurer's investment portfolio is adequately diversified to avoid significant aggregate credit risk.
- Perform sector analysis of Schedule D holdings with assistance of the NAIC Capital Markets Bureau if concerns exist that indicate a sector of the market may be experiencing financial distress that could result in credit risk to holders of bonds or stocks in that sector.
- If concerns exist regarding counterparty credit risk on derivatives, review Annual Financial Statement, Schedule DB, Part D to identify the counterparties and use available information (e.g., rating agency reports) to identify any concerns with the credit quality of the counterparty. Refer to IV.A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations for general information and a primer on derivatives.
- Review the Legal Risk Assessment to determine whether the insurer's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws.
- Inquire of the insurer:

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- Planned asset mix and diversification strategies.
- How the insurer manages counterparty credit risk, including diversification risk of counterparties.

Default and Volatility of Bond Exposures

The procedure assists analysts in determining whether concerns exist due to the level of investment in non-investment grade bonds. Bonds which have NAIC designations of 3, 4, 5 or 6 are considered non-investment grade bonds and represent a significantly higher credit or default risk to the insurer than do investments in investment-grade bonds. In addition, the prices of non-investment grade bonds are frequently more volatile than the prices of investment grade bonds which makes the price at which bonds are held an important consideration.

The risk of impairment of bonds or other assets may be indicated by deterioration in the credit quality which may result in other-than-temporary impairments impacting income and surplus. Investment grade bonds that have declined to a non-investment grade status may not recover lost value (bondholder default risk).

Procedures / Data

- Distinguish between the different non-investment grade classes as the risks are materially different. Consider the level of exposure to non-investment grade bonds in comparison to policyholder surplus (P/C), to capital and surplus plus AVR (L/H) and to capital and surplus (Health), to total bonds, or to total invested assets.
- Consider fluctuations in non-investment grade bond holdings by designation.
- Review Annual Financial Statement, Schedule D – Part 1A and compare the insurer's holdings of non-investment grade bonds to the limitations included in *Investments in Medium and Lower Grade Obligations Model Regulation* (#340) (or similar state law). Given the potential volatility in prices and that the main concern is risk of loss to capital, an important consideration is the price at which non-investment grade bonds are held. The NAIC's Model #340 establishes limitations on the concentration of non-investment grade bonds because of concerns that changes in economic conditions and other market variables could adversely affect insurers having a high concentration of these types of bonds.
    - Review the amount of non-investment grade bonds by NAIC designation compared to total net admitted assets (excluding separate accounts) utilizing Model #340:
        - Aggregate amount of all bonds owned which have an NAIC designation of 3, 4, 5, or 6.
        - Aggregate amount of all bonds owned which have an NAIC designation of 4, 5, or 6.
        - Aggregate amount of all bonds owned which have an NAIC designation of 5 or 6.
        - Aggregate amount of all bonds owned which have an NAIC designation of 6.

Within the six NAIC Designations are NAIC Designation Modifiers, which when combined result in the NAIC Designation Category. These categories are 20 granular delineations of investment risk within the NAIC 1 through NAIC 6 investment risk scale used to relate investment risk in insurer-owned securities to a risk-based capital factor.

Refer to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for detailed information on how the following NAIC designations and modifiers are determined.

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NAIC Designation	NAIC Designation Modifier	NAIC Designation Category
1	A	1A
	B	1B
	C	1C
	D	1D
	E	1E
	F	1F
	G	1G
2	A	2A
	B	2B
	C	2C
3	A	3A
	B	3B
	C	3C
4	A	4A
	B	4B
	C	4C
5	A	5A
	B	5B
	C	5C
6		6

Additional Review Considerations

- If the level of non-investment grade bonds is material, review Annual Financial Statement, Schedule D Part 1A, Jumpstart Reports (e.g., Bond Investment Designation Exception Report), Risk-Based Capital report, and the Financial Profile Reports and Dashboards to assess and understand the composition of non-investment grade bonds:
  - Amount and/or percentage of bonds in each NAIC designation 3, 4, 5 or 6.
  - Amount and/or percentage of bonds within each NAIC designation 3, 4, or 5 by designation category.
  - Fluctuations and shifts in concentrations by class; new purchases; downgrades or upgrades.
  - Concentration by sector or issuer, including affiliates.
  - Whether or not bonds have been rated by a credit rating provider (CRP) (e.g., Moody's Investors Service, Standard & Poor's, A.M. Best, or Fitch Ratings).
  - Issuers that the rating agencies have on negative watch.
- Inquire of the insurer:
  - Explanation of significant exposures.
  - Policies and strategy for investing in non-investment grade bonds. Determine if the insurer is adhering to those investment policies.
  - For the more significant non-investment grade bonds, consider requesting from the insurer audited financial statements and a rating agency report from a CRP for the issuer of the bonds to assess the issuer's current financial position and ability to repay its debt.

Borrower Default and Volatility for Asset-Backed Securities, OR Prepayment Variability for RMBS

Determine whether concerns exist over borrower default risk due to the level of investments in asset-backed scecurities (ABS) including residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS) and other financial or non-financial asset-backed securities reported on Schedule D Part 1, Section 2; or prepayment variability risk in RMBS. Lower credit quality of the borrowers (i.e., prime versus subprime) may result in higher risk of default, leading to credit losses in the event of a housing and/or commercial real estate market downturn.

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Of the structured securities, RMBS can be among the most complex and volatile. RMBS convert a pool of mortgage loans into a series of securities that have expected maturities which vary significantly from the underlying pool as a result of slicing the pool into numerous tranches with different repayment characteristics. RMBS are often issued or backed by the U.S. government, and when they are, they carry very little credit risk. As a result, agency-backed RMBS have been designated category 1.

Of the structured securities, RMBS can be among the most complex and volatile. RMBS convert a pool of mortgage loans into a series of securities that have expected maturities which vary significantly from the underlying pool as a result of slicing the pool into numerous tranches with different repayment characteristics. RMBS are often issued or backed by the U.S. government, and when they are, they carry very little credit risk. As a result, agency-backed RMBS have been designated category 1.

However, the credit rating does not consider the prepayment or interest rate risk inherent in the RMBS investment. Prepayment variability in RMBS could result in actual cash flows and investment yields to be materially different from expectations. If the underlying mortgage loans are repaid by the borrowers faster or slower than anticipated, the RMBS repayment streams will be affected and the expected durations will either contract or extend. Thus, the cash flows on these investments are much more unpredictable than those for more traditional bonds and the cash flows can be either more or less variable than for mortgage pass-through certificates. If the RMBS prepayments are significantly faster than anticipated, and the insurer had paid a large premium for the RMBS when it was acquired, the insurer could experience a significant loss on the investment even though the par value was received. In addition, cash flows on RMBS are harder to match with corresponding payments on policy liabilities which leads to the risk that prepayments may not be able to be reinvested in investments earning comparable yields in order to support the liability payment streams. When interest rates rise, prepayment will likely slow and the investors will be unable to take advantage of higher rates.When interest rates decline, prepayments will rise, forcing investors to reinvest at the lower rates which impacts the value of bonds on the secondary market.

Procedures / Data

- Review the following ratios to determine the level of concentration in asset-backed securities owned.
  - Ratio of all asset-backed securities compared to total net admitted assets.
  - Ratio of all asset-backed securities compared to policyholder surplus (P/C), or capital and surplus or capital and surplus [L/H or Health].
  - RMBS compared to total cash and invested assets, or to capital and surplus.
  - Any increasing trend in a material exposure from the prior year.

Additional Review Considerations

- Review the asset-backed securities securities categories in Annual Financial Statement, Schedule D – Part 1 – Section 2 for bonds with a book/adjusted carrying value (BACV) significantly in excess of par value. This could result in a loss being realized if bond prepayments occur faster than anticipated.
- Review the asset-backed securities categories in Annual Financial Statement, Schedule D – Part 1 – Section 2 for bonds with an unusually high effective yield.
- The effective yield on most debt securities is generally linked to its credit risk and duration. However, significant prepayment risk can also increase the effective yield.
- Review Annual Financial Statement, Schedule D, Part 1 – Section 2, and the Snapshot Investment Summary Report on iSite+ to assess exposure to agency versus non-agency asset-backed securities.
- Consider having the asset-backed securities modeled by an independent actuary as a part of an independent cash flow analysis.

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- Inquire of the insurer:
  - Estimated prepayment speeds on its RMBS. Several standardized forms of calculating the rate of prepayments of a mortgage security exist in the market. Historically, the constant prepayment rate (CPR) and the standard prepayment model of the Bond Market Association (PSA curve) are simple methods used to measure prepayments. Numerous other methods have evolved. Analysts should consider further analysis in those instances that prepayment risk appears high.
  - There are many different types of RMBS, each of which have different characteristics and inherent risks. Therefore, consider requesting information from the insurer regarding the percentage distribution and amounts of each type of asset-backed securities held; planned amortization class (PAC), support bonds, interest-only (IO) tranches, and principle-only (PO) tranches to evaluate the help evaluate the riskiness of the portfolio and the level of prepayment risk in the portfolio. IO bonds are particularly volatile.
  - Projected prepayment speeds on its RMBS portfolio and compare with historical prepayments, as well as the prepayment assumption at the time of purchase.

For Life/A&H Insurers:

- Consider a review of the insurer's life risk-based capital (RBC) formula or its Statement of Actuarial Opinion. The life RBC formula includes a C-3 Interest Rate Risk Component that charges insurer's for securities that have not been cash flow tested. The insurer is charged 0.5 times the excess of the statement value over the value of the security if all of the collateral was immediately repaid.
- Alternatively, or in addition, the Statement of Actuarial Opinion should be reviewed for comments regarding the modeling of the RMBS portfolio in the cash flow testing performed by the insurer.
- The rationale behind requesting information on these types of investments is to provide analysts with some insight regarding the level of prepayment risk the insurer holds in its RMBS portfolio and the measurement and monitoring tools the insurer uses to manage this risk. RBC C-3 Interest Rate Risk Component and the Actuarial Opinion cash flow testing ask the insurer to break down its RMBS portfolio by general definitional classes, each of which has its own relative level of prepayment and cash flow volatility risk. Individual insurers may use different measures and monitoring techniques. If an insurance company cannot supply this data with reasonable ease, analysts may want to look more closely at the management and monitoring systems in place for the RMBS portfolio.

Default Risk of Foreign Securities

Material exposure to foreign investments could result in credit losses if those investments are impacted by negative changes in geopolitical or foreign economic environments.

Procedures / Data

- Review the ratio of foreign bonds to total net admitted assets to determine the signficance of non-U.S. bond investments.

Additional Review Considerations

- If material and concerns exist, inquire of the insurer about the investment strategy for foreign investments and the nature of the foreign investments.
- Evaluate if the insurer is following the investment strategy as it pertains to these investments.

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Default or Volatility of Mortgage Loans

Determine whether concerns exist due to the level of expsoure or the quality of investment in mortgage loans, leading to possible default risk. The risk of impairment of mortgage loans may be indicated by deterioration in the credit quality which may result in other-than-temporary impairments impacting income and surplus. Mortgage loans may be at risk based on the volatility or impacts of economic changes in geographic regions.

Procedures / Data

- Consider the following metrics to assess materiality of exposure to mortgage loan default risk.
  - Ratio of mortgage loans to total net admitted assets.
  - Increase in exposure to mortgage loans from the prior year.
  - Total mortgage loans compared to capital and surplus plus AVR (L/H), to policyholder surplus (P/C).
  - Ratio of troubled mortgage loans compared to capital and surplus plus AVR (L/H), to policyholder surplus (P/C) or to capital and surplus (Health).
  - Ratio of commercial mortgages compared to total mortgages.

Additional Review Considerations

- Utilize postal code and property type information along with the city and state location information in Schedules A and B to identify geographic concentrations and to identify differences in volatility based on the property type and geographic location.
- Review Annual Financial Statement, Schedule B – Part 1 to determine the amount of each type of mortgage loan owned. Commercial mortgages have historically been riskier investments than farm mortgages and residential mortgages.
- If concerns exist, review Schedule B – Part 1, determine the amount of each type of mortgage loan owned.
- Determine whether any of the mortgage loans are to an officer, director, parent, subsidiary, or affiliate.
- Inquire of the insurer about increases by adjustment in book value/recored investment during the year.

Default of Second Lien Mortgage Loan

Most states restrict mortgage loan investments to first liens on property, with some states allowing second liens in instances where the insurer also owns the first lien. Second liens are more risky because, in the event of default, the holder of the first lien would be repaid out of any proceeds from the sale of the underlying property prior to the holder of the second lien.

Procedures / Data

- Assess the materiality of exposure to second lein mortgage loans.
  - Amount of any “Other than first liens” compared to the total admitted mortgage loans [Annual Financial Statement, Assets (page 2)].

Inadequate Collateral for Mortgage Loan Risk

An important consideration in the analysis of mortgage loans is the adjusted loan-to-value and debt service coverage ratio for each property owned, which are used in the determination of the mortgage’s Commercial Mortgage Risk Category and are detailed in the RBC worksheet. Out-of-date appraisals may result in inaccurate valuation, resulting in an undervalued underlying collateral asset.

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Procedures / Data

- Review debt service coverage ratios and adjusted loan-to-values (i.e., book value/recorded investment of each loan compared to the value of the land and buildings mortgaged) of the individual mortgage loans to determine whether the mortgage loans are adequately collateralized.

Additional Review Considerations

- For mortgage loans with interest overdue or in process of foreclosure, review the date of the last appraisal or valuation (Schedule B – Part 1) to determine whether updated appraisals should be obtained.

Default or Volatility of Other Invested Assets (Schedule BA)

Determine whether concerns exist due to the level of investment in other invested assets (Schedule BA). The types of investments included in Annual Financial Statement, Schedule BA include: debt securities that do not qualify as bonds; surplus notes; capital notes; joint ventures, partnerships, and limited liabilty companies; collateral loans; non-collateral loans; federal and state tax credit investments; working capital finance investments; and residual tranches or interests. Refer to SSAP No. 21 and the guidance above on the PBBD as it relates to debt securities that do not qualify as bonds. Joint ventures and partnerships typically involve real estate. These types of assets also tend to be fairly illiquid and may contain significant credit risk. BA assets often have complex investment strategies and unpredictable cash flows. The volatility of underlying assets (e.g., certain hedge funds and private equity funds) may result in underlying assets not being adequate.

Credit risks for Schedule BA assets include:

- Credit quality of the investments that may result in impairment and default.
- Complexity of BA assets.
- Adequacy of collateral of BA assets.
- Volatility of cash flows.
- Portfolio volatility driven by economic changes on BA assets.

Procedures / Data

- Consider the following ratios to determine the exposure to BA Asset credit risk.
    - Ratio of Schedule BA assets to total net admitted assets.
    - Ratio of Schedule BA assets to policyholder surplus (P/C), to capital and surplus plus AVR (L/H), to capital and surplus (Health).
    - Increase in Schedule BA Assets from the prior year, where the investments in Schedule BA assets are material.

Additional Review Considerations

Review Schedule BA to determine the amount and types of other invested assets owned and to determine whether they are properly categorized as other invested assets. Significant categories within Schedule BA are hedge funds and private equity funds. These and other investments in Schedule BA are characterized by complex strategies, lack of transparency for expected yields and cash flows, as well as high management fees.

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- Review Annual Financial Statement, Schedule BA – Other Invested Assets Owned, to determine the amount and types of other invested assets owned and identify if the insurer's exposure to certain classes of BA assets are significant (e.g., hedge funds, private equity funds, etc.).
    - Determine whether concerns exist regarding the insurer's exposure to non-traditional investments, (i.e., hedge funds and private equity funds) as compared to capital and surplus and impact on liquidity.
    - Review the experience of the insurer with respect to investing in alternative investments such as hedge funds and private equity funds.
    - Obtain and review cash flow projections to ensure that the insurer understands the cash flow characteristics of such investments.
    - Perform procedures to test the accuracy of reporting for non-traditional investments.
    - Ensure that senior management and the Board of the insurer have signed off on non-traditional investments.
- Review Schedule BA to determine if a significant amount of BA assets have NAIC ratings of 3, 4, 5 or 6 or have a "Z" designation.
- Inquire of the insurer:
    - Investment strategy regarding investment in Schedule BA assets.
    - Request information necessary to determine the fair value of collateral to the amount loaned to ensure the loan is adequately collateralized.
    - See Market Risk and Liquidity Risk for other related inquiries.

Credit Quality of Assets Supporting Collateral Loans (Life/A&H Insurers)

The procedure assists analysts in determining whether concerns exist due to the level of investment in collateral loans. Analysts should review Annual Financial Statement, Schedule BA. In most states, collateral loans are required to be secured or collateralized by assets which have a value in excess of the amount of the loan and which are considered admitted assets for an insurer.

Procedures / Data

- Review the following ratios to determine the level of concentration in collateral loans.
    - Ratio of collateral loans to total net admitted assets.
    - Ratio of collateral loans to capital and surplus plus AVR.

Additional Review Considerations

- Compare the fair value of the collateral to the amount loaned to determine whether the loan is adequately collateralized. In those instances where the underlying collateral is comprised of securities, analysts might consider verifying the rate used to obtain the fair value of the securities by referencing the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual).
- Review Annual Financial Statement, Schedule BA – Other Invested Assets Owned and perform the following for each such loan:
    - Determine whether the collateral for the loan is invested in a quality asset.
    - Determine whether the collateral loan is to an officer, director, parent, subsidiary, or affiliate.

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Impairment of Invested Assets Exposed to Climate Change and/or Transition Risk

Identify and assess the potential exposure of the insurer's investment portfolio to the impact of material climate change and/or energy transition risks. Transition risks refer to stresses on certain investment holdings arising from the shifts in policy, consumer and business sentiment, or technologies associated with the changes necessary to limit climate change. A few examples of investment holdings and sectors generally subject to greater levels of transition risk include oil/gas, transportation, heavy manufacturing, and agriculture. The insurer's investment portfolio is subject to prospective devaluation or impairment of the assets or changes in the asset return associated with its holdings of climate-affected assets.

Procedures / Data

- Review the information disclosed by the insurer in its responses to the NAIC's Climate Risk and Disclosure Survey (if available) on its exposure to material climate change/energy transition risk and related mitigation activity in this area.
- Review other relevant information provided in the Own Risk and Solvency Assessment (ORSA) Summary Report, and/or U.S. Securities and Exchange Commission (SEC) 10K or 10Q filings (if available) that discusses the insurer's exposure to material climate change/energy transition risk and related mitigation activity in this area.
- Review results of basic scenario analysis conducted by the NAIC using insurers' Annual Statement filings in the NAIC's U.S. Insurance Industry Climate Affected Investment Analysis to identify potential concentrations in insurer exposure.

Additional Review Considerations

- Review the insurer's investment policies and strategies to assess whether material climate change, transition and asset devaluation risk considerations have been appropriately implemented into the investment processes.
- Review the most recent examination report and summary review memorandum (SRM) for any findings regarding climate change/energy transition risks.
- If concerns exist, consider requesting information from the insurer regarding its management of exposure to material climate change/energy transition risk, including how it identifies and estimates current and prospective exposures and the limits (if any) in place to avoid concentrations.

Collectability of Reinsurance Recoverables,
OR
Reinsurer Credit Quality

Determine whether reinsurance recoverables and receivables are significant and if so, whether the amounts involved are collectable. Reinsurance payments may be delayed or not be paid when due, resulting in cash flow mismatch.

Under a reinsurance contract, the primary insurer transfers or cedes to another insurer (reinsurer) all or part of the risk. Reinsurance does not modify in any way the obligation of the direct insurer to pay policyholder claims. Only after claims have been paid can the direct insurer seek reimbursement from a reinsurer for its share of paid losses. As a result, evaluating the collectability of the recoverables and receivables, as well as the overall creditworthiness of the reinsurers is important. Evaluating the collectability of reinsurance recoverables and receivables requires an understanding of the specific facts and circumstances relating to each reinsurer.

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Reinsurance is generally obtained from one of the following categories of insurers:

- Professional Reinsurers – The main business of professional reinsurers is assuming premiums from non-affiliated insurers.
- Reinsurance Departments of Primary Insurers – Many insurers assume reinsurance from non-affiliates but also write business on a direct basis. These types of insurers may pose a larger collectability concern than professional reinsurers since the specialized reinsurance expertise may not be as strong.
- Alien Insurers – Reinsurers domiciled in another country may pose a collectability concern, if the reinsurer is domiciled in a jurisdiction with a solvency framework that may not be as strong as the U.S.

The fundamental issue involved with evaluating collectability is an assessment of the financial stability of the underlying reinsurers. To evaluate the collectability of reinsurance recoverables, analysts should consider the need to collect as much financial information as necessary to evaluate the financial condition of reinsurers assuming a material portion of risk, including various regulatory and governmental filings, rating agency reports, and financial analyses available from industry analysts.

A ceding insurer may not take credit for reinsurance recoverables in dispute with an affiliate, which may result in a recoverability issue. Occasionally, a reinsurer will question whether an individual claim is covered under a reinsurance contract or may even attempt to nullify an entire treaty. A ceding insurer, depending on the individual facts, may or may not choose to continue to take credit for such disputed balances.

Collectability of Reinsurance Recoverables for Life/A&H Insurers

Procedures / Data

Review the following ratio results to determine whether amounts recoverable (paid and unpaid) or amounts receivable from reinsurers are significant and collectable.

- Reinsurance amounts recoverable on paid and unpaid losses on claims as a percentage of capital and surplus.
- Reserve credits as a percent of capital and surplus.
- Other amounts receivable under reinsurance contracts as a percentage of capital and surplus.
- Total amount of funds withheld for payment of losses by ceding companies as a percentage of capital and surplus.

Additional Review Considerations

- Review L/H Annual Financial Statement, Schedule S – Part 3 – Section 1 and Schedule S – Part 3 – Section 2 and determine if any unusual items were noted regarding the types of reinsurance or the concerns with specific reinsurers.
- If concerns exist, review the reinsurer's history of payments of recoverables and determine compliance with the NAIC *Life and Health Reinsurance Agreements Model Regulation* (#791) regarding quarterly settlements of payments due from reinsurers.
- Review the Annual Financial Statement, Notes to Financial Statements, Note #23 and determine if the insurer reported any items of concern regarding reinsurance balances.
- Determine if and assess any significant write-offs of reinsurance collectables that have occurred during the period.
- Verify by direct contact or confirmation that funds withheld for payment are valid and adequately segregated for payment of losses.

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- Inquire of the insurer the aging of reinsurance amounts payable (e.g., concerns with reinsurance related transactions that may require inquiry to the insurer)/receivable.

Collectability of Reinsurance Recoverables For P/C Insurers

Review the following ratio results to determine whether amounts recoverable (paid and unpaid losses) or amounts receivable from reinsurers are material and collectable.

- Overdue paid losses and LAE reinsurance recoverables (91 days or more) to surplus.
- Total reinsurance recoverables from unauthorized reinsurers to surplus.
- Total reinsurance recoverables from alien reinsurers to surplus.
- Provision for overdue authorized and reciprocal jurisdiction reinsurance to authorized and reciprocal jurisdiction reinsurance recoverables on paid losses and LAE in dispute.
- Non-affiliated reinsurance recoverables on paid losses to surplus.
- Non-affiliated reinsurance recoverables on unpaid losses and LAE to surplus.
- Provision for unauthorized and certified reinsurance to total reinsurance recoverables from unauthorized and certified reinsurer.
- Total amount of funds withheld for payment of losses by ceding insurers to surplus.
- Unsecured reinsurance recoverables to surplus.
- Total reinsurance recoverables from any unauthorized or certified reinsurer to surplus.
- Total reinsurance recoverables from any alien reinsurer to surplus.
- Reinsurance recoverables in dispute to surplus.
- Maximum amount of return commissions due to reinsurers in the event of cancellation of all ceded reinsurance to surplus.
- Uncollectable reinsurance written off during the year to surplus.

Another important accounting concern for P/C insurers relates to the provision for reinsurance. Under statutory accounting practices, the insurer must establish a liability by a formula that considers:

- The amount of overdue reinsurance recoverable on paid losses due from authorized insurers and reciprocal jurisdictions, certified reinsurers, or unauthorized reinsurers.
- Any collateral deficiency with respect to the amount of reinsurance recoverable on paid and unpaid losses due from certified reinsurers or unauthorized reinsurers.

Additional Review Considerations

- Review, by individual reinsurer, the amounts shown as collateral. Identify any unusual trends and determine the need to examine the underlying collateral in more detail to ensure its validity.
- Credit quality and poor financial strength of a reinsurer may result in future collectability risk, which may result in ongoing credit risk and future liquidity issues.
- If the insurer holds a material letter of credit (LOC) securing unauthorized and/or certified reinsurance recoverables, identify the amount of the LOC and the issuing bank. Identify any concerns and assess whether the collateral is at an adequate level.

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- Review the Annual Financial Statement, Notes to Financial Statements, Note #23 and determine if there are any relevant concerns regarding reinsurance balances.
- Review the reinsurer's history of recoverables and note on findings or concerns.
- Verify by direct contact or confirmation that funds withheld for payment are valid and adequately segregated for payment of losses.
- Inquire of the insurer the aging of reinsurance amounts payables (e.g., concerns with reinsurance related transactions that may require inquiry to the insurer)/receivable.

Collectability of Reinsurance Recoverables for Health Insurers

Procedures / Data

Review the following ratio results to determine whether amounts recoverable (paid and unpaid) or amounts receivable from reinsurers are material and collectable.

- Reinsurance amounts recoverable as a percent of capital and surplus.
- Ceded premiums written to gross premiums written.
- Reserve credits as a percent of capital and surplus.

Additional Review Considerations

- Review Health Annual Financial Statement, Schedule S – Part 3 – Section 2 and determine if any unusual items were noted regarding the types of reinsurance and their relative significance, or the specific reinsurers involved.
- Review the Annual Financial Statement, Notes to Financial Statements, Note #23 and determine if the insurer reported any items of concern regarding reinsurance balances.
- Review the results of the Actuarial Opinion analysis and determine if any concerns were noted regarding the collectability of reinsurance recoverables.
- Review the reinsurer's history of recoverables and note any findings or concerns.
- Determine if and assess any significant write-offs of reinsurance collectables that have occurred during the period.
- Inquire of the insurer the aging of reinsurance amounts payable/receivable.

Collectability of Reinsurance Recoverables Due to Credit Quality of Retrocessionaires

Additional Review Considerations

- Determine whether retrocession may be occurring that could cause significant collectability risk to the insurer if the retrocessionaire is of poor credit quality and unable to pay its obligations to the reinsurer.
    - For the five largest individual unauthorized reinsurers and the five largest individual certified reinsurers listed in the Annual Financial Statement, [P/C Schedule F – Part 3; L/H and Health Schedule S–Part 3] consider the need to obtain the reinsurer's Annual Financial Statement and determine the extent to which the reinsurer has engaged in retrocession agreements.
    - Determine if any unauthorized and/or certified reinsurers have ceded reserves greater than 50% of total gross reserves.

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- If so, consider reviewing the Annual Financial Statement of the more significant reinsurers or inquiring of the insurer, to evaluate the extent to which the reinsurers cede business to other reinsurers.
- If significant collectability concerns surface as a result of these procedures, perform the appropriate procedures to evaluate collectability.

- Consider discussing with the insurer and/or the reinsurer or retrocessionaire's domiciliary regulator any identified risks or concerns with credit quality of the reinsurer or retrocessionaire.

Credit Quality, OR Default of Reinsurer

Additional Review Considerations

Assess the credit quality and financial solvency of the reinsurers that the insurer cedes a material amount of business to or has material reinsurance recoverable due from. Credit quality and poor financial strength of a reinsurer may result in future collectability risk, which may result in ongoing credit risk and future liquidity issues.

- Determine the current ratings of the reinsurer from the major rating agencies and investigate significant changes during the past 12 months.
- Obtain and review the Audited Financial Report, Annual Financial Statement, Actuarial Opinion and U.S. Securities and Exchange (SEC) Filings (if applicable) of the reinsurer for additional insight regarding collectability and credit quality of the reinsurer.
- Review information about the reinsurer available from industry analysts and benchmark capital adequacy with top performers and peer groups.
- Contact the domiciliary state to determine whether any regulatory actions are pending against the reinsurer. Also, review iSite+ data on the reinsurer (i.e., financial statements, Regulatory Information Retrieval System [RIRS] and Global Receivership Information Database [GRID]).
- Determine whether the reinsurance transactions involved going "in and out" of treaties in such a manner that, in substance, the transactions are for financial reinsurance purposes (See Strategic Risk for more on financial reinsurance).
- Review [L/H and Health Schedule S – Part 4; P/C Schedule F] and determine if adequate levels of collateral (e.g., letters of credit) are maintained for unauthorized reinsurance and to secure outstanding losses.
- Review results of reinsurance Jumpstart Reports to determine if material differences exist between amounts reported on reinsurance schedules of the insurer compared to the ceding insurers.
  - If significant differences are noted, further investigate if the amounts appear to be due to timing and/or consider asking the insurer for aging of amounts payable/receivable.
- Review the individual authorized reinsurers listed in Schedule S – Part 3 – Section 2 and determine if any of the reinsurers generally known to enter into significant retrocession agreements.
- Inquire of the insurer:
  - Request a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section for unusual items.
  - If concerns exist regarding the credit quality and financial solvency of an unauthorized reinsurer, request a copy of the reinsurance agreement(s), and confirm amounts included on Annual Financial Statement,

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[L/H and Health Schedule S – Part 4 – Reinsurance Ceded to Unauthorized Companies; P/C Schedule F – Part 3].

Reserve Credits Taken are Inappropriate (Life/A&H Insurers, Health)

Determine whether the insurer's accounting treatment for reinsurance is proper and in accordance with the *Annual Statement Instructions* to determine if the reserve credit taken is appropriate.

Procedures / Data

- Briefly scan the individual reinsurers listed in Annual Financial Statement, Schedule S – Part 3 – Section 1 - Reinsurance Ceded Life and Annuities and Schedule S – Part 3 – Section 2 - Reinsurance Ceded Accident and Health and Schedule S – Part 3 – Section 2 – Health and determine if any of the reinsurers classified as authorized appear to be improperly classified as such.
- Determine if there is a liability established for reinsurance with unauthorized reinsurers to the sum of reserve credits taken, paid and unpaid losses, and other debits material. [Annual Financial Statement, Schedule S – Part 4].

Additional Review Considerations

- Review Annual Financial Statement, Schedule S – Part 4. Determine if there are any concerns about the appropriateness of reinsurance credits taken. Note any concerns in the Statement of Actuarial Opinion regarding the insurer failing to properly establish a reserve relating to reinsurance assumed from another reinsurer for accident and health.
- Briefly scan the Annual Financial Statement pages relating to Assets; Liabilities, Surplus and Other Funds; and Summary of Operations and determine if any unusual items are noted relating to write-ins or significant changes or inconsistencies from prior years regarding reinsurance activities.
- Generate Examination Jumpstart analysis to determine whether ceding company credits are appropriately "mirrored" by the reinsurer, after considering the impact of normal timing delays.
- If the insurer holds a material LOC securing unauthorized reinsurance recoverables, identify the amount of the LOC, the issuing bank, and the rating of the bank.

Credit Quality, Adequacy and Appropriateness of Assets Held for Modco or FWH Agreements (Life/A&H Insurers)

Concerns may exist regarding the quality, adequacy and appropriateness of assets held to support Modified Coinsurance (Modco) or Funds Withheld (FWH) reinsurance, particularly as investments become increasingly complex. Concerns may include controls and governance over investment practices, valuation and ratings of assets, and if material amounts of assets involve related party transactions.

Where collateral held is related to Modco and FWH reinsurance, the analyst should review the information in Note to the Financials #5L(1), #5L(4) and #5L(5), and Schedule S—Part 8—Reinsurance Agreements with Funds Withheld and Modified Coinsurance, in conjunction with other credit, operational and strategic risk of the insurer's reinsurance program. Additionally, review the analysis considerations related reserve reporting required by AG 53 (complex assets) and AG 55 (assets supporting reinsurance) outlined in the Reserving Risk Assessment and SOA procedures and guidance.

Where the company is engaged in material Modco and FWH arrangements, the analyst can use the detail of collateral received and held under Note 5L(4) to identify the types of assets held by investment schedule, and gain an understanding of the materiality of aggregate BACV of the collateral received to the insurer's asset portfolio. Further, the Note #5L(5) disclosure identifies if securities held as collateral under Modco or FWH agreements are

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also pledged under other arrangements, in which case they would not be for the benefit of the reinsurer or available to fulfill the liabilities of the reinsurance contract. The analyst can use the information in Schedule S—Part 8 to identify any concerns with the types of assets and credit quality of assets held under ceded or assumed Modco or FWH agreements.

Procedures / Data

- Identify the types of reinsurance agreements and jurisdiction of the reinsurer [Annual Financial Statement, Schedule S – Part 3] and determine if concerns may exist over the adequacy and quality of assets held by reinsurers in support of ceded reserves that may require further analysis or inquiry to the insurer.
- Compare the BACV of the collateral received and assets held under Modco/FWH Reinsurance Agreements to the recognized obligation for Modco and FWH assets. [Annual Financial Statement, Notes to the Financials #5L(4)(m and n)].
- Identify if investments held under FWH agreements (including Modco) are related to the Modco/FWH reinsurer [Annual Financial Statement, Notes to the Financials 5L(5)(o-v)].
- Identify if the insurer is engaged in ceding business under Modco and FWH agreements with offshore reinsurers.
    - Gain an understanding, through review of Schedule S - Part 3, of the types of insurance business ceded, the reinsurer's jurisdiction, if affiliated or non-affiliated, and applicable collateral requirements by type of reinsurer (i.e. authorized, unauthorized, reciprocal jurisdiction, certified)
- Review Schedule S – Part 8 to determine if concerns exist regarding the types of assets held or the credit quality of assets held under Modco/FWH agreements. Consider if the aggregate of medium or lower quality assets held represent a material amount of the related Modco/FWH liabilities.
    - Review Schedule S – Part 8 in comparison to Life RBC (asset schedules) to ensure asset subtotals match. If differences exist, inquire of the insurer, as differences may have an impact on the RBC calculation.
- Determine if assets held under Modco or FWH agreements are also pledged under other agreements [Annual Financial Statement, Notes to the Financials #5L(5)].

Additional Review Considerations

- If concerns exist regarding the types of assets held or the credit quality of assets held under Modco or FWH agreements, or concerns over reinsurance reporting, inquire of the insurer to:
    - Identify the applicable reinsurers and reinsurance agreements.
    - Has the insurer entered into new offshore unaffiliated Modco or FWH agreements for which the agreement was not required to be reviewed by the Department?
    - If offshore reinsurance, gain an understanding of the insurer's business purpose for ceding business offshore.
    - Gain an understanding of the collateral requirements for the type of reinsurance and jurisdiction.
    - Request a copy of the applicable Modco/FWH reinsurance agreements and assess if the investment requirements are in compliance with the terms of the agreement and the state's reinsurance statutes.
    - Gain an understanding of the insurer's investment practices, governance policies and use of asset managers for reinsurance assets.
- If a material amount of assets held under Modco or FWH agreements are also pledged under other arrangements, inquire of the insurer to gain a better understanding of their use of collateral assets within their reinsurance program and to ensure the insurer is in compliance with collateral requirements.

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- Refer significant concerns identified to the examiner for further review, if warranted.

Collectability of LOCs, OR Credit Quality of Issuing/Confirming Banks

Determine if there are credit quality or collectibilty concerns with banks that have issued or confirmed LOCs where the insurer is the beneficiary of a material LOC.

Additional Review Considerations

- Review Annual Financial Statement, General Interrogatories, Part 1, #15.1 and 15.2. Determine whether the beneficiary of an LOC that is unrelated to reinsurance where the issuing or confirming bank in not on the SVO Qualified U.S. Financial Institutions List.
- If "yes," identify and understand the issuing or confirming bank, the circumstances that can trigger the LOC and the amount.

Collectability of Affiliated Receivable or Payable

Consider if any affiliated transactions have exposed the insurer to significant collectability risk. Credit quality and poor financial strength of an affiliate may result in future collectability risk, which may result in ongoing credit risk and future liquidity issues. For example, if the insurer is included in a consolidated federal income tax return and a significant asset for Federal Income Tax Recoverable is recorded on the financial statements of the insurer, analysts should closely review the financial statements of the parent to determine the parent's ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectability risk to the insurer. When the amounts of structured settlements are significant, analysts should review and understand the financial statements and payment ability of the life insurance affiliate.

Significant affiliated payables should be considered in relation to the extent of affiliated relationships, transactions, and activities. Refer to Operational Risk for further consideration of significant amounts of affiliated payables.

Procedures / Data

- Review the balance sheet asset receivable from parent, subsidiaries, and affiliates, as well as the liability payable to parent, subsidiaries, and affiliates to determine whether there are concerns with the level of affiliated receivables or payables.
    - Affiliated receivable to capital and surplus (L/H, Health) or to policyholder surplus (P/C).
    - Affiliated payable to capital and surplus (L/H, Health) or to policyholder surplus (P/C).

Additional Review Considerations

- If there are concerns regarding collectability of affiliated receivables, review the Annual Financial Statement, Schedule Y – Part 2, Notes to the Financial Statements, Management's Discussion and Analysis (MD&A) and other available information (e.g., Form D filings) for more information about the nature and timing of the receivable.
- Review the Operations Risk Reference Guide for more procedures on affiliated transactions.

Collectability or Default of Investments Involving Related Parties

Determine related party exposure in the investment portfolio and assess any related credit risk.

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Related parties are entities that have common interests as a result of ownership, control, affiliation or by contract as definited in *SSAP No. 25—Affiliates and Other Related Parties* (SSAP No. 25). Refer to the *Insurance Holding Company System Model Act* (Model #440) and SSAP No. 25 for a broader definition of "affiliate," "related party" and "control".

Related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the reporting entity or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny.

The anlayst should utilize the tools available in iSite+ to identify if the insurer has a material exposure to investments involving related parties, either on an asset category basis or in aggregate, and by the related party designation noted below. If a material exposure exists, further assessment of the credit risk may be warranted. For example, what is the NAIC designation of investments involving related parties? Analysts may also consider the extent to which related parties are involved in securitizing or originating business for the insurer, and what differences may exist in how investments involving related parties are valued (market risk). If the role of the related party is that of a third-party advisor, factors to consider may include for example, the expertise of the related party advisor, any potential conflicts of interest, and if related parties are originating investments only for the insurer or also to the public, the latter being subject to SEC requirements.

Within the Annual Financial Statement investment Schedules B, BA, D, DA, DB, DL, and E (Part 2), all investments involving related parties must incude disclosure to ensure full transparency. This disclosure is in the column "Investments Involving Related Parites". It designates investments by the following roles:

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.
2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.
3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.
4. Securitization or similar investment vehicles such as mutual funds, limited partnerships, and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer, or another similar influential role.
5. The investment is identified as a related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.
6. The investment does not involve a related party.

<u>Procedures / Data</u>

- Review the Annual Financial Statement investment schedules, as disclosed in the column "Investments Involving Related Parties" and utilizing iSite+ tools, determine if the insurer has material related party exposures in its investment portfolio. This disclosure is included in:
    - Schedule B – Part 2
    - Schedule BA – Part 2
    - Schedule D – Part 1, Sections 1 and 2

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- Schedule DA – Part 1
- Schedule DB – Part A Section 1
- Schedule DL – Part 1 and 2
- Schedule E, Part 2

Consider exposure by asset class and in aggregate, and by the role of the related party in the investment as designed by the "Investments Involving Related Parties" disclosure.

- If concerns exist regarding a material related party exposure in the investment portfolio, assess the credit quality of those investments and assess any historical default experience.

Additional Review Considerations

If concerns exist regarding a material related party exposure in investment management or advisory services, consider the following.

- The analyst may consider utilizing suggested procedures in the "Additional Procedures" section below on third-party advisors, if applicable.
- In addition to the additional analysis procedures regarding third party investment advisors, consider the following:
  - Review the insurer's investment policy guidelines and determine whether the related party investments follow the guidelines and are in compliance with regulatory requirements.
  - Review whether the fee structure for asset management is fair, reasonable, and appropriately recognized as investment expenses.
  - If the related party asset manager also originates/securitizes investments held by the insurer, consider requesting additional information from the insurer to determine the following:
    - Whether the asset manager has adequate experience and knowledge in originating and managing the types of investments.
    - Whether the asset manager follows appropriate underwriting practices and applicable regulatory requirements in originating investments.
    - Whether the fee structures embedded in securities (if applicable) are fair, reasonable, and appropriately account for potential duplication of fees or conflicts of interest.

Collectability of Uncollected Premiums and Agents' Balances for P/C and Health Insurers

The asset for uncollected premiums and agents' balances in the course of collection includes amounts receivable that have been billed but have not yet been collected. Payments may be delayed or not be paid when due, resulting in a cash flow mismatch. Additionally, the credit quality and poor financial strength of an agent may result in future collectability risk, which may result in ongoing credit risk and future liquidity issues.

Agencies and brokers receive premium payments from insureds in a fiduciary capacity. Most states have laws that require the agent or producer to maintain trust accounts for the premiums they collect, which must be kept separate from their business operating funds. The premiums, net of commissions, are then remitted to the insurer or general agents from the accounts, leaving an audit trail.

Although agents are used by health entities, they are generally used more extensively with P/C insurers or even life insurers. Agents' balances are admitted to the extent that the assets conform to the requirements of *SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts due from Agents and Brokers*, which also requires that premiums owed by agents should be reported net of commissions and are non-admitted

under a 90-day rule. Remaining amounts that are determined to be uncollectable must be written off. Generally, if a contract with an agent permits offsetting, amounts payable to an agent may be offset against a receivable from that agent. Agents' balances carry credit risk and can have a material impact on the net income and capital and surplus of an insurer if the balances are significant. Significant or growing balances can also lead to liquidity problems if the insurer is unable to convert the receivables into cash to be used to pay claims.

Irrespective of the type of business written, inadequate systems and controls over the collection process can lead to uncollectable premiums. Uncollected premium balances on non-government business that is over 90 days due non-admitted under SSAP No. 6. On all business, an evaluation of any remaining asset balance is required to determine any impairment. Amounts deemed uncollectable are required to be written off against income in the period the determination is made. These accounting requirements are designed to limit the total impact that collectability issues can have on an insurer at a given point in time.

Despite the efforts to mitigate the impact of uncollected premiums and agents' balances, write-offs and non-admitted unpaid premium assets can still have a material impact on the net income and capital and surplus of an insurer. These issues can lead to liquidity problems if the insurer is unable to convert the receivable into cash to be used to pay claims. Analysts should monitor the level of this asset as well as the change in the balance to help identify potential collection problems that can ultimately lead to significant decreases in surplus.

A material amount of uncollected agents' balances warrants further investigation to ensure that adequate controls are in place and that trust accounts are properly managed. An increase or trend of material non-admitted balances or write-offs may be a sign of mismanagement or misappropriation of trust accounts by the agency and should be investigated. Although this could occur at any agency, the risk is greater at affiliated agencies for the following reasons:

- The same owner controls both sides of the transaction.
- There is a lack of internal controls in relation to management overrides.
- Affiliated agency balances are often more material to small or medium-sized insurers.
- Affiliated agencies may not be subject to the same level of oversight as unaffiliated agencies.
- In the event of financial stress to the insurer or the agency, there may be an inherent conflict of interest.

If the analyst has concerns about the timely collection of agents' balances, the additional procedures related to premium trust accounts in the repository should be considered.

For Health Insurers:

The collectability of amounts reported for uncollected premiums may also be impacted as a result of retroactive additions and deletions that are made subsequent to the date the group was invoiced. There may be a delay (sometimes several months) between the time that a large group adds a new covered employee or deletes an employee that is no longer covered and notice of the change is sent to the health entity. This length of the delay increases since the invoicing of the monthly premium is frequently in advance of the effective date of the coverage. This delay can result in the health entity reporting part of the monthly billing as more than 90 days overdue and ultimately collecting less than what was billed. SSAP No. 6 states that if an installment premium is over 90 days due, the amount over ninety days due plus all future installments that have been recorded on that policy shall be non-admitted. However, for group accident and health contracts, a non-admitted *de minimus* over ninety-day balance would not cause future installments (i.e., monthly billed premiums on group accident & health) that have been recorded on that policy to also be non-admitted. The *de minimus* over 90-day balance itself would be non-admitted and the entire current balance would be subject to a collectability analysis.

The balance for uncollected premiums may also result from amounts due from the Centers for Medicare and Medicaid Services or other government plans. Although coverage periods for this type of business are usually the same as comprehensive group business, the payment cycle can be much different due to the longer settlement

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periods experienced under government contracts. However, collectability of balances associated with government plans is usually not an issue. Because of this, the 90-day rule that is applied to other receivables is not applicable to receivables from these types of government plans.

Procedures / Data (P/C Insurers)

Review and assess uncollected premiums and agents' balances for potential collectability issues. Consider the following ratios.

- Ratio of uncollected premiums and agents' balances to surplus [IRIS ratio #10].
- Change in uncollected premiums and agents' balances from the prior year.
- Ratio of uncollected premiums to net premium income.
- Ratio of non-admitted uncollected premiums to total uncollected premiums.
- Net agents' balances and premium balances charged off and recovered to total uncollected agents' balances and premium balances.

Procedures / Data (Health Insurers)

Review and assess uncollected premiums and agents' balances for potential collectability issues. Consider the following ratios.

- Ratio of uncollected premiums and agents' balances to capital and surplus.
- Change in uncollected premiums and agents' balances from the prior year.
- Ratio of uncollected premiums to net premium income.
- Amount due from any one group or subscriber as percent of the uncollected premiums.
- Ratio of non-admitted uncollected premiums to total uncollected premiums.
- Net agents' balances and premium balances charged off and recovered to total uncollected agents' balances and premium balances.

Additional Review Considerations (P/C and Health Insurers)

- Review amounts non-admitted and compare to prior years.
- With respect to agents' balances, verify the creditworthiness of the agent.
- Inquire of the insurer:
    - Explanation for the significant balance.
    - Listing of balances of subscribers, which individually account for 10% or more of the premiums uncollected and compare to a similar list from prior years.
    - Amounts of any uncollectable balances that have been written off in the current period. Compare the write-offs to those of the prior reporting period, if any.
    - Written procedures for monitoring and collecting uncollected premiums, including amounts already written off.
    - If the insurer has factored or sold its uncollected premium balances to a third party, note whether the receivables were discounted in the transaction.
    - Concerns over uncollected agents' balances warrant further investigation to ensure that adequate controls are in place and that trust accounts are properly managed. An increase or trend of material non-

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admitted agents' balances or write-offs may be a sign of mismanagement or misappropriation of premium trust accounts by the agency. If there are concerns in this area, consider the following:

- Request additional data/information from the insurer to identify the source(s) of the balances and the reason(s) for the non-admitted or charged-off amounts.
- Request the insurer to provide a summary of the controls in place over agencies and ensure proper management and oversight of trust accounts.
- Request monthly reports from the insurer.

- Discuss concerns with the exam team, including whether a targeted exam is necessary.

Collectability of Uninsured Plan Receivables for Health Insurers

Payments on uninsured plan receivables may be delayed or not be paid when due, resulting in a cash flow mismatch.

SSAP No. 47—Uninsured Plans defines uninsured accident and health plans, including HMO administered plans, as plans for which a health entity, as an administrator, performs administrative services such as claims processing for an at risk third party. Accordingly, the administrator does not issue an insurance policy. Two of the more common types of uninsured accident and health plans include an Administrative Services Only (ASO) plan or an Administrative Services Contract (ASC) plan.

Under uninsured plans, there is no underwriting risk to the health entity. The plan bears all of the-utilization risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. Although there is no underwriting risk on these types of plans, credit risk can still be an issue. Under these types of agreements, it is common for a receivable to be established for services performed by the health entity, and/or amounts due to the health entity for claims paid by the health entity on behalf of the uninsured plan. The credit risk varies on these types of plans because under an ASC plan, the health entity pays the claims directly from its own bank account and would seek reimbursement at a later date. In contrast, under an ASO plan, the claims are paid from a bank account owned and funded directly by the uninsured plan sponsor or are paid by the health entity but only after receiving funds to cover the amount paid. Combination plans may also be administered which contain elements of both an uninsured and an insured plan. If the funds held for disbursement under the uninsured plans are inadequate to meet disbursement needs, the insurer may advance funds to cover such disbursements.

As a result of such advances, the receivable should be recorded as an asset. Liabilities can also result from administering this type of business. This type of liability would result from funds of the uninsured plans being held by the health entity for making plan disbursements. Generally, the asset for the receivable and the liability for funds held should not be netted unless individual receivables and payments meet the requirements of *SSAP No. 64—Offsetting and Netting of Assets and Liabilities*.

Expense risk can also result from uninsured plans. This risk results primarily from the health entity incurring more expenses to administer the business than reimbursed from the uninsured plan. Analysts should use the information in Annual Financial Statement, Notes to Financial Statements, Note #18 — Uninsured Plans, to better assess the business risk to which the health entity is exposed under its uninsured plans. Refer to Section IV.B. Supplemental Analysis Guidance – Notes to Financial Statements, for guidance on reviewing Note #18.

Procedures / Data

- Compare the ratio of ASO/ASC claim payments to total hospital and medical expenses plus ASO/ASC claim payments [Annual Financial Statement, Notes to Financial Statements, Note #18, Part A and Part B].

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- Compare the ratio of reimbursements from uninsured plans to total expenses plus reimbursements from uninsured plans [Annual Financial Statement, Underwriting and Investment Exhibit – Part 3].
- Ratio of receivables relating to uninsured plans to capital and surplus.
- Change in uninsured receivable relating to uninsured accident and health plans.
- Non-admitted uninsured receivables relating to uninsured accident and health plans.

Additional Review Considerations

- Determine whether any concerns exist regarding the profitability of uninsured accident and health plans and the uninsured portion of partially insured plans for which the insurer serves as an Administrative Services Only (ASO) or an Administrative Services Contract (ASC) plan administrator. [Annual Financial Statement, Notes to Financial Statements, Note #18].
- Determine whether the insurer reported ASO and/or ASC amounts in its Risk–Based Capital (RBC) filing (worksheet XR021) and not reported receivables or assets related to uninsured accident and health plans on its Annual Financial Statement or vice versa.
- Evaluate the adequacy of funds held for the plans' claims and expenses.
- Evaluate the financial condition of the uninsured plans.
- Determine whether the asset receivables relating to uninsured accident and health plans on page 2 of the Annual or Quarterly Financial Statement have been netted against the liability on page 3 for amounts held under uninsured accident and health plans. One indication that these amounts have been netted would be if there was an uninsured receivable relating to uninsured accident and health plans (Page 2, Column 3, Line 17) without a liability for amounts held under uninsured accident and health plans (Page 3, Column 3, Line 22) or vice versa.
- Determine whether the disclosures been made in the Notes to Financial Statements regarding the possible uncollectability of amounts receivable under uninsured plans.
- Inquire of the Insurer:
    - Listing of plans administered by the insurer.
    - Aging schedule of receivables related to uninsured plans.
    - Amounts of any uncollectable receivables under uninsured plans that have been written off in the current period. Compare the write-offs to those of the prior reporting period, if any.
    - Request a copy of the I.D. card used by members covered under ASO and ASC arrangements to determine potential exposure to financial risk and compliance penalties.

Collectability of Health Care Receivables for Health Insurers

Health care receivables can include pharmaceutical rebate receivables, claim overpayment receivables, loans and advances to providers, capitation arrangement receivables, risk-sharing receivables and government insured plan receivables. Similar to other assets in general, each of the above types of health care receivables is individually unique and can carry its own risks to the health entity. Some of them carry a higher degree of risk because of the use of estimates in establishing them. Others carry a low level of risk because the accounting requirements only allow the receivable to be established in certain circumstances. However, ultimately each of the health care receivables can present the same kind of financial risks as uncollected premiums. Like uncollected premiums, the collectability of health care receivables should be monitored by the health entity, as it could become a source of future problems if write-offs of uncollectable receivables become material.

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Procedures / Data

- Review and assess health care receivables for potential collectability issues.
  - Ratio of health care receivables to capital and surplus.
  - Amount due from any one debtor equals or exceeds 10% of gross health care receivable.
  - Change in health care receivables increased from the prior year.
  - Ratio of non-admitted health care receivables to admitted health care receivables.

Additional Review Considerations

- Review amounts non-admitted and compare to prior years.
- Review capitation and other agreements with providers and hospitals and the level of receivables from these parties.
- Inquire of the insurer:
  - Explanation for the significant balance.
  - Listing of balances of debtors, which individually account for 10% or more of the balance of health care receivables and compare to a similar list from prior years.
  - Amounts of any uncollectable balances that have been written off in the current period. Compare the write-offs to those of the prior reporting period, if any.
  - Written procedures for monitoring and collecting uncollected premiums, including amounts already written off.
  - Inquire whether the insurer has factored or sold its health care receivables to a third party. Note whether the receivables were discounted in the transaction.

Collectability Risk of Recoverables for High-Deductible Policies for P/C Insurers

Large deductible programs for workers' compensation insurance marketplace create added risk. Credit quality and poor financial strength of a professional employer organization (PEO), for example, may result in future collectability risk, which may result in ongoing credit risk and future liquidity issues. Large deductible programs can be complex arrangements and depend on the employer's fulfillment of its obligation to reimburse all claims within the deductible. If the employer is unable to fulfill that obligation, the financial consequences to the employer could be catastrophic, and the employer's inability to pay could have a cascading impact on the financial health of the insurer. In order to manage this risk successfully, insurers and state insurance regulators must have a clear understanding of the nature and size of the insurer's exposure. Additionally, they must ensure that there are adequate measures in place to limit and mitigate the risk of the employer's failure to pay and ensure injured workers will receive benefits in compliance with state law. For further information and guidance on high-deductible workers' compensation insurance, refer to the *2016 Workers' Compensation Large Deductible Study*.

Additional Review Considerations

Gain an understanding of the materiality of any reserve credit that has been recorded and is recoverable, as well as the materiality, aging and collateral held on any deductible recoverables and unpaid balances.

- Review Annual Financial Statement, Notes to Financial Statements, Note #31 for exposure to high-deductible policies.
  - Determine the materiality of any reserve credit that has been recorded and is recoverable.

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- Determine the materiality, aging and collateral held on any deductible recoverables and unpaid balances.

ADDITIONAL PROCEDURES

Investment Strategy

Consider requesting and reviewing a copy of the insurer's formal adopted investment plan. This should be evaluated to determine if the plan appears to result in investments that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs and to determine whether the insurer appears to be adhering to its plan. For example, the insurer's plan for investing in non-investment grade bonds should be reviewed for guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location.

Two possible credit risks associated with Investment Stategy include:

- Investment strategy contemplates higher credit risk.
  - The insurer's investment strategy may not be structured to support its ongoing business plan, which could indicate the strategy enjoys higher credit, market and liquidity risks than are appropriate for the liabilities of the insurer and may lead to financial concerns in the future.
- Variance in actual to projected investment results.
  - The insurer's actual investment portfolio and/or portfolio performance may vary significantly from projections if the insurer is not adhering to the strategy in place (i.e., higher actual credit compared to the plan).

If concerns exist, request and review insurer's investment strategy outlined in the business plan for:

- Quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, geographic location, and issues/sectors exposed to material climate change, transition, and asset devaluation risks.
- Expected rate of returns on investments (projected investment income) compared to actual results.
- Planned increases in investment types, sectors, markets, etc.
- Appropriateness of the investment plan for the liability structure of the insurer. (This may require a review of asset adequacy analysis for asset liability management (ALM) and discussion with the insurer's management to better understand their plan).
- Upon review of the investment plan, compare the plan to actual results and determine if the insurer and its investment manager(s) appear to be adhering to the investment policies and guidelines in the investment plan.

Examination Findings

Consider a review of the recent examination report, summary review memorandum and communication with the examination staff to identify if any credit risk issues were discovered during the examination.

Identify any examination findings regarding credit risks associated with:

- Investment concentration.
- Exposure to riskier asset classes.
- Climate change, transition, and asset devaluation.

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- Asset liability management.
- Adherence to investment policies and strategies.
- Investment management and use of and monitoring of external investment managers.
- Proper classification (i.e., authorized, unauthorized, certified) and calculation of reinsurance collateral and provision.

If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

NAIC Capital Markets Bureau Analytical Assistance

Consider requesting the NAIC's Capital Markets Bureau (CMB) to assist with investment portfolio or investment management agreement analysis. The CMB has different levels of analysis that can be arranged to assist the state.

Consider requesting the following analytical reviews:

- Review of the insurer's investment portfolio.
- Review of investment management agreements (IMA).

Third-Party Investment Advisors

Determine whether concerns exist regarding the use of third-party investment advisers. As investments and investment strategies grow in complexity, insurers may consider the use of unaffiliated third-party investment advisers to manage their investment strategy. Investment advisers may operate independently or as part of an investment company. Investment advisers and companies are subject to regulation by the U.S. Securities and Exchange Commission (SEC) and/or by the states in which they operate, generally based on the size of their business. In certain situations, insurers may use a broker-dealer for investment advice. Broker-dealers are subject to regulation by the Financial Industry Regulatory Authority (FINRA). Regardless, most broker dealers and investment advisers will register with the SEC and annually update a Form ADV–Uniform Application for Investment Adviser Registration and Report Form by Exempt Reporting Advisers, which provides extensive information about the nature of the organization's operations. To locate these forms, analysts can go to *https://adviserinfo.sec.gov* and perform a search based on the company name.

Key information provided on a Form ADV includes:

a. Regulatory agencies and states in which the adviser/broker is registered.

b. Information about the advisory business including size of operations and types of customers (Item 5).

c. Information about whether the company provides custodial services (Item 9).

d. Information about disciplinary action and/or criminal records (Item 11).

e. A report of the independent public accountant verifying compliance if the investment advisor also acts as a custodian.

It is important to note that the information provided on Form ADV is self-reported and is subject to limited regulatory oversight. However, the information may be valuable to analysts in assessing the suitability and capability of investment advisers providing advisory services to insurers. In addition, although not expressly prohibited (as discussed at e. above), it is a best practice for the insurer to choose a national bank, state bank, trust company or broker/dealer which participates in a clearing corporation, other than its investment manager/advisor, to hold its assets in custody to promote segregation of duties. See additional guidance on custodial expectations in Section 1, Part 3, F – Outsourcing of Critical Functions of the NAIC's Financial Condition Examiners Handbook.

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Analysts should consider any significant risks identified in the most recent risk-focused examination and whether any follow-up procedures were recommended by the examiner. The examiner may have performed steps to determine the following: whether the investment adviser is suitable for the role (including whether he/she is registered and in good standing with the SEC and/or state securities regulators); whether the investment advisory agreements contain appropriate provisions; whether the adviser is acting in accordance with the agreement; and whether management/board oversight of the investment adviser is sufficient for the relationships in place.

Analysts should determine if changes have occurred in the insurer's use of investment advisers that may prospectively impact the insurer's investment strategy and overall management of the investment portfolio. If changes have occurred analysts may consider asking the insurer for an explanation for the change in investment advisers and obtain a copy of the new adviser agreement to gain an understanding of the provisions including the advisor's authority, specific reference to compliance with the insurer's investment strategy and/or policy statements, as well as state investment laws; conflicts of interest; fiduciary responsibilities; fees; and the insurer's review of the adviser's performance. Refer to the *Financial Condition Examiners Handbook* for further guidance and see V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for additional guidance on reviewing affiliated investment management agreements.

Analysts can determine if the investment advisor is in good standing with the SEC. The SEC does not officially use the term "good standing;" however, for this analysis, the term is used to mean a firm that is registered as an investment adviser with the SEC and does not report disciplinary actions or criminal records in Item 11 of the Form ADV.

If the insurer uses an external asset manager and if investments on Schedule BA assets are invested in funds that are affiliated with the asset manager or are managed by that asset manager, analysts should consider several possible issues that may result from this scenario. A possible concern may exist when the asset manager is also managing other funds in addition to managing assets for the insurer and then invests the insurer's assets in those other funds that the asset manager manages. While those funds may be good investments, both in general and for the insurer, there are a few issues that may need to be considered. First, is the potential for a conflict of interest if the asset manager is using the insurer's available funds to provide seed money or fund the manager's other funds. Second, is if any concerns exist regarding the appropriateness of the fund for the insurer's investment portfolio and if the transactions would be considered on an arm's-length basis. Third is the understanding that the insurer may be paying overlapping fees as the insurer would pay the asset manager a fee for the investment and then also pay a fee within the fund investment. There may be similar concerns with other complex investments such as structured securities that are originated by the asset manager or one of its affiliates/related parties. The fees associated with these investments could be considered arms-length and appropriate but would require further review and potentially additional support or documentation to make that determination.

Assess and determine if any concerns exist regarding third party investment advisers and associated contractual arrangements.

- Review Annual Financial Statement, General Interrogatories, Part 1, #29.05 and determine if the insurer utilizes third party investment advisors, broker/dealer or individuals acting on behalf of the insurer with access to their investment accounts.

If "yes," consider the following procedures:

- Verify that all affiliated and unaffiliated investment advisors the analyst is aware of are disclosed in the interrogatory, whether primary or sub-advisors.
    - Verify that Investment Management Agreements required to be filed with the department have been filed and consider requesting copies of agreements that have not been filed with the department for review.
    - Gain an understanding of the types of investments that are being managed by each of the advisors/sub-advisors disclosed in the interrogatory.

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- Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners and determine if the examination identified any issues with regard to investment advisers and associated contractual arrangements that require follow-up analysis or communication with the insurer. If "yes," document the follow-up work performed.
- Compare Annual Financial Statement, General Interrogatories, Part 1, #29.05 for the current year to the prior year to determine if there have been any changes in advisors.
    - Consider obtaining an explanation for the change from the insurer.
    - Consider obtaining a copy of the new investment advisor agreement and review it for appropriate provisions.
- Using the information reported in Annual Financial Statement, General Interrogatories, Part 1, #29.05, obtain and review SEC Form ADV (if available), to determine if the investment advisor is in good standing with the SEC. If not in good standing, contact the insurer to request an explanation.
- Determine if agreements with third party investment advisers are affiliated, have the appropriate Form D – Prior Notice of Transactions been filed and approved by the department and note any concerns or follow-up recommendations.
    - See additional guidance in V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for reviewing affiliated investment manager agreements.
- Request information from the insurer regarding the background and expertise in any complex or non-traditional assets (such as structured securities, mortgage loans, investment funds) of its investment advisors (in-house and/or contractual) and its analytical system capabilities. Determine whether the advisors and systems are adequate to allow the insurer to continuously monitor its investments.
- If the insurer uses an external asset manager, consider if there are any investments that may represent a potential conflict. Examples of this are: (1) if there are investments reported on Schedule BA that are funds that are affiliated/related with the asset manager or are managed by that asset manager, (2) structured securities in which the asset manager or an affiliate/related party had a role in originating, or (3) direct investments in the asset manager or any of its affiliates/related parties. If the external asset manager qualifies as a related party, utilize guidance provided in the "Related Party Exposure in the Investment Portfolio" section above to assist in this review. Consider the following issues:
    - Have any potential conflicts of interest been reviewed and formally approved by the Board or Investment Committee.
    - If the investment is appropriate for the insurer's portfolio and is arm's-length.
    - If the insurer is paying overlapping fees.

Inquire of the Insurer

Consider requesting additional information from the insurer if credit risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of credit risk for specific topics where concerns have been identified.

If concerns exist, consider requesting information from the insurer regarding:

- If management has adequately reviewed the investment portfolio and understands the yields, underlying collateral, cash flows and investment volatility.
- Any additional concentration by collateral type.

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- Management's process for valuing securities so as to assist the analyst in assessing if the securities are valued appropriately.
- Management's intended use of certain riskier investments and purpose within the insurer's portfolio.
- Credit risk associated with sector concentration.
- If management has an appropriate level of knowledge and expertise with the type of securities being purchased/held.
- If the insurer has controls implemented to mitigate the risks associated with this investment type.
- Sources of liquidity, such as LOCs.

Own Risk and Solvency Assessment (ORSA)

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing risks faced by the insurer.

If the insurer is required to file ORSA or part of a group that is required to file ORSA,

- Determine whether the ORSA Summary Report analysis conducted by the lead state indicates any credit risks that require further monitoring or follow-up.
- Determine whether the ORSA Summary Report Analysis conducted by the lead state indicates any mitigating strategies for existing or prospective credit risks.

Holding Company Analysis

Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

- Determine whether the Holding Company Analysis conducted by the lead state indicates any credit risks affecting the insurer that require further monitoring or follow-up.
- Determine whether the Holding Company Analysis conducted by the lead state indicates any mitigating strategies for existing or prospective credit risks affecting the insurer.

Asset Liability Management (ALM)

Consider a review of assets in conjunction with a review of sufficiency of reserves.

- Determine whether the review of the Statement of Actuarial Opinion or other actuarial filings indicate any concern regarding the adequacy of ALM and the sufficiency of assets to meet the business obligations of the insurer.
- If concerns are identified regarding overall liquidity of the asset portfolio, request a copy of the insurer's asset/liability matching policy and/or liquidity stress testing/scenario analysis.

QUARTERLY CREDIT RISK ASSESSMENT

The quarterly credit risk procedures are designed to identify the following. For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

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Significant Investment Concentration by Asset Class

Determine whether the insurer's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by class, sector, type or issue.

Procedures/Data

- Review admitted asset classes compared to total net admitted assets (excluding separate accounts).
  - Preferred Stock
  - Non-Investment Grade Gonds
  - Mortgage Loans
  - Other Invested Assets (Schedule BA)
  - Aggregate Write-ins for Invested Assets
  - Investments in Affiliates
- Determine if the total book/adjusted carrying value net of collateral for derivative investments open as of current statement date greater than 10% of surplus. [Quarterly Financial Statement, Schedule DB – Part D – Section 1].

Additional Procedures

- Review the Percentage Distribution of Total Assets for significant shifts in the mix of investments owned during the past five quarters.
- Review Schedule B, Part 2 to identify any mortgage loans or additions made during the quarter that include material amounts of mortgage loans with overdue interest or in the process of foreclosure.

Increased Exposure to Possible Default,

OR

Volatility Risk by Asset Class

Determine whether the insurer has a significant portion of its assets invested, or has significantly increased its holdings since the prior year-end, in certain types of investments that tend to be riskier.

Procedures/Data

- Review and determine whether there are concerns due to the change in certain asset classes from the prior year-end.
  - Increase in non-investment grade bonds and non-investment grade short-term investments from the prior year-end, where such investments are material compared to cash and invested assets (L/H) or policyholder surplus (P/C), or capital and surplus (Health).
  - Increase in mortgage loans from prior year-end, where the ratio of total mortgage loans are material compared to cash and invested assets (L/H) or policyholder surplus (P/C), or capital and surplus (Health).
  - Increase in BA assets from prior year-end, where the ratio of BA assets is material compared to cash and invested assets (L/H) or policyholder surplus (P/C) or capital and surplus (Health).
    - Note: Beginning with quarterly 2026, collateral loans are classified and reported on Schedule BA Parts 2 and 3, in accordance with the type of collateral that secures the loan, enabling analysts

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the ability to identify the type of collateral. (Refer to 2026 Quarterly Blanks Instructions and *SSAP No. 21–Other Admitted Assets)*.

- Increase in aggregate write-ins from prior year-end, where the ratio of aggregate write-ins is material compared to cash and invested assets (L/H) or policyholder surplus (P/C) or capital and surplus (Health).
- Increase in affiliated investments from the prior year-end, where the ratio affiliated investments are material compared to cash and invested assets (L/H) or policyholder surplus (P/C) or capital and surplus (Health).
- [Life only] Review Schedule DB – Part D – Section 1. Increase in derivative investments where the ratio of potential exposure to counterparty exposure for derivative instruments to capital and surplus plus AVR is material.

Additional Procedures

- If the level of non-investment grade bonds is material, review Quarterly Financial, Schedule D – Part 1B and the Quarterly Financial Profile Report to assess and understand the composition of non-investment grade bonds:
  - Amount and/or percentage of bonds in each designation 3, 4, 5 or 6.
  - Concentration by sector or issuer, including affiliates.
  - If bonds have been rated by a credit rating provider (CRP).
- For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Collectability of Reinsurance Recoverables,

OR

Reinsurer Credit Quality

Procedures/Data

- Determine whether amounts recoverable (both paid and unpaid losses on claims and reserve credits) or amounts receivable from reinsurers are significant and collectable.
  - Reinsurance amounts recoverable on paid and unpaid losses on claims to capital and surplus [L/H, Health] or policyholder surplus (P/C).
  - Change in reinsurance recoverables/receivables from prior year-end where recoverables/receivables are material.
  - Provision for reinsurance to policyholder surplus (P/C).
  - Change in the provision for Reinsurance, where the provision is material (P/C).
  - Review Quarterly Financial Statement, [L/H or Health Schedule S; P/C Schedule F] and notate any new reinsurers added since the prior quarter.
  - Determine if there are any agreements to release reinsurers from liability during the quarter. [P/C Quarterly Financial Statement, General Interrogatories, Part 2, #2].
  - Determine if there are any cancellations of primary reinsurance contracts during the quarter. [P/C Quarterly Financial Statement, General Interrogatories, Part 2, #3.1 and #3.2].
  - Determine whether the liability for reinsurance in unauthorized and certified companies is significant.

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- Liability for reinsurance in unauthorized and certified companies.
- Change in liability, reinsurance in unauthorized and certified companies.
- Change in liability for reinsurance in unauthorized and certified companies

- Determine whether the insurer experienced any material transactions requiring the filing of Disclosure of Material transactions with the state of domicile as required by the Model Act. [Quarterly Financial Statement, General Interrogatories, Part, #1.1].
  - If "yes," determine whether the insurer failed to make the appropriate filing of Disclosure of Materiality Transactions with the state of domicile. [Quarterly Financial Statement, General Interrogatories, Part 1, #1.2].

Additional Procedures

- If amounts recoverable or amounts receivable from reinsurers are significant, and concerns exist, consider the following procedures:
  - Determine the current ratings of the new reinsurer from the major rating agencies and investigate significant changes during the past 12 months.
  - Obtain and review the Annual Audited Financial Report, Financial Statements, Annual Actuarial Opinion and U.S. Securities and Exchange Commission (SEC) Filings (if applicable) of the reinsurer for additional insight regarding collectability and credit quality of the reinsurer.
  - Review information about the reinsurer available from industry analysts and benchmark capital adequacy with top performers and peer groups.
  - Contact the domiciliary state to determine whether any regulatory actions are pending against the reinsurer. Also, review iSite+ data on the reinsurer (i.e., financial statements, Regulatory Information Retrieval System [RIRS] and Global Receivership Information Database [GRID]).
- For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Collectability of Affiliated Receivables,

OR

Significant Payable to Affiliates

Procedures/Data

- Review the balance sheet asset receivable from parent, subsidiaries, and affiliates, as well as the liability payable to parent, subsidiaries, and affiliates to determine whether there are concerns with the level of affiliated receivables/payables.
  - Affiliated receivable or payable to capital and surplus [L/H, Health] or policyholder surplus (P/C).
  - Change in affiliated receivable or payable, where receivables or payables are material compared to capital and surplus [L/H, Health] or policyholder surplus (P/C).
  - Change in federal and foreign income tax recoverables where recoverables are material compared to total admitted assets (excluding separate accounts for L/H).

Additional Procedures

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- Determine whether there were any indications that significant or unusual transactions involve an affiliate or other related party.
- If there are concerns regarding collectability of affiliated receivables, review Notes to the Financial Statements and other available information (e.g., Form D filings) for more information about the nature and timing of the receivable.
- For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.
- Review the Operational Risk procedures on affiliated transactions.

Collectability of Uncollected Premium and Agents' Balances for P/C and Health Insurers

Procedures/Data

- Review and assess uncollected premiums and agents' balances for potential collectability issues.
    - Ratio of uncollected premiums and agents' balances to policyholder surplus (P/C) or capital and surplus (Health).
    - Change in uncollected premiums and agents' balances from the prior year-end.
    - Change in non-admitted uncollected premiums from the prior year-end.

Additional Procedures

- For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Collectability of Receivables Relating to Uninsured Plans for Health Insurers

Procedures/Data

- Ratio of receivables relating to uninsured plans to capital and surplus.
- Change in receivables relating to uninsured plans from prior year-end.

Collectability of Health Care Receivables for Health Insurers

Procedures/Data

- Ratio of health care receivables to capital and surplus.
- Change in health care receivables from the prior year-end.
- Change in non-admitted health care receivables.

Additional Procedures

For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

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LEGAL RISK: Non-conformance with laws, rules, regulations, prescribed practices or ethical standards in any jurisdiction in which the entity operates will result in a disruption in business and financial loss.

The Legal Risk Assessment is focused on risks emerging from company activities that might not be in accordance with legal and regulatory requirements. Given the wide range of legal and regulatory requirements that insurers are exposed to, including various jurisdictions and agencies, legal risks can emerge from many different areas. As such, the analyst will need to have a good understanding of the insurer and its operations in order to identify the applicable legal and regulatory requirements that could have a significant impact on the insurer's financial position and prospective solvency.

The Current Period Analysis section of the Risk Assessment Worksheet includes a procedure step related to Compliance Analysis, which may assist in identifying various risks addressed in the legal risk procedures. In addition, some of the detailed procedures below may be useful in completing your state's Compliance Analysis. However, if significant compliance issues are identified that represent a risk to the insurer's financial position or prospective solvency, analysis of such risks should be discussed and documented under Legal Risk in the Risk Assessment section of the worksheet (Section III).

In analyzing legal risk, the analyst may analyze a wide range of risk exposures related to the insurer's compliance with laws and regulations. An analyst's risk-focused assessment of legal risk should take into consideration the following areas (but not be limited to):

- Market conduct activities and violations
- Expenses and potential liabilities associated with ongoing litigation
- Fraudulent activities
- Compliance with code of ethics
- Compliance with state laws and reporting requirements
- Compliance with federal agency requirements
- Compliance with federal Affordable Care Act (ACA) provisions (health business only)
- Compliance with audit requirements, including those pertaining to the audit committee

ANNUAL LEGAL RISK ASSESSMENT

Impact of Market Conduct Examination/Material Findings

Determine if concerns exist regarding Market Conduct, including complaints, market conduct actions, communication with market conduct staff, etc., that could have an impact on financial position and prospective solvency. If concerns exist, communicate risks/issues to the state insurance department's Market Conduct Unit to investigate further. For example, large fines levied by states, suspensions or revocations of licenses, market conduct exam settlements (whether financial or other), or other regulatory actions taken based on market

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conduct violations may have a material impact on the financial solvency of the insurer. Additionally, if a recently concluded market conduct examination resulted in regulatory requirement to perform remediation (e.g., reprocessing denied claims) the financial impact may be material to the insurer.

Procedures

- Review any market conduct information available from the NAIC market analysis tools available on iSite+ (Market Analysis Profile (MAP), Examination Tracking System (ETS), Market Analysis Review System (MARS), Regulatory Information Retrieval System (RIRS), Special Activities Database (SAD), Market Initiative Tracking System (MITS), Market Conduct Annual Statement (MCAS) and the Complaints database). Note any unusual items or negative trends for the following items that translate into financial risks or indicate further review is needed:
    - Count of Regulatory Actions for the current and prior two years
    - Aggregate of Regulatory Fines for the current and prior two years
    - Market Conduct Examination Called or Concluded in the current and prior two years
- For Health insurers, determine the average number of days of unpaid claims. If concern is noted, review the Financial Profile Report to identify changes in the average number of days of unpaid claims in past years for unusual fluctuations or negative trends between years and determine if the insurer has met state statutes and regulations regarding timely payment of claims.
- In reviewing the items disclosed in the Market Conduct Examination and other Market Conduct findings, the analyst should assess their potential impact on the insurer's financial condition and prospective solvency by placing and discussing risk information within the appropriate branded risk classification, if not a legal matter.

Additional Review Considerations

- Review any market conduct information, including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee). Note any unusual items that translate into financial risks or indicate further review is needed.
- Review any inter-departmental communication, as well as communication with other state, federal or international insurance regulators and the insurer. Note any unusual items or prospective risks that indicate further analysis or follow-up is necessary.
- If market conduct information is unusual and indicates potential financial risks, analysts can perform the following procedures:
    - Describe and document the findings of the most recent market conduct examination and analysis and communication with the insurance department's market conduct staff.
    - Describe any current or future actions of the insurance department, other state insurance departments or other regulatory bodies against the insurer related to market conduct violations.
    - Describe the actual or projected financial impact of any settlements, fines, or remediation to operations and surplus.
- Determine if the insurer has met state statutes and regulations regarding timely payment of claims.

High Litigation, Legal and Government Expenses

Identify and evaluate risks related to expenses paid for litigation, other legal issues and/or government lobbying. Determine if the insurer has reported high legal, litigation or government expenses that are material to overall operating expenses.

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Procedures/Data

- Review General Interrogatories, Part 1, #41.1 and #41.2 and investigate any individual payments for legal expenses that represent a material amount of total legal payments made during the year.
- Review Exhibit 2 of the Annual Financial Statement to determine whether legal expenses of investigation and settlement of policy claims make up the bulk of legal expenses (Life only).
- Review General Interrogatories, Part 1, #42.1 and #42.2 and investigate any individual payments for government expenditures in connection with matters before legislative bodies, officers or government departments that represent a material amount of total legal payments made during the year.

Additional Review Considerations

- Compare legal expenses with industry averages (Industry aggregate totals are available in the NAIC publication *Statistical Compilation of Annual Statement Information)*.
- Review Annual Financial Statement, Schedule P – Part 1 for Defense and Cost Containment Expenses, Notes to Financial Statements Note #23 for Reinsurance Recoverable in Dispute and Note #14 for Contingencies and identify any legal concerns.
- Review the Annual Financial Statement including the Notes to Financial Statements, Audited Financial Report, and Examination findings and follow-up monitoring and identify if there were any legal concerns.
- Upon review of the Notes to Financial Statements, determine whether the insurer was a party to any significant litigation not in the normal course of business? If so, review and understand a description of the litigation and any contingent liabilities for accrued legal expenses.
- Inquire of the insurer:
    - Negative financial impact on the insurer and/or group should the litigation not be ruled in favor of the insurer
    - Negative reputational impact of litigation to the insurer and/or group
    - Negative impact of litigation to shareholders and/or policyholders

Material Fraudulent Activity/Investigation Results

Identify and evaluate the materiality of any fraudulent activity and the impact on the financial position and prospective solvency of the company. If fraud, allegations of fraud or ongoing investigations are identified, the analyst is encouraged to document his/her understanding and assessment of the ongoing issues and to contact the company regarding its plans to address the situation.

Review Considerations

- Review the Annual Financial Statement (including the Notes), Audited Financial Statement, and examination findings (i.e., Exhibit G) for any disclosures of fraud concerns.
- Contact the state insurance department's Fraud Unit (if applicable) to see if the state insurance department has concluded any fraud investigations involving the insurer? If so, identify the following:
    - Nature and scope of the investigation and its findings
    - Regulatory and/or corrective actions required of the insurer
    - Insurer's plan to address the fraudulent activity
    - Financial impact of the investigation and corrective actions

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- Review news/media reports, information from the insurer or other information available to the analyst that may indicate the insurer is under investigation by any regulatory body other than the state insurance department. If so, identify the nature and scope of the investigation and impact on the insurer to determine whether further information should be requested from the other regulatory body.
- Review Regulatory Actions (through RIRS) to identify whether any regulatory actions taken by other states were identified as fraud. If so, and if not communicated to the state insurance department, contact the reporting state insurance department to obtain information regarding the regulatory action.
- Contact other regulatory agencies that have regulatory authority over the business of the insurer (e.g., federal agencies where the insurer is engaged in government contracts) to identify whether any regulatory authorities have concluded any fraud investigations involving the insurer, its management or board of directors. If so, request the following information:
    - Nature and scope of the investigation and its findings
    - Regulatory and/or corrective actions required of the insurer
    - Insurer's plan to address fraudulent activity
    - Financial impact of the investigation and corrective actions
- Review the Group Profile Summary (GPS) and any other information provided by the lead state for any legal risks of the group or the insurance entity (e.g., from the Form F - Enterprise Risk Report) for any reported investigations, regulatory activities or litigations that may impact the insurer or holding company.
- If the above analysis indicates concerns related to current or prior fraud, inquire of the insurer regarding its internal processes and controls for preventing fraud.

Failure to Comply with Code of Ethics Standards

Identify and evaluate risks related to the insurer's compliance with code of ethics standards. If concerns regarding an insurer's failure to implement or abide by a code of ethics are identified, the analyst should correspond with the company to address these concerns and/or identify other compensating controls in place.

Procedures/Data

- Review General Interrogatories, Part 1, #14.1 and #14.11 to identify if senior officers are not subject to code of ethics standards.
- Review General Interrogatories, Part 1, #14.2 and #14.21 to identify if the code of ethics has been amended.
- Review General Interrogatories, Part 1, #14.3 and #14.31 to identify if the code of ethics has been waived.

Additional Review Considerations

- Review the Corporate Governance Annual Disclosure (CGAD) and identify any concerns.
    - If the CGAD is filed on an insurance entity bases, verify that the information provided in the CGAD filing on ethics policies does not conflict with the information reported in the General Interrogatories.
    - If the CGAD is filed on a group basis, rely on the information provided in the GPS for group risks or provided by the lead state if risks apply to the insurance entity and verify that the information does not conflict with the information reported in the General Interrogatories.

Failure to Comply with State Laws and Reporting

Assess the insurer's compliance with NAIC reporting practices, internal policy, laws, regulations and prescribed practices. The analyst should determine whether there are any legal or regulatory impediments that could affect

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the insurer's operations or result in a significant legal liability. If a compliance violation is found, the analyst should specify the violation and the impact.

Procedures/Data

- Review General Interrogatories, Part 1, #6.1 and #6.2 and identify if any certificates of authority, licenses or registrations have been suspended or revoked.

Additional Review Considerations

- Identify if the insurer is compliant with state statutes and regulations, including those that are new or revised (e.g., hazardous financial condition analysis, investment limitation analysis, etc.).
- Assess whether surplus meets the statutory minimum amount required by state law (varies by state and business type).
- Review the Notes to Financial Statements, Note #1 and the iSite+ Validation Exceptions tool and determine whether the insurer reported significant corrections of errors, validation errors, or other accounting and reporting changes that indicate possible concerns regarding the accuracy of the financial reporting. Potential missing data, data that does not conform with standards, or any crosscheck errors could materially impact the outcome of an analysis and corrective measures may need be taken by the insurer prior to proceeding with an analysis.
    - Determine whether the insurer is in compliance with permitted or prescribed practices as reported in Note #1.
- If the insurer failed to comply with the state's statutes and regulations enacted during the period, identify the following and complete a detailed written explanation of the violation to ensure proper documentation should non-compliance issues recur:
    - Nature of the non-compliance
    - Impact to the insurer's financial position and reporting
    - Outcome of any department communication with the insurer regarding the non-compliance issues
    - Resolution of any non-compliance issues or resolution plans of the insurer
- If the insurer had any certificates of authority, licenses, or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period, identify the following:
    - Nature of the suspension or revocation
    - Reason(s) stated for the revocation or suspension
    - Outcome of any department communication with the insurer and/or with the other regulatory authority who issued the revocation or suspension
    - Resolution of any non-compliance issues or resolution plans of the insurer
- If the insurer has been issued any consent orders or agreements by other regulators/jurisdiction, identify or perform the following:
    - Request a copy of the consent order or agreement from the other regulator/jurisdiction
    - Reason(s) stated for the consent order or agreement
    - Outcome of any department communication with the insurer and/or with the other regulatory authority
    - Resolution of any non-compliance issues or plans of the insurer

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Failure to Comply with State Investment Laws

Assess the insurer's compliance with the state's investment laws.

Review Considerations

- Using your state's investment compliance checklist, determine whether the insurer's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws.
- Determine whether the insurer is reporting its investments (including the related income and expenses) in accordance with NAIC practices, internal policy, Statutory Accounting Principles and the filing requirements set forth in the Purposes and Procedures Manual of the NAIC SVO.
- Determine whether affiliated investments are in violation of state statutes. If so, gain an understanding of the primary business activity of the affiliate and why such an investment does not comply with regulatory requirements.
- If analysis of investment compliance indicates concerns or a pattern of non-compliance, review the most recent examination file for investment compliance and inquire of the insurer about its internal processes and controls for compliance with state investment laws.

Failure to Comply with Affiliated Management and Service Agreements

Assess the insurer's compliance with affiliated management and service agreements.

Review Considerations

- Determine whether management and service agreements between affiliates either submitted and/or approved are in conformity with regulatory requirements and verify that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
- Determine whether the amount of the shareholder dividend was at a level that required prior regulatory approval or notification. If so, determine whether the insurer obtained proper prior regulatory approvals.

Failure to Comply with Transactions Involving Other Jurisdictions

Assess the insurer's compliance with transactions involving other jurisdictions.

Review Considerations

- If the insurer redomesticated to your state, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.
- If the insurer engaged in a transaction(s) to redomesticate a subsidiary offshore, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.
- If the insurer engaged in any transactions to acquire a subsidiary domiciled in a non-U.S. jurisdiction, determine whether the insurer failed to comply with any regulatory requirements or stipulations expected to be met subsequent to the acquisition and identify any legal implications that represent risk to the insurer due to the acquisition.

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Failure to Comply with Federal Regulatory Agencies

Identify and assess compliance with other federal regulatory agencies. In addition to the HHS and the CMS oversight of health insurance, insurers may be subject to regulation by the Federal Reserve, U.S. Securities and Exchange Commission (SEC), U.S. Department of the Treasury and other federal regulatory bodies depending upon the nature, scope and extent of the insurer's or insurance group's activities.

Review Considerations

- Review General Interrogatories, Part 1, #8 and determine whether the insurer is subject to regulation by a federal regulatory agency. If so, consider contacting the applicable federal regulatory agency to request any information about the results of that agency's oversight, including any issues identified, federal compliance violations, fraud investigations and regulatory actions.

Failure to Comply with the Federal Affordable Care Act (Health Business Only)

Identify and assess compliance with the federal Affordable Care Act (ACA), Medical Loss Ratio (MLR), MLR Rebate calculations and other ACA requirements. If the insurer is not subject to the ACA, it is recommended to skip the following procedures.

For purposes of reviewing the SHCE, the analyst should refer to the Annual Financial Statement Instructions for details on reporting requirements for health entities in run-off or that only have assumed and no direct business, and health entities that have no business that would be reported in the columns for Comprehensive Health Care, Mini-Med Plans, Expatriate Plans, and Medicare Advantage Part C and Medicare Part D Stand-Alone Plans. If the health entity's SHCE was reviewed or is under review by examination staff, the analyst should contact the examiner-in-charge (EIC) to inquire about any material examination findings.

Review Considerations

- Determine whether the insurer filed the Supplemental Health Care Exhibit (SHCE) and the SHCE Expense Allocation Report filed in accordance with the Annual Statement Instructions.
- Review the Notes to the Financial Statement (primarily Note #24), the SHCE – Part 1, and the final rebate reporting to the U.S. Department of Health and Human Services (HHS). If the amount of MLR rebate liability reported is material, determine whether there are concerns regarding the insurer's liability for rebates.
- Compare the MLR rebate liability, as provided in the SHCE, and the actual rebate calculation in the HHS Medical Loss Ratio Reporting Form. If any material differences were identified, consider requesting an explanation of the differences from the insurer.
- During the review of the health care business pursuant to the federal Public Health Service Act and all applicable filings, identify any unusual items or areas of concern, not previously noted, that indicate further review is necessary.
- If concerns exist, contact the federal Centers for Medicare & Medicaid Services (CMS) to request information about CMS sanctions or supervision by the CMS and MLR audits.

Preliminary Medical Loss Ratio Concerns (Health Business Only)

The following procedures are only applicable to insurers that write insurance premiums subject to the ACA. The ACA requires health entities to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). Concerns in this area should be reviewed in conjunction with the pricing and underwriting risk assessment.

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Procedures/Data

- Determine whether there are concerns regarding the components of the insurer's Preliminary MLR:
    - Review the Preliminary MLR from the SHCE by line of business (either the national Preliminary MLR or the state-level MLR) (or the thresholds applicable under state law) for individuals or small group employers with a ratio less than 80% or large group employers with a ratio less than 85%. For Medicare plans, determine whether the preliminary MLR is less than 85%.
    - Review the change in Preliminary MLR for a material increase or decrease from the prior year by line of business (either the national Preliminary MLR or the state-level MLR).
    - In the analyst's review of the components of the Preliminary MLR, review and assess any material differences between the unadjusted and adjusted amounts for premium and claims. Compare Health Premium Earned to Adjusted Premium Earned by line of business.
    - In the analyst's review of the components of the Preliminary MLR, review and assess any material differences between the unadjusted and adjusted amounts for premium and claims. Compare Incurred Claims excluding prescription drugs to Total Incurred Claims by line of business.
    - Identify any components that appear unusual, or that increased or decreased materially from the prior year that would indicate further review is warranted. If so, request additional information from the insurer.

Additional Review Considerations

- Review the Expense Allocation Report including the expense allocation methodology to determine whether quality improvement (QI) expenses are appropriate and properly accounted for.
    - During the review of the health care business pursuant to the Public Health Service Act and all applicable filings, identify any unusual items or areas of concern, not previously noted, that indicate further review is warranted.
    - After completing analysis in this area, if specific concerns are identified regarding MLR compliance, the analyst is encouraged to contact the CMS to request information on CMS sanctions and remediation, as well as CMS supervision and regulatory concerns (including MLR audits).

The ACA requires health entities to spend at least 80% of premium for individual and small group policies or 85% of premium for large group policies on medical care, with review provisions imposing tighter limits on health insurance rate increases. When reviewing the results of the preliminary MLR, by state, by line of business, the analyst should be aware that individual states can and may require a higher MLR pursuant to state law. If the health entity fails to meet these standards, the health entity will be required to provide a rebate to policyholders. The purpose of the SHCE is to assist state and federal regulators in identifying and defining elements that make up the MLR as described in Section 2718(b) of the Public Health Service Act (PHSA) and for purposes of submitting a report to the HHS Secretary required by Section 2718(a) of the PHSA. During the review of the Preliminary MLR, the analyst should also consider how the individual state's Preliminary MLR compares to the grand total (refer to the Financial Profile Report).

Beginning in 2014, a similar MLR requirement applies to Medicare Advantage Plans and Medicare Part D Stand-Alone Plans. The health entity must spend at least 85% of premium (with certain adjustments) on clinical services and quality improvement, or rebate premium to the HHS.

In some cases, it may be more useful to use the Preliminary MLR that is calculated by totaling the data from all SCHEs submitted by a company to the states where it has business. This national Preliminary MLR will reduce the impact of potential issues with statistical credibility of claims experience and allocation of various expenses over states and lines of business.

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For lines of business in a given state with exposures of less than 1,000 life-years looking at a 5-year trend is of very limited usefulness since in such cases, claims experience is not considered credible and is subject to greater variability. More than 1,000 life years, the experience is considered credible, but still subject to large variations until exposures are well above 1,000 life years.

The MLR is not calculated in the traditional sense where medical expenses are simply divided by premiums. Premiums are adjusted for certain taxes and expenses. The numerator in the calculation will include health improvement expenses and fraud and abuse detection and recovery expenses in addition to medical expenses. The expenses for fraud and abuse detection and recovery are limited by the amount actually recovered.

The MLR calculated on the SHCE is a preliminary calculation and will not be used in determining rebates. Health entities will report information concerning rebate calculations directly to the HHS. The numbers that will be utilized for rebate purposes include revisions for claim reserve run-off subsequent to year end, statistical credibility concerns and other defined adjustments.

The analyst should review completeness or consistency validation exceptions on iSite+ that may indicate if the SHCE has not been prepared and submitted for each jurisdiction in which the company has written direct comprehensive major medical business in accordance with the *Annual Statement Instructions*.

The aggregation of data reported on the SHCE is by state, by market (individual, small group, large group) and by licensed entity. In other words, each health insurance issuer needs to meet the minimum loss ratio targets in each state, and market.

The NAIC iSite+ Financial Profile Report for the SHCE should be reviewed and significant fluctuations investigated. For example, how does the percentage change from the prior year in incurred claims compare to total incurred claims?

In addition, the analyst should ensure that the Supplemental filing was made providing a description of the methods utilized to allocate “Improving Healthcare Quality Expenses” to each state and to each line and column on the SHCE Part 3. When reviewing this Supplemental filing the analyst should consider whether the detailed descriptions of the Quality Improvement expenses were included and whether such descriptions conform to the definitions provided in the Annual Statement Instructions.

Note that the preliminary MLR included in this SHCE (for any given state) is not the MLR that is used in calculating the federal mandated rebates. The MLR used in the rebate calculation (i.e., the ACA MLR) will differ for two reasons. First, the ACA MLR will reflect the development of claims and claims reserves between December 31 of the Statement Year and March 31 of the following year. The second and far more important reason is that the ACA MLR includes a credibility adjustment that is based on the number of covered lives and certain benefit provisions of the coverages provided. The adjustment takes the form of an addition of percentage points to the calculated MLR. The ACA MLR is then used to determine whether a rebate is due and to calculate the amount of the rebate. If the ACA MLR is greater than the relevant MLR standard no rebate is due. If the ACA MLR is less than the relevant MLR standard the rebate is calculated by multiplying the difference between the ACA MLR and the standard MLR by earned premium. Except for very large blocks of business (75,000 lives or more), the ACA MLR will always be larger than the Preliminary MLR. Conversely, for very small blocks of business (under 1,000 lives) the ACA MLR is not calculated since no rebate is due.

Despite the differences, the validity and reasonableness of the ACA MLR calculation, and therefore of the rebate calculation can be assessed using the data from the SHCE. The following elements from the SHCE and the rebate calculation can be used for such an assessment. For the following items there should be little or no difference between the amounts in the SHCE and the rebate calculation:

- Earned premium
- Federal and state taxes and licensing or regulatory fees
- Expenses to improve health care quality

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For other items there are expected to be differences between the SHCE and the rebate calculation due to the difference in the time of reporting between the two:

- Paid claims, unpaid claim reserve, and incurred claims
- Experience rating refunds and reserves for experience rating refunds
- Change in contract reserves
- Incurred medical pool incentives and bonuses
- Net healthcare receivables

For the Contingent Benefit Reserve, the expected relationship between the SHCE and the rebate calculation is unknown as yet.

Failure to Comply with Audit Committee Requirements

Assess compliance with audit committee requirements. As mandated by the *Annual Financial Reporting Model Regulation*, every insurer required to file an audited financial report is also required to have an audit committee that is directly responsible for the appointment, oversight and compensation of the auditor. Insurers with less than $500 million in direct and assumed premium may apply for a waiver from this requirement based on hardship. Based on various premium thresholds, a certain percentage of the audit committee members must be independent from the insurer. However, if domiciliary law requires board participation by otherwise non-independent members, such law shall prevail, and such members may participate in the audit committee.

Procedures/Data

- Review General Interrogatories, Part 1, #10.5 and #10.6 to determine whether the insurer failed to establish an Audit Committee in compliance with the domiciliary state insurance laws and any explanation.
- Review General Interrogatories, Part 1, #10.1, #10.2, #10.3 and #10.4 to determine whether the insurer has been granted any exemptions under Sections 7H, or 18A of the NAIC *Annual Financial Reporting Model Regulation* and if so, review any information about the exemption.

Additional Review Considerations

- Determine whether the Audit Committee membership meets independence requirements of the domiciliary state insurance laws.
- Review the Corporate Governance Annual Disclosure (CGAD):
    - If filed on an insurance entity basis, determine whether the information provided in the CGAD on auditor independence identified any concerns or conflict with information reported in the Annual Financial Statement, General Interrogatories, Part 1, #10.
    - If filed on a group basis, determine whether the information provided in the GPS or provided by the lead state identified any auditor independence concerns or conflict with information reported in the Annual Financial Statement General Interrogatories, Part 1, #10.

Management's Discussion and Analysis Report

Assess the insurer's compliance with the Management's Discussion and Analysis (MD&A) report requirements and identify any legal risks noted in the report. To assist the analyst in conducting the review, an optional MD&A review workpaper is included in the Handbook and available to download from iSite+. The MD&A workpaper breaks down analysis of the MD&A into two distinct steps: 1) Compliance Analysis; and 2) Assessment. For purposes of simplifying the review of the MD&A, guidance for consideration in performing both of these steps has been included within this reference guide.

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Procedures (Compliance and Assessment)

- In considering compliance, the analyst should determine whether the MD&A addresses the two-year period covered in the insurer's Annual Financial Statement and discusses any material changes.
- In addition, the analyst should determine whether the insurer prepared the MD&A on a non-consolidated basis, which is required unless one of the following conditions were met: 1) the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or a 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves, and the insurer ceded substantially all of its direct and assumed business to the pool (an insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if it has less than $1 million total direct plus assumed written premiums during a calendar year that is not subject to a pooling arrangement, and the net income of the business not subject to the pooling arrangement represents less than 5% of the company's capital and surplus); or 2) the insurer's state of domicile permits audited consolidated financial statements.
- Additional compliance requirements apply to the overall completeness of the MD&A, including elements as described below:
    - Overall material historical and prospective disclosure – Insurers should supply information necessary to assess the insurer's financial condition, including a short and long-tailed analysis of the business of the insurer.
    - Results of operations – Insurers should provide a description of any unusual or infrequent events or transactions or any significant economic changes that materially affected the amount of reported net income or other gains/losses in surplus. Insurers should also describe any known trends or uncertainties that have had or are reasonably probable to have a material favorable or unfavorable impact on premiums, net income, or other gains/losses in surplus. If the insurer knows of events that will cause a material change in the relationship between expenses and premium, the change in the relationship shall be disclosed. To the extent that the Annual Financial Statement discloses material increases in premium, reporting entities should provide a narrative discussion of the extent to which such increases are attributable to increases in prices, increases in the volume or number of existing products being sold, or the introduction of new products.
    - Prospective information – Insurers are encouraged to supply forward-looking information. The MD&A may include discussions of known trends or any known demands, commitments, events, or uncertainties that will result in or that are reasonably likely to result in the reporting entity's liquidity improving or deteriorating in any material way. Further, descriptions of known material trends in the insurer's capital resources and expected changes in the mix and cost of such resources should be included. Disclosure of known trends or uncertainties that the insurer reasonably expects will have a material impact on premium, net income, or other gains/losses in surplus is also encouraged.
    - Material changes – Insurers are required to provide adequate disclosure of the reasons for material year-to-year changes in line items, or discussion and quantification of the contribution of two or more factors to such material changes. An analysis of changes in line items is required:
        - Where material
        - Where the changes diverge from modifications in related line items of the Annual Financial Statement
        - Where identification and quantification of the extent of contribution of each of two or more factors is necessary to an understanding of a material change
        - Where there are material increases or decreases in net premium
- Liquidity, asset/liability matching and capital resources – Insurers are required to discuss both short-term and long-term liquidity and capital resources. Short-term liquidity shall include a discussion of the nature

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and extent of restrictions on the ability of subsidiaries to transfer funds to the reporting entity in the form of cash dividends, loans, or advances, and the impact, if any, such restrictions may have on the ability of the reporting entity to meet its cash obligations. The discussion of long-term liquidity and long-term capital resources must address material expenditures, significant balloon payments or other payments due on long-term obligations, and other demands or commitments, including any off-balance sheet items, to be incurred beyond the next 12 months, as well as the proposed sources of funding required to satisfy such obligations. Also, identify and separately describe internal and external sources of liquidity, and briefly discuss any material unused sources of liquid assets. Insurers should describe any known material trends, favorable or unfavorable, in their capital resources, and indicate any expected material changes in the mix and relative cost of such resources.

- Loss reserves – The MD&A should include a discussion of those items that affect the insurer's volatility of loss reserves, including a description of those risks that contribute to the volatility.
- Off-balance sheet arrangements – Insurers should consider the need to provide disclosures concerning transactions, arrangements, and other relationships with entities or other persons that are reasonably likely to materially impact liquidity or the availability of or requirements for capital resources. Material sources of liquidity and financing, including off-balance sheet arrangements and transactions with limited purpose entities, should be discussed.
- Participation high-risk transactions and investments – The insurer should disclose and discuss participation in high-yield financing, highly leveraged transactions, or non-investment grade loans and investments, if such participation or involvement has had or is reasonably likely to have a material effect on financial condition or results of operations. For each such participation or involvement or grouping thereof, there shall be identification consistent with the Annual Financial Statement schedules or detail, description of the risks added to the reporting entity, associated fees recognized or deferred, amount (if any) of loss recognized, the insurer's judgment whether there has been material negative effects on the insurer's financial condition, and the insurer's judgment whether there will be a material negative effect on the financial condition in subsequent reporting periods.
- Preliminary merger/acquisition negotiation – The insurer should disclose and discuss its involvement in any merger/acquisition negotiations, to the extent they are likely to have a material effect on financial condition or operations.
- In reviewing the items disclosed in the MD&A filing, the analyst should assess their potential impact on the insurer's financial condition and prospective solvency by placing and discussing risk information within the appropriate branded risk classification.

Audited Financial Report

Assess the insurer's compliance with Audited Financial Report requirements and identify any legal risks noted in the report.

Risks identified in the Audited Financial Report may include:

- Audited Financial Opinion other than unmodified
  - E.g., Going Concern
- Material differences or material audit adjustments
  - E.g., material differences to the filed Annual Financial Statement and/or resulted in material audit adjustments that will be made to the current or next financial filing
- Material internal control weakness, and the impact of a corrective action plan
- Potential impact of items in the report on the insurer's financial condition and prospective solvency

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- Consider placing and discussing specific risk information within the appropriate branded risk classification.

To assist the analyst in conducting the review, an optional Audited Financial Report review workpaper is included in the Handbook and available to download from iSite+. This workpaper highlights both compliance and assessment considerations, as discussed below:

Audited Financial Report Compliance – The financial statements are required to be prepared in conformity with statutory accounting practices prescribed or otherwise permitted by the domiciliary state insurance department. In addition, the financial statements should be prepared on a stand-alone basis, unless the insurer has made written application to the domiciliary commissioner to file audited consolidated or combined financial statements if the insurer is a part of a group of insurance companies that utilizes a pooling or 100% reinsurance agreement.

Procedures

- If the insurer is filing financial statements on a consolidated or combined basis, the analyst should determine whether the domiciliary commissioner approved the insurer's application to file on a consolidated or combined basis, and whether a consolidating or combining worksheet has been included with the financial statements. This worksheet should show amounts for each insurer separately, including explanations for consolidating and eliminating entries, and reconciliations for any differences between the amounts shown for an individual insurer and the amounts per the insurer's Annual Financial Statement.

Audited Financial Report Detailed Assessment – In addition to reviewing for compliance, the analyst should review information provided in the financial statements to assist in risk identification and detailed assessment. One key step in this area is to determine the type of audit opinion that was issued by the independent certified public accountant (CPA). The opinion may be an unmodified or a modified opinion; however, there are three types of modified opinions: qualified, adverse and disclaimer of opinion.

- Unmodified Opinion – The auditor should express an unmodified opinion when the auditor concludes that the financial statements are presented fairly, in all material respects, in accordance with the applicable financial reporting framework.
- Modified Opinion – The auditor should modify the opinion in the auditor's report, if the auditor concludes that, based on the audit evidence obtained, the financial statements as a whole are materially misstated or is unable to obtain sufficient appropriate audit evidence to conclude that the financial statements as a whole are free from material misstatement. There are three types of modified opinions: qualified, adverse and disclaimer of opinion, as explained below:
  - The auditor should express a qualified opinion when:
    - The auditor, having obtained sufficient appropriate audit evidence, concludes that misstatements, individually or in the aggregate, are material but not pervasive to the financial statements; or
    - The auditor is unable to obtain sufficient appropriate audit evidence on which to base the opinion, but the auditor concludes that the possible effects on the financial statements of undetected misstatements, if any, could be material but not pervasive.
  - The auditor should express an adverse opinion when the auditor, having obtained sufficient appropriate audit evidence, concludes that misstatements, individually or in the aggregate, are both material and pervasive to the financial statements.
  - The auditor should disclaim an opinion when the auditor is unable to obtain sufficient appropriate audit evidence on which to base the opinion, and the auditor concludes that the possible effects on the financial statements of undetected misstatements, if any, could be both material and pervasive.

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Procedures

- If a modified opinion is issued, the analyst should document the reasons for the modification and assess the impact of the modification on the insurer's financial position and prospective solvency.
- In addition to reviewing and assessing the opinion, the analyst should also determine whether total assets, net income, and surplus per the Audited Financial Report agree with the amounts per the insurer's Annual Financial Statement.
    - If differences exist, the independent CPA is required to include in the Notes to Financial Statements a reconciliation of the differences between the Audited Financial Report and the Annual Financial Statement along with a written description of the nature of these differences.
    - If differences are identified, the analyst should document these differences and the reasons for the differences based on a review of the independent CPA's reconciliation in the Notes to Financial Statements.
    - The analyst should also consider the impact of the audit adjustments made by the independent CPA on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (i.e., complete additional procedures for items impacted by the audit adjustments) on the Annual Financial Statement information.

Additional Review Considerations

- If further concerns exist, the analyst should consider performing one or more of the following procedures:
    - Obtain and review a copy of the signed management representation letter, which acknowledges that management is responsible for the presentation of the financial statements and has considered all uncorrected misstatements and concluded that any uncorrected misstatements are immaterial. The analyst should review the entire management representation letter to determine whether there are representations that would impact the insurer's solvency.
    - Obtain and review all recorded and unrecorded audit adjustments along with supporting documentation regarding the adjustments or explanations from the external auditor. The analyst may use the information regarding audit adjustments to identify risk or internal control weaknesses to determine what the impact of significant audit adjustments might be on the insurer's solvency.
    - Obtain and review the internal control-related matters presentation materials, including the Management Letter, prepared by the external auditor for the audit committee's review. Note the external auditor is required to provide written communication to the audit committee of all significant deficiencies or material weaknesses known. The comments from the external auditors may be used as guidance as to areas that may require additional investigation and the analyst's view of this documentation.
    - Obtain and review any other audit work papers deemed appropriate or necessary (e.g., Statement on Auditing Standards (SAS) No. 99 Consideration of Fraud in a Financial Statement Audit). This documentation should impact the analysts' consideration of risk inherent within the entity and impact the overall risk assessment and analysis procedures completed by the analyst. Further, obtain copies of all legal letters and determine the status of all pending litigation and the impact that potential settlements might have on the insurer's solvency.

CPA Letter of Qualifications – The analyst should perform procedures in this area whenever there has been a change in the independent CPA from the prior year, although it may be completed annually whether or not there has been a change in independent CPA. The analyst should determine if the independent CPA furnished to the insurer, in connection with and for inclusion in the filing of the Audited Financial Report, a Letter of Qualifications which includes all of the statements listed in the procedure.

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Procedures

- If any of the statements are missing from the letter, the analyst should contact the CPA firm to discuss and address.
- In addition, the analyst should determine whether the CPA retained for review by the domiciliary state insurance department all audit work papers prepared during the audit, unadjusted journal entries, letter of representation, management's letter and any communications between the CPA and the insurer related to the audit.

Change in CPA – The insurer is required to notify the domiciliary state insurance department within five business days when the insurer's independent CPA is dismissed or resigns. The insurer is also required to furnish a separate letter within 10 business days of the previous notification stating whether, in the 24 months preceding such event, there were any disagreements with the former independent CPA on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, and which disagreements, if not resolved to the satisfaction of the former independent CPA, would have caused the CPA to make reference to the disagreement in connection with the opinion. In addition, the insurer is further required to furnish a letter from the former independent CPA stating whether the independent CPA agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he or she does not agree.

Procedures

- The analyst should determine whether the CPA who issued an opinion on the insurer's financial statements in the current period is the same CPA who issued the opinion in the prior year. If not, the analyst should determine whether all required reports were filed with the state insurance department as outlined above and assess the impact of the change in CPA on the insurer.

Reports on Internal Controls – In addition to the Audited Financial Report, insurers are required to furnish the domiciliary state insurance department with a written Management's Report of Internal Control Over Financial Reporting by the independent CPA describing material weaknesses in the insurer's internal control structure as noted by the independent CPA during the audit, if applicable. Such a report is required regardless of whether material weaknesses have been identified. In those instances where material weaknesses are noted, the insurer is also required to provide a description of remedial actions taken or proposed to correct the material weaknesses if such actions are not described in the CPA's report.

Effective for audits as of December 31, 2021, and thereafter, the NAIC's Model Audit Rule Implementation Guide requests that the name of the current lead audit partner and the year at which he or she began serving in that capacity be included in the internal control report, so it can be provided to regulators but kept confidential. Such information may be useful in verifying compliance with audit partner qualification and rotation requirements.

Management of insurance companies with more than $500 million in direct and assumed premiums are also required to file with the state insurance department an assessment of internal control over financial reporting. This report states whether or not management is confident the internal controls are effective in providing accurate statutory financial statements.

Procedures

- If material weaknesses are identified or management cannot attest to effective internal controls over financial reporting, the analyst should consider performing additional procedures as highlighted in the worksheet.
- The analyst should consider the financial impact of any corrective actions the insurer is undertaking to correct those weaknesses.

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Additional Review Considerations

- Upon review of the Audited Financial Report and Management's Report of Internal Control Over Financial Reporting, if material risks were noted or weaknesses in internal controls were reported, identify what corrective actions are planned to resolve the issues.
- Inquire of the insurer:
  - Letter of Representation
  - Schedule of all recorded and unrecorded audit adjustments
  - Internal control related presentation materials including Management's Comment Letter
  - Any other audit work papers deemed appropriate or necessary (i.e., Statement of Auditing Standards (SAS) 99 Fraud and Legal Representations Letters)
  - If internal control weaknesses are noted and no corrective action plan is proposed, contact the insurer and request detailed information regarding the insurer's remediation and corrective action plan to resolve the weaknesses.

ADDITIONAL PROCEDURES

Examination Findings

Review the most recent examination report and the Summary Review Memorandum (SRM) for any findings regarding legal risks. If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

Inquire of the Insurer

Consider requesting additional information from the insurer if legal risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of legal risk for specific topics where concerns have been identified.

If concerns exist, consider requesting information from the insurer regarding:

- **Policies and Strategies for Compliance with State, Federal and International Laws and Regulations:**
  - Information on how the legal/compliance function ensures compliance with relevant laws and regulations
- **News, Press Releases and Industry Reports:**
  - The financial impact of any legal issues on the insurer and/or group's operations and surplus
  - Disclosures of financial impact to the public and agent distribution force
  - The insurer's efforts to mitigate any impact of the risk. For ORSA filers, this may be identified in the ORSA Summary Report for certain risks.
  - Policies and procedures in place to mitigate adverse publicity
  - Revised business plan
- **Legal Risk Assessment by Management:**
  - How the insurer assesses its legal risk and reports it to senior management
  - The involvement of legal counsel in changes to existing products and development of new products

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- The degree to which compliance programs are utilized to control, monitor and report legal risk

Own Risk and Solvency Assessment (ORSA) Summary Report

If the insurer is required to file ORSA or part of a group that is required to file ORSA, determine whether the ORSA Summary Report analysis conducted by the lead state indicated any of the following:

- Legal risks that require further monitoring or follow-up
- Mitigating strategies for existing or prospective legal risks

Holding Company Analysis

Determine whether the Holding Company analysis conducted by the lead state indicated any of the following:

- Legal risks impacting the insurer that require further monitoring or follow-up
- Mitigating strategies for existing or prospective legal risks impacting the insurer

QUARTERLY LEGAL RISK ASSESSMENT

The quarterly legal risk procedures are designed to identify the following.

Market Conduct Examination/Material Findings

Determine if concerns exist regarding Market Conduct, including complaints, market conduct actions, communication with market conduct staff, etc., that could have an impact on financial position and prospective solvency. If concerns exist, communicate risks/issues to the state insurance department's Market Conduct Unit to investigate further. For example, large fines levied by states, suspensions or revocations of licenses, market conduct exam settlements (whether financial or other), or other regulatory actions taken based on market conduct violations may have a material impact on the financial solvency of the insurer. Additionally, if a recently concluded market conduct examination resulted in regulatory requirement to perform remediation (e.g., reprocessing denied claims) the financial impact may be material to the insurer.

Procedures/Data

- Review any market conduct information available from the NAIC market analysis tools available on iSite+ (Market Analysis Profile (MAP), Examination Tracking System (ETS), Market Analysis Review System (MARS), Regulatory Information Retrieval System (RIRS), Special Activities Database (SAD), Market Initiative Tracking System (MITS), Market Conduct Annual Statement (MCAS) and the Complaints database). Note any unusual items or negative trends for the following items that translate into financial risks or indicate further review is needed:
  - Count of Regulatory Actions
  - Aggregate of Regulatory Fines
  - Market Conduct Examination Called or Concluded
- In reviewing the items disclosed in the Market Conduct Examination and other Market Conduct findings, the analyst should assess their potential impact on the insurer's financial condition and prospective solvency by placing and discussing risk information within the appropriate branded risk classification, if not a legal matter.

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Additional Procedures

- Review any market conduct information, including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee). Note any unusual items that translate into financial risks or indicate further review is needed.
- Review any inter-departmental communication, as well as communication with other state, federal or international insurance regulators and the insurer. Note any unusual items or prospective risks that indicate further analysis or follow-up is necessary.
- If market conduct information is unusual and indicates potential financial risks, analysts can perform the following procedures:
    - Describe and document the findings of the most recent market conduct examination and analysis and communication with the insurance department's market conduct staff.
    - Describe any current or future actions of the insurance department, other state insurance departments or other regulatory bodies against the insurer related to market conduct violations.
    - Describe the actual or projected financial impact of any settlements, fines, or remediation to operations and surplus.
- Determine if the insurer has met state statutes and regulations regarding timely payment of claims.

High Litigation, Legal and Government Expenses

Identify and evaluate risks related to expenses paid for litigation, other legal issues and/or government lobbying. Determine if the insurer has reported high legal, litigation or government expenses that are material to overall operating expenses.

Procedures

- Review the Quarterly Financial Statement including the Notes to Financial Statements, and Examination findings and follow-up monitoring to determine whether any legal concerns were identified.
- Upon review of the Notes to Financial Statements, determine whether the insurer was a party to any significant litigation not in the normal course of business. If so, review and understand a description of the litigation and any contingent liabilities for accrued legal expenses.

Material Fraudulent Activity/Investigation Results

Identify and evaluate the materiality of any fraudulent activity and the impact on the financial position and prospective solvency of the company. If fraud, allegations of fraud or ongoing investigations are identified, the analyst is encouraged to document his/her understanding and assessment of the ongoing issues and to contact the company regarding its plans to address the situation.

Procedures

- Review the Quarterly Financial Statement, including the Notes to Financial Statements, Examination findings (i.e., Exhibit G – Consideration of Fraud) to identify if any fraud concerns were disclosed.
- Contact the state insurance department's Fraud Unit (if applicable) to see if the state insurance department has concluded any fraud investigations involving the insurer? If so, identify the following:
    - Nature and scope of the investigation and its findings
    - Regulatory and/or corrective actions required of the insurer

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- Insurer's plan to address the fraudulent activity
- Financial impact of the investigation and corrective actions

- Review news/media reports, information from the insurer or other information available to the analyst that may indicate the insurer is under investigation by any regulatory body other than the state insurance department. If so, identify the nature and scope of the investigation and impact on the insurer to determine whether further information should be requested from the other regulatory body.
- Review Regulatory Actions (through RIRS) to identify whether any regulatory actions taken by other states were identified as fraud. If so, and if not communicated to the state insurance department, contact the reporting state insurance department to obtain information regarding the regulatory action.
- Contact other regulatory agencies that have regulatory authority over the business of the insurer (e.g., federal agencies where the insurer is engaged in government contracts) to identify whether any regulatory authorities have concluded any fraud investigations involving the insurer, its management or board of directors. If so, request the following information:
  - Nature and scope of the investigation and its findings
  - Regulatory and/or corrective actions required of the insurer
  - Insurer's plan to address fraudulent activity
  - Financial impact of the investigation and corrective actions
- If the above analysis indicates concerns related to current or prior fraud, inquire of the insurer regarding its internal processes and controls for preventing fraud.

Failure to Comply with Code of Ethics Standards

Identify and evaluate risks related to the insurer's compliance with code of ethics standards. If concerns regarding an insurer's failure to implement or abide by a code of ethics are identified, the analyst should correspond with the company to address these concerns and/or identify other compensating controls in place.

Procedures/Data

- Review the following and identify any concerns with the insurer's compliance with the code of ethics.
  - General Interrogatories, Part 1, #9.1 to identify if senior officers are subject to code of ethics standards.
  - General Interrogatories, Part 1, #9.2 to identify if the code of ethics has been amended.
  - General Interrogatories, Part 1, #9.3 to identify if the code of ethics has been waived.

Additional Procedures

- Review the Corporate Governance Annual Disclosure (CGAD) and identify any concerns.
  - If the CGAD is filed on an insurance entity bases, verify that the information provided in the CGAD filing on ethics policies does not conflict with the information reported in the General Interrogatories.
  - If the CGAD is filed on a group basis, rely on the information provided in the GPS for group risks or provided by the lead state if risks apply to the insurance entity and verify that the information does not conflict with the information reported in the General Interrogatories.

Failure to Comply with State Laws and Reporting

Assess the insurer's compliance with NAIC reporting practices, internal policy, laws, regulations and prescribed practices. The analyst should determine whether there are any legal or regulatory impediments that could affect

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the insurer's operations or result in a significant legal liability. If a compliance violation is found, the analyst should specify the violation and the impact.

Procedures/Data

- Review General Interrogatories, Part 1, #7.1 and #7.2 and identify if any certificates of authority, licenses or registrations have been suspended or revoked.

Additional Procedures

- Identify if the insurer is compliant with state statutes and regulations, including those that are new or revised (e.g., hazardous financial condition analysis, investment limitation analysis, etc.).
- Assess whether surplus meets the statutory minimum amount required by state law (varies by state and business type).
- Review the Notes to Financial Statements, Note #1 and the iSite+ Validation Exceptions tool and determine whether the insurer reported significant corrections of errors, validation errors, or other accounting and reporting changes that indicate possible concerns regarding the accuracy of the financial reporting. Potential missing data, data that does not conform with standards, or any crosscheck errors could materially impact the outcome of an analysis and corrective measures may need be taken by the insurer prior to proceeding with an analysis.
    - Determine whether the insurer is in compliance with permitted or prescribed practices as reported in Note #1.
- If the insurer failed to comply with the state's statutes and regulations enacted during the period, identify the following and complete a detailed written explanation of the violation to ensure proper documentation should non-compliance issues recur:
    - Nature of the non-compliance
    - Impact to the insurer's financial position and reporting
    - Outcome of any department communication with the insurer regarding the non-compliance issues
    - Resolution of any non-compliance issues or resolution plans of the insurer
- If the insurer had any certificates of authority, licenses, or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period, identify the following:
    - Nature of the suspension or revocation
    - Reason(s) stated for the revocation or suspension
    - Outcome of any department communication with the insurer and/or with the other regulatory authority who issued the revocation or suspension
    - Resolution of any non-compliance issues or resolution plans of the insurer
- If the insurer has been issued any consent orders or agreements by other regulators/jurisdiction, identify or perform the following:
    - Request a copy of the consent order or agreement from the other regulator/jurisdiction
    - Reason(s) stated for the consent order or agreement
    - Outcome of any department communication with the insurer and/or with the other regulatory authority
    - Resolution of any non-compliance issues or plans of the insurer

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Failure to Comply with State Investment Laws

Assess the insurer's compliance with the state's investment laws.

Procedures

- Using your state's investment compliance checklist, determine whether the insurer's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws.
- Determine whether the insurer is reporting its investments (including the related income and expenses) in accordance with NAIC practices, internal policy, Statutory Accounting Principles and the filing requirements set forth in the Purposes and Procedures Manual of the NAIC SVO.
- Determine whether affiliated investments are in violation of state statutes. If so, gain an understanding of the primary business activity of the affiliate and why such an investment does not comply with regulatory requirements.
- If analysis of investment compliance indicates concerns or a pattern of non-compliance, review the most recent examination file for investment compliance and inquire of the insurer about its internal processes and controls for compliance with state investment laws.

Failure to Comply with Affiliated Management and Service Agreements

Assess the insurer's compliance with affiliated management and service agreements.

Procedures/Data

- Review General Interrogatories, Part 1, #1.1 to determine whether the insurer experienced any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile as required by the Model Act. If so, determine whether the insurer made the appropriate filing of a Disclosure of Material Transactions with the state of domicile.

Additional Procedures

- Determine whether management and service agreements between affiliates either submitted and/or approved are in conformity with regulatory requirements and verify that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
- Determine whether the amount of the shareholder dividend was at a level that required prior regulatory approval or notification. If so, determine whether the insurer obtained proper prior regulatory approvals.

Failure to Comply with Transactions Involving Other Jurisdictions

Assess the insurer's compliance with transactions involving other jurisdictions.

Procedures

- If the insurer redomesticated to your state, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.
- If the insurer engaged in a transaction(s) to redomesticate a subsidiary offshore, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were

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expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.

- If the insurer engaged in any transactions to acquire a subsidiary domiciled in a non-U.S. jurisdiction, determine whether the insurer failed to comply with any regulatory requirements or stipulations expected to be met subsequent to the acquisition and identify any legal implications that represent risk to the insurer due to the acquisition.

Failure to Comply with Federal Regulatory Agencies

Identify and assess compliance with other federal regulatory agencies. In addition to the HHS and the CMS oversight of health insurance, insurers may be subject to regulation by the Federal Reserve, U.S. Securities and Exchange Commission (SEC), U.S. Department of the Treasury and other federal regulatory bodies depending upon the nature, scope and extent of the insurer's or insurance group's activities.

Procedures

- Review General Interrogatories, Part 1, #8 and determine whether the insurer is subject to regulation by a federal regulatory agency. If so, consider contacting the applicable federal regulatory agency to request any information about the results of that agency's oversight, including any issues identified, federal compliance violations, fraud investigations and regulatory actions.

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Note: The worksheet is intended to provide procedures for reviewing the Audited Financial Report for compliance and assessment of risks. The worksheet provides for the results of the review to be documented by the analyst. Analysts should document overall results of the risks identified in Section III: Risk Assessment of the insurer within the relevant risk category.

Note that overall Audit Report compliance and legal risks are included in the Legal Risk Assessment.

Part 1 – Audited Financial Report

1. Assess compliance with Audited Financial Report requirements. Were the financial statements included in the Audited Financial Report:

	Comments
a. Based on statutory accounting practices?	
b. Specific to the insurer rather than on a consolidated or combined basis?	
c. If prepared on a consolidated or combined basis: i. Was this basis approved by the domiciliary commissioner upon application by the insurer due to a pooling or a 100% reinsurance agreement with affiliates? ii. Was a consolidating or combining worksheet included with the financial statements that: • Shows amounts separately for each insurer (non-insurance operations may be shown on a combined or individual basis)? • Provides explanations for consolidating and eliminating entries? • Includes a reconciliation of any differences between the amounts shown for an individual insurer and the amounts per the insurer's Annual Financial Statement?	

2. Assess the details of the Audited Financial Report and identify risks.

	Comments
a. What type of opinion was issued by the certified public accountant (CPA)? • Unmodified • Modified • Qualified • Adverse • Disclaimer of opinion	
b. If the opinion was modified, which type of opinion was issued and what was the reason for the deviation?	
c. Were any differences noted between information included in the Audited Financial Report and the insurer's Annual Financial Statement? • Total Assets • Net Income • Surplus	

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If "yes," review the reconciliation of differences and identify the reasons for the difference, consider the impact of the audit adjustments made by the independent CPA on the conclusions reached as a result of the analysis, and consider the need to perform additional analysis.	
d. If further concerns exist, consider additional procedures that may include, but not limited to, requesting and reviewing the following: • Letter of Representation • A schedule of all recorded and unrecorded audit adjustments • Internal control related presentation materials including Management's Comment Letter • Any other audit work papers deemed appropriate or necessary (i.e., Statement on Auditing Standards (SAS) 99 Fraud and Legal Representation Letters)	

CPA Letter of Qualifications

A review of the CPA's Letter of Qualifications should be completed whenever there has been a change in the independent CPA from the prior year and may be completed annually whether there has been a change in the independent CPA.

3. Confirm that the CPA's Letter of Qualifications includes the following:

	Comments
a. A statement that the CPA is independent with respect to the insurer and conforms to the standards of the profession.	
b. Information regarding the background and experience, including the experience in audits of insurers, of the staff assigned to the audit, and whether each is a CPA.	
c. A statement that the CPA understands that the domiciliary commissioner will be relying on the Audited Financial Report, and the CPA's opinion thereon, in the monitoring and regulation of the financial position of the insurer.	
d. A statement that the CPA is properly licensed by an appropriate state licensing authority.	
e. A statement that the auditor is in compliance with the following qualifications, which are specified in the NAIC *Annual Financial Reporting Model Regulation* (#205) for the Audited Financial Reports: i. The CPA is in good standing with the American Institute of Certified Public Accountants and with all states in which the CPA is licensed to practice or, for a Canadian or British insurer, is a chartered accountant. ii. The CPA conforms to the standards of the profession. iii. The partner or other person responsible for rendering the Audited Financial Report has not acted in that capacity for more than five consecutive years and, following any such period of service, that	

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person shall be disqualified from serving in that or a similar position for the same insurer for a period of five years. iv. The domiciliary commissioner has not ruled that the CPA is unqualified for purposes of expressing an opinion on the financial statements included in the Audited Financial Report and by providing prohibited non-audit services to the insurer. v. The domiciliary commissioner has not ruled that the CPA is unqualified if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any other person serving in an equivalent position for that insurer, was employed by the independent CPA and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due.	
f. A statement that the CPA agrees to: i. Make available for review by the domiciliary state insurance department examiners, at any reasonable place designated by the domiciliary commissioner, all work papers prepared in the conduct of the audit and any communications between the CPA and the insurer related to the audit. ii. Retain the audit work papers and communications until the domiciliary state insurance department has filed an examination report covering the period of the audit but no longer than seven years from the date of the audit report. iii. Allow copies of pertinent audit work papers to be made and retained by the domiciliary state insurance department examiners.	
g. Were any deviations identified between the statements in the CPA's Letter of Qualifications and the required statements per Model #205 for insurers as summarized above?	

Change in CPA

4. Identify any concerns if a change in CPA has occurred.

	Comments
a. Was the CPA who issued the opinion on the insurer's financial statements the same CPA who issued the opinion on the insurer's financial statements in the prior year?	
b. If the CPA who issued the opinion on the insurer's financial statements this year is different from the CPA in the prior year: i. Was the domiciliary state insurance department notified of the change? ii. Has a letter from the new CPA been filed with the domiciliary state insurance department that affirms: (1) the CPA is aware of the provisions of the Insurance Code and the rules and regulations of the domiciliary state insurance department that relate to accounting and financial matters; and (2) the CPA will express an opinion on the	

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financial statements of the insurer in terms of the insurers conformity to the statutory accounting practices prescribed or otherwise permitted by that department, specifying such exceptions as the CPA may believe appropriate? iii. Did the insurer file a letter with the domiciliary state insurance department stating whether, in the 24 months preceding the change in CPAs, there were any disagreements with the former CPA regarding accounting principles or practices, financial statement disclosure, or auditing scope or procedure which, if not resolved to the satisfaction of the former CPA, would have caused the CPA to make reference to the subject matter of the disagreement in connection with the CPA's opinion? iv. With regard to the letter referred to in procedure #4.b.iii., did the insurer also file a letter from the former CPA stating whether the CPA agrees with the statements regarding disagreements in the insurer's letter?	
c. Were any disagreements noted in the letters from either the insurer or the former CPA?	

Part II – Report on Internal Controls

5. Identify if any concerns exist regarding Management's Report on Internal Controls.

Per the NAIC's *Annual Financial Reporting Model Regulation*, the Management's Report of Internal Control Over Financial Reporting (Section 16) and Communication of Internal Control Related Matters Noted in an Audit (Section 11) are both required by August 1 each year (or 60 days after the Audited Financial Report). The following procedures are applicable to these two filings.

	Comments
a. Review the Communication of Internal Control Related Matters Noted in an Audit and comment on any weaknesses noted and the improvements made or proposed by the insurer to correct those weaknesses.	
b. Review Management's Report of Internal Control Over Financial Reporting and note any unremediated material weaknesses disclosed in the report.	
c. If internal control weaknesses are noted in either the Management's Report of Internal Control Over Financial Reporting or the Communication of Internal Control Related Matters Noted in an Audit, consider the following additional procedures: i. Assess the internal control weaknesses impact on key processes (e.g., the accuracy of financial reporting, reserve valuation, claims processing, or investment practices, etc.). ii. Assess the source of internal control weaknesses and determine if attributed to issues within the insurance entity or the insurance holding company system (i.e., parent, subsidiary or affiliate). If at the holding company system level, contact the lead state to discuss if applicable holding company analysis procedures should be performed	

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by the lead state. iii. If the internal control weaknesses relate to market conduct or rate review practices, communicate with the department's market conduct staff to assess any financial or reputational risk that may result.	
d. If weaknesses were noted and no corrective action plan proposed, contact the insurer and request detailed information regarding the insurer's remediation and corrective action plan to resolve the weaknesses.	
e. Review the Communication of Internal Control Related Matters Noted in an Audit for information provided on the name of the current lead audit partner and the year at which he or she began serving in that capacity, as outlined in the Model Audit Rule Implementation Guide. Consider the following additional procedures to verify compliance with requirements outlined in the CPA Letter of Qualifications section above: i. Utilize the information provided on the partner's name to verify compliance with auditor qualification requirements (i.e., in good standing). ii. Utilize the information provided on the year at which the lead audit partner began serving in that capacity to verify compliance with partner rotation requirements.	

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Note: The worksheet is intended to provide procedures for reviewing the Management's Discussion and Analysis (MD&A) report for compliance and assessment of risks. The worksheet provides for the results of the review to be documented by the analyst. Analysts should document overall results of the risks identified in Section III: Risk Assessment of the insurer within the relevant risk category.

Note that overall MD&A compliance and legal risks are included in the Legal Risk Assessment.

Compliance

1. Assess compliance with MD&A Report requirements. Did the MD&A filed in accordance with the Annual Financial Statement Instructions include the following content?

Analysts should refer to the Annual Statement Instructions for detailed explanation of specific content expectations. Below is an abbreviated list.

	Comments
a. Overall material historical and prospective disclosure to assess financial condition, including a short and long-tailed analysis of the business of the insurer	
b. Results of operations	
c. Prospective information	
d. Material changes	
e. Liquidity, asset/liability matching and capital resources	
f. Loss reserves	
g. Off-balance sheet arrangements	
h. Participation in high-yield financings, highly-leveraged transactions, or non-investment grade loans and investments	
i. Preliminary merger and acquisition negotiation	

Assessment of Management's Discussion and Analysis

2. In review of the MD&A, were any previously unknown and undocumented risks, concerns or unusual items noted in the information reported?

	Comments
a. Changes in business	
b. Material events	
c. Results of operations	
d. Prospective information	
e. The insurer's explanation of material changes in line items	
f. Liquidity, asset/liability matching and capital resources	
g. Items that affect the volatility of loss reserves (P/C only)	
h. Off-balance sheet arrangements	

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i. Participation in high-yield financings, highly-leveraged transactions, or non-investment grade loans and investments	
j. Discussion on preliminary merger/acquisition negotiations	
k. Any other items reported in the MD&A	

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LIQUIDITY RISK: Inability to meet contractual obligations as they become due because of an inability to liquidate assets or obtain adequate funding without incurring unacceptable losses.

The Liquidity Risk Assessment is focused primarily on overall liquidity, liquidity of investments, receivables, and cash flow from operations. In analyzing liquidity risk, analysts may analyze specific types of investments and receivables held by insurers. An analyst's risk-focused assessment of liquidity risk should take into consideration the following areas (but not be limited to):

- Liquidity ratios/metrics
- Liquidity of certain investments, including private placement bonds and common stock, highly structured investments, investments on Schedule BA, and affiliated investments
- Liquidity of certain receivables, including health care receivables and special deposits
- Cash flow from operations
- Stockholder dividends
- Surrender and withdrawal activity for life insurers

Principles-Based Bond Definition (PBBD)

Beginning in 2025, investment schedules and certain other Notes to the Financial, General Interrogatories, 5-Year History, and related pages of the quarterly and annual financial statement were amended along with the implementation of the statutory accounting principles-based bond definition (PBBD) revisions.

Analysts should be aware that in some cases, changes between amounts reported on investment schedules and certain lines of the schedules may not be comparable to prior year (2024) or may vary from the prior year due to the bond definition change, in which an insurer may hold some securities that no longer meet the definition of a bond (or vice versa).

****Refer to the Credit Risk Assessment chapter of this Handbook for further information on the PBBD.***

ANNUAL LIQUIDITY RISK ASSESSMENT

Insufficient Overall Liquidity, OR Illiquid Assets are Significant

Evaluate the insurer's liquidity position and examine its ability to meet financial obligations as they come due, including claim payments, operational expenses, and other financial commitments. Less liquid assets may be unavailable to pay policyholder claims as they are not as easily or quickly marketable. The assessment of liquidity involves a detailed analysis of changes in the insurer's liquid assets, asset-to-liability ratios, and liquidity trends. Comparison with industry averages and peer companies offers valuable insight into the insurer's liquidity standing within its market segment.

Procedures / Data

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- Analyze the insurer's liquidity position by reviewing the following metrics and data elements:
  - Change in liquid assets
    - A significant increase in an insurer's total liquid assets could indicate that it has been unable to collect on receivables. If the change is significant, an analyst may consider a more detailed review of the change in the asset mix from the prior period to determine the cause of the fluctuation.
  - Ratio of restricted assets to total cash and invested assets
    - Assessment of materiality of restricted assets is intended to determine if any liquidity concerns exist regarding the level of assets not under the insurer's exclusive control. Analysts should review General Interrogatories and Notes to the Financial Statement #5 to determine the reason the assets are not under the insurer's exclusive control (e.g., loaned to others, subject to repurchase or reverse repurchase agreements, pledged as collateral, placed under option agreements) and who holds the assets in order to evaluate whether there are liquidity concerns. Analysts should also consider the potential for pledging additional assets, as in variation margin requirements for derivatives transactions.
    - Assess if collateral received and assets held under Modco/Funds Withheld reinsurance contracts reflected as assets within the insurer's financial statement have also been pledged under other agreements and are not available for the benefit of the reinsurer (e.g., securities lending, repo transactions, FHLB collateral, etc.), per Notes to the Financials 5L(5).
  - Ratio of adjusted liabilities to liquid assets (P/C)
    - The P/C liquidity ratio calculation compares the insurer's adjusted liabilities with its liquid assets (IRIS ratio #9) available to fund future liabilities. Affiliated holdings are excluded from liquid assets because they are considered less liquid and may not be readily converted to cash. In addition to assessing the insurer's current liquidity ratio, analysts should review the five-year trend within the Financial Profile Report. Significant fluctuation should be noted and the underlying causes analyzed.
  - Ratio of capital and surplus and AVR to total assets less separate accounts (Life/A&H)
    - For life insurers, analysts should be aware that stress liquidity inquiries and templates are included in the NAIC *Financial Condition Examiners Handbook*. Information captured in these templates is considered confidential; therefore, it is not captured within the annual financial statements. In order to obtain this information, regulators must request that reporting entities complete the forms. As noted in the *Examiners Handbook*, requests for reporting entities to complete these templates may occur at any time and are not limited to instances of comprehensive statutory examinations. Analysts should communicate with the examiner to determine if the insurer has recently submitted responses to the stress liquidity inquiries and templates or if a request should be made to the insurer for the information.
  - Ratio of total liabilities to liquid assets (Health)
    - The primary method in evaluating a Health entity's liquidity is accomplished comparing its liabilities with its liquid assets available to fund such liabilities in the future. However, as previously mentioned, various other comparisons can be used to help assess liquidity or potential liquidity concerns. Liquid assets in this calculation include all bonds but exclude affiliated investments. A significant increase in the liabilities to liquid assets ratio could indicate the health entity's growing inability to satisfy its financial obligations without having to sell long-term investments. Liquid assets in this calculation include all bonds but exclude affiliated investments.
  - Ratio of liquid assets and receivables to current liabilities (Health)

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- This ratio measures the health entity's ability to pay current obligations with current assets including marketable securities. Results of less than 200 percent may not pose a serious threat to the health entity if it has access to other assets that can be liquidated. This ratio excludes non-investment grade bonds and affiliated investments but includes certain receivables not included in the two procedures above.

- Ratio of aggregate write-ins for other than invested assets to capital and surplus (Health)

Additional Review Considerations

- Review the trends over years in the liquidity ratios noted above and not any unusual fluctuations or negative trends between years.
- Compare the results of liquidity ratios noted above with industry or peer group averages to identify any significant deviations.
- Review the Annual Supplemental Investment Risks Interrogatories. Note any unusual items or areas that would indicate inadequate liquidity.
- Request and review the insurer's most recent investment plan. Determine if the investment plan is adequate to meet the liquidity needs of the insurer's liability structure.
- If there are concerns regarding liquidity or cash flows:
  - For a P/C insurer, consider having a cash flow analysis performed by an actuary.
  - For a Life/A&H or Health insurer, review the Statement of Actuarial Opinion for comments regarding cash flow testing performed and the results obtained.
- If an examination is in progress or recently completed, communicate with the examiner to determine if the insurer has recently provided responses to the stress liquidity inquiries and templates included in the NAIC *Financial Condition Examiners Handbook*. If such has occurred, review this information to ascertain whether the analyst's liquidity concerns have been alleviated. If not, request the insurer to submit responses to these inquiries.
- If restricted assets are material, gain an understanding and assess the types of investments and products that may require collateral to be posted (e.g., derivatives, guaranteed investment contracts (GICs), Federal Home Loan Bank, etc.).
- If concerns are identified regarding overall liquidity of the asset portfolio, identify and assess other sources of liquidity available to the insurer. Request information from the insurer if necessary.
- Assess the impact of market conditions through consideration of industry and economic events (i.e., news, industry analytics). Is the analyst aware of any market conditions that may threaten the liquidity of insurers' investment portfolios (e.g., market dislocation or other events that could affect liquidity of assets classes such as structured securities, structured notes, Schedule BA assets, non-investment grade bonds)?

Risk of Insufficient Liquidity for Health Entities

There are a number of situations that can elevate the risk of a negative impact on a health entity's cash flow and liquidity including the credit risk of receivables, the level of borrowed money and other liabilities, and dividends to shareholders. For example, if a health entity relies heavily on risk transfer arrangements with provider groups and the parties involved in the arrangements are unable to meet their obligations, the collectability of those obligations could negatively impact the liquidity of the health entity. Credit risk is a concern for other receivables as well, including amounts due from affiliates and reinsurance receivables. An analyst should be aware of the domiciliary state's requirements for downstream risks such as provider groups and reinsurance. Other situations involve significant increases in liabilities such as unpaid claim reserves or borrowed money, which can increase

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the health entity's short-term cash requirements. Additional cash would also be needed in order for the health entity to pay dividends to a parent company or other shareholder.

Health entities have a shorter benefit payout period than other insurers and consequently understanding the need for liquidity is an important issue for management. Because a health entity writes short-tail business, it will generally have a shorter average maturity on its bonds and hold more cash and short-term investments than other insurers. The key liquidity risks to a health entity include substantial declines in enrollment, underpricing, and spikes in claims. If this were to occur, the entity's cash outflows for claims payments would exceed its inflows from newly received premiums. However, a health entity with a relatively stable enrollment and claims experience within expectations may feel it can safely accept some durational mismatch between its assets and liabilities and may invest in more long-term invested assets in order to increase its investment yield. Therefore, the analyst should consider reviewing the Pricing/Underwriting Risk Assessment in conjunction with Liquidity. Those health entities writing long-tailed business may also own long-term invested assets to support those lines' liabilities.

Z-Score Analysis (Health Only)

The Z-Score analysis included in the Annual Financial Profile. The Z-Score is a way to measure and monitor financial performance by analyzing specific ratios over a period of time. If a result of less than 2.6 occurs, analysts should consider reviewing the individual ratios within the Z-Score. An unstable trend of the Z-Score or a low Z-Score may indicate increased risk to the solvency of the health entity and analysts should take a closer look at each of the ratio results in the Financial Profile. There are four ratios in the Z-Score; however, the Z-Score places the most emphasis on working capital and earnings. The following briefly explains each ratio within the Z-Score, although more detail is available in the link to the *Z-Score Document* on iSite+.

- *Working Capital to Total Assets* measures the ability of a health entity to manage working capital, which is fundamental for all business. While a health entity may have sufficient surplus, they may have insufficient working capital to pay claims due to related party transactions and other non-liquid long-term investments. Analysts should also consider that while working capital may be above the threshold, it may still not provide a sufficient cushion for significant unexpected losses. Refer to the discussion of procedure #1c above.
- *Retained Equity to Total Assets* reflects the age of the business and the philosophy of management. This assumes that a more mature business would normally have more capital and surplus. Companies that have been in business fewer years and have insufficient management experience tend to have higher failure rates.
- *Earnings Before Interest & Taxes (EBIT) to Total Assets* measures a health entity's earnings performance. This ratio is weighted the highest for several reasons including the following: 1) significant shifts in earnings may indicate a highly risky industry with unstable cash flows; 2) health entities must balance consumer demands with cost management; and 3) Medicare and Medicaid programs and other outside factors can have a significant impact on the health entity's financial condition.
- *Capital and Surplus to Total Liabilities* is the leverage measure within the Z-Score and is the inverse of the traditional debt to equity ratio.

Procedures / Data

- Total Z-Score.
- Decrease in Z-Score from the prior year where the total Z-Score is 6.0 or less in the current year.
- Decrease in the Z-Score over the past three years if the Z-Score is 6.0 or less in the current year.
- Ratio of working capital to total assets.

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- Review the working capital to total assets ratio for the past years and assess any unusual fluctuations or negative trends.

Impact of Volatility in the Value of Bond Portfolio on Liquidity, OR Impact of Maturity of Bond Portfolio on Liquidity

Bond holdings are a substantial component of most insurers' investment portfolios. Their value and maturity can significantly affect an insurer's liquidity. Bond prices fluctuate due to factors like interest rate changes, issuer creditworthiness, and economic conditions. A decline in bond values can reduce an insurer's overall assets and potentially impact its liquidity. The maturity of an insurer's bond portfolio is also crucial. Short-term bonds offer more predictable cash flows as they approach redemption, benefiting insurers needing to meet regular claims payments or other liquidity demands. Longer-term bonds are more sensitive to interest rate changes. Bond prices and interest rates have an inverse relationship. Rising interest rates can decrease the value of existing bonds, potentially affecting an insurer's liquidity.

Procedures

- Review the Annual Financial Statement, Schedule D – Part 1A and identify any material fluctuations/trends.
- Determine if the the maturity of the insurer’s bond portfolio aligns with its most recent investment plan and adequately matches future liabilities.
- Review the Annual Financial Statement, Schedule D – Part 1, Sections 1 and 2 and determine the extent to which the fair value of bonds varies from the statement value. Assess the impact of such variance on the insurer’s overall liquidity.
- Review the Annual Financial Statement, including Notes to Financial Statements – Note #5 to assess if there are liquidity concerns due to a material exposure to highly structured bonds, including RMBS, loan-backed and structured securities and structured notes.

Exposure to Private Placement Bonds

Significant investments in privately-placed bonds may cause concerns regarding the insurer’s liquidity because some of these investments cannot be resold, while those that can be resold have restrictions on whom they can be sold to, including restrictions under securities laws. There is no structured market for privately-placed bonds like there is for publicly-traded bonds. Therefore, even if the privately-placed bonds can be sold, it may be difficult to find a willing buyer.

Procedures / Data

- Ratio of private-placement bonds owned to policyholder surplus (P/C), to capital and surplus plus AVR (Life/A&H) and to capital and surplus (Health)
- Increase in private placement bonds from the prior year

Additional Review Considerations

- Review Annual Financial Statement, Schedule D – Part 1A to determine the amount, issue type, NAIC designations, maturity distribution of privately-placed bonds owned, and the amount of privately placed bonds that are freely tradeable under U.S. Securities and Exchange Commission (SEC) Rule 144 or qualified for resale under SEC Rule 144A.
- For significant privately-placed bonds rated by a chief revenue officer, review the issuer’s rating or request the Securities Valuation Office’s assessment of the designation to evaluate the issuer’s financial position and ability to repay its debt.

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Exposure to Other Invested Assets (Schedule BA)

Other Invested Assets (or Schedule BA Assets) are long-term investments not clearly or normally categorized within other asset schedules. These investments often involve a higher degree of complexity or illiquidity. Examples include joint ventures and partnerships, structured securities, oil and gas production, mineral rights, surplus debentures, collateralized and non-collateralized loans, and other specialized investments. While generally considered less liquid, the liquidity of Schedule BA Assets can vary significantly based on market conditions and the specific nature of each asset.

Specific liquidity risks related to BA Assets may include:

- Significant amount of Schedule BA assets held with commitments/ collateral requirements—Schedule BA assets may include commitments for additional funding, which is common in private equity funds. Schedule BA assets may have the potential to be required to post additional collateral, similar to variation margin for derivatives.
- Expected cash flows from Schedule BA assets and types of other structured bonds—Certain Schedule BA assets and highly structured bonds, including RMBS, LBaSS, and structured notes, may include liquidity risks where expected cash flows do not match the actual cash flows.
- Significant amount of BA Assets held with resale restrictions—Illiquidity of certain assets may be due to provisions of the asset, such as restrictions on resale. (E.g., certain BA assets, such as investment hedge funds, may have time restrictions on when investment can be sold/liquidated.)

Procedures / Data

- Ratio of Schedule BA Assets to policyholder surplus (P/C), to capital and surplus plus AVR (Life/A&H) and to capital and surplus (Health)
- Increase in Schedule BA Assets from the prior year

Additional Review Considerations

- Review Annual Financial Statement – Schedule BA to detrmine whether the insurer invested in any assets, such as hedge funds or private equity funds, that may include restrictions on an investor's ability to liquidate the assets, commitments for additional funding (common in private equity funds), or have the potential to be required to post additional collateral.

Exposure to Restricted Assets within the Securities Lending Program,
OR
Liquidity of Reinvested Collateral within the Securities Lending Program (P/C and Life/A&H)

Determine if concerns exist regarding the materiality of securities lending activity and the nature of the reinvested collateral.

Procedures / Data

- Does the reporting entity engage in securities lending transactions?
  - Ratio of securities lending collateral reinvested to total assets
  - Aggregate total collateral received

Additional Review Considerations

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- Review Annual Financial Statement investment schedules, General Interrogatories, and Notes to Financial Statements to gain an understanding of the scope of the securities lending program and restricted assets, and to understand how the cash collateral is reinvested (Schedule DL, Parts 1 and 2).

Illiquidity of Separate Account Assets, OR Negative Economic Impacts on Liquidity of Separate Accounts (Life/A&H)

Determine the materiality of separate account assets and the potential impact on the liquidity of the insurer in the event of large withdrawals from separate accounts. Liquidity risks related to separate accounts can include:

- Illiquidity of separate account assets—Risk that liquid assets are insufficient to meet surrender benefits, resulting in insufficient cash flows.
- Negative economic impact on separate account liquidity—Risk that market decline results in the need for policyholder cash, resulting in the potential negative impact or a "run on the bank" scenario.

Procedures / Data

- Does the reporting entity engage in securities lending transactions with separate account transactions?
  - Ratio of total separate account assets to total assets
  - Aggregate total collateral received

Additional Review Considerations

- Review the investment schedules, General Interrogatories and Notes to the Financial Statements to gain an understanding of the scope of the securities lending program and restricted assets, and to understand how the cash collateral is reinvested (Schedule DL – Parts 1 and 2).
- Does the reporting entity report Federal Home Loan Bank (FHLB) funding agreements within the separate account(s)? If so, assess the materiality of the FHLB agreements.

Exposure to Affiliated Investments

This procedure involves assessing the significance of investments in affiliated companies. Affiliated investments are often illiquid, which can negatively affect the insurer's overall liquidity, especially when they constitute a significant portion of its portfolio. Investments in parent, subsidiaries, or affiliates (PSA) may not be marketable and unavailable to pay policyholder claims. Excessive affiliated investments may also divert capital from other opportunities with potentially higher returns. Therefore, a thorough analysis of the business purpose and benefits of such investments is essential. When affiliated investments are substantial, analysts should carefully review the financial statements of the affiliate to gain a comprehensive understanding of its financial health and potential risks.

Procedures / Data

- Ratio of affiliated investments to policyholder surplus (P/C), to capital and surplus plus AVR (Life/A&H) and to capital and surplus (Health)
- Change in total affiliated investments from the prior year
- Change in any category of affiliated investments from the prior year

Additional Review Considerations

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- If the Company owns interest in the capital stock of another insurance company, review Schedule Y to determine if the investment was properly disclosed.
- Review the results of the Holding Company Analysis completed by the lead state to determine if any concerns exist regarding affiliated entities.
- Review Annual Financial Statement, Notes to Financial Statements, Note #10 and Note #14 to identify if the insurer is subject to any guarantees or other commitments to (PSA). If the guarantee or commitment is material to the insurer, assess the nature of the agreement and the financial strength of the PSA.

Exposure to Other Less Liquid Receivables (Health)

Review the assets of a health entity that may have limited marketability, such as furniture, equipment, and software.

Furniture and equipment includes not only administrative furniture and equipment but also health care delivery assets such as furniture, medical equipment and fixtures, pharmaceuticals and surgical supplies, and durable medical equipment.

Statement of Statutory Accounting Principles (SSAP) *No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities* describes health care delivery assets as those assets that are used in connection with the direct delivery of health care services in facilities owned or operated by the health entity. SSAP No. 73 further provides that these types of assets shall be admitted provided they meet the definitions of health care delivery assets as set forth in the SSAP. As a result of this accounting guidance, it is possible that a health entity with these types of assets will have a much different mix of assets than other health entities that do not use these types of assets in its operations. It should be noted that the depreciation period for health care delivery assets is limited to three years, which varies from the depreciation period for similar assets that are non-admitted.

Analysis of these assets should consist primarily of ongoing monitoring of the balances, the relative change, and the relationship of that change with what is expected based upon other trends/activity within the health entity.

As discussed in SSAP *No. 16—Electronic Data Processing Equipment and Software,* electronic data processing (EDP) equipment and operating system software are admitted assets to the extent they conform to the requirements of *SSAP No. 4—Assets and Nonadmitted Assets*. The admitted asset is limited to three percent of capital and surplus; adjusted to exclude any EDP equipment and software, net deferred tax assets, and net positive goodwill. However, SSAP No. 16 provides that non-operating system software is a non-admitted asset. EDP equipment and software depreciated for a period not to exceed three years using methods detailed in *SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements*.

EDP assets generally are subject to various state specific limitations, such as a minimum amount that can be capitalized as an asset, a maximum depreciable life, and/or limits that may be admitted as a percentage of total admitted assets or capital and surplus. These limitations are put in place to avoid undue concentrations of assets that have less marketability than other admitted assets and rapid technological obsolescence. Because of this, the amount reported by a health entity is generally limited to an amount that is not significantly material to the health entity's financial position. It is also common to find that the health entity reports no EDP assets. In these cases, the health entity often relies upon a parent or an affiliated company to provide EDP services with a resultant charge back through a management or service agreement.

Analysis of EDP assets should consist primarily of ongoing monitoring of the balances, the relative change, and the relationship of that change with what is expected based upon other trends/activity within the health entity.

Procedures / Data

- Ratio of admitted furniture, equipment and supplies to capital and surplus

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- Change in the admitted balance of furniture, equipment and supplies from the prior year
- Ratio of admitted EDP equipment and software to capital and surplus
- Change in admitted EDP equipment and software from the prior year

Additional Review Considerations

- Review Annual Financial Statement – Exhibit 8 for the reporting distribution of furniture, equipment and supplies.
- If there are concerns regarding furniture, equipment and supplies, request and review:
  - Clarification of any unusual responses from its independent auditor.
  - Information regarding depreciation and review for reasonableness. Determine if the depreciation period exceeds three years.
- Regarding EDP equipment:
  - Review disclosures in the Notes to the Audited Financial Report for reasonableness.
  - Perform a review to determine whether the minimum capitalization amount, depreciable life and admissibility are in compliance with statutory limitations.
  - Request a description of the methodology used to compute depreciation.
    - Determine if the period of depreciation exceeds three years.
    - Determine if the insurer non-admitted non-operating software.
- Review the management or service agreements, if any, which provide for EDP services and evaluate whether the charges appear reasonable for the services provided.
- If the insurer did not report an asset for EDP equipment and operating system software, does a management or service agreement exist that provides for electronic data processing services?

Significant Amount of Special Deposits

Determine if the insurer is exposed to greater-than-normal liquidity risk with respect to special deposits.

Special deposits are segregated into two sections: 1) for the benefit of all policyholders; and 2) all other special deposits. Both categories reflect amounts aggregated by state. Deposits for the benefit of all policyholders are held by individual states. The assets composing these deposits are held on the various investment schedules in the financial statement. However, the assets are not held in custody of the insurer, and restrictions are placed on the assets disposal. Special deposit assets may be unavailable to pay policyholder claims. In a situation of a rehabilitation of an insurer or a troubled insurer, these restrictions on assets may cause concerns, particularly those not held for the benefit of all policyholders.

This procedure also assists analyst in determining if the domiciliary state may be having difficulty in calling deposits that are deemed “all other special deposits,” specifically when the level of deposits that are not for the benefit of all policyholders as a percentage of total assets is high, or in cases when the insurer has been determined to be troubled. Analysts may consider this assessment necessary in either of those cases because, once the insurer has moved into rehabilitation, the cash flow position of the insurer may deteriorate rapidly.

Procedures / Data

- Review Annual Financial Statement – Schedule E Part 3 to determine if any concerns exist regarding special deposits.
  - Ratio of book adjusted carrying value of total special deposits to total net admitted assets.

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- Ratio of book adjusted carrying value of all other special deposits (not for the benefit of all policyholders) to total special deposits.
- Difference between the book adjusted carrying value and fair value of total special deposits.

Additional Review Considerations

- Review the listing of special deposits held by the insurer not for the benefit of all policyholders and there is overall liquidity risk regarding the insurer, consider:
  - The number of states in which the insurer has these types of deposits. The greater the number, the more difficult it could be for the domiciliary state to call on these deposits in a rehabilitation.
  - The amount of concentration in any one particular state.
- Contact the domiciliary state or perform research to determine if any of the states have restrictions on the ability of those deposits to be called by the domiciliary state during a rehabilitation.

Liquidity Strain of Surrender and Withdrawal Activity (Life/A&H)

Determine whether surrenders and withdrawals on life and annuity products are significantly affecting the insurer's liquidity position and are trending negatively. In addition, significant levels of guaranteed interest contracts or amounts subject to minimal or no surrender charges can be identified as well.

Liquidity strain of surrenders and withdrawals may be the result of:

- Market decline that results in the need for policyholder cash, resulting in the potential negative impact on availability of liquid assets or a "run on the bank" scenario.
- That liquid assets are insufficient to meet surrender benefits, resulting in insufficient cash from operations.
- Poor asset-liability matching and the potential negative impact

Procedures / Data

- Ratio of surrender benefits and withdrawals on deposit-type contracts to net premiums and deposits on deposit-type contracts
- Ratio of group surrenders to net group premiums in group annuities where group annuity surrenders exceed 20% of total surrenders
- Ratio of surrender benefits and withdrawals on deposit-type contracts to capital and surplus

Additional Review Considerations

- Review Annual Financial Statement, Notes to Financial Statements, Note #32. Determine if the insurer has a material amount of annuity reserves that can be withdrawn with minimal or no charge. (See the Financial Profile Report.)
- Determine which lines of business had significant surrender activity during the year or if there appears to be a negative trend in surrender activity over the past five years.
- Review the insurer's plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy withdrawal features and surrender charges.

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Negative (or Negative Trend in) Cash Flow from Operations

The Cash Flow Statement provides a comprehensive overview of an insurer's cash inflows and outflows. It is organized into three primary areas: operations, investing, and financing. By examining these components, analysts can gain valuable insights into the insurer's liquidity and overall financial health.

Identify situations where the insurer's operations are generating negative cash flow. Negative cash flow in this area can signal underlying financial weaknesses, such as increased claims activity, inefficient expense management, and changes in premiums collected due to revised business strategy or reinsurance agreements, among other factors that can drive negative cash flow from operations. Negative trends in cash flow from operations may create liquidity needs that may result in the sale of investments at a loss. Negative cash flow from operations should be evaluated closely for persistent negative trends. Additionally, analysts may scrutinize the insurer's reliance on investment income to offset negative cash from operations. While this practice is not inherently problematic, excessive reliance can indicate potential vulnerabilities to market fluctuations. For life insurers, analysts should also closely evaluate significant net transfers to or from separate accounts, as this could provide insights regarding potential financial problems.

The Cash Flow Statement also provides valuable information about how the insurer finances negative cash from operations. This can involve borrowing funds, issuing surplus notes, or receiving capital support from the parent company. Conversely, positive cash flow from operations is a positive indicator, suggesting the insurer's ability to generate sufficient revenue and manage claims and expenses effectively. Analysts may explore how this positive cash flow is allocated, whether it is reinvested in the business or returned to stockholders through dividends. A high reliance by affiliated companies on dividends paid by the insurer may represent an ongoing liquidity need.

Procedures / Data

- For Property/Casualty:
  - Ratio of net cash from operations to policyholders surplus
- For Life/A&H:
  - Ratio of net cash from operations to to capital and surplus
  - Ratio of prior year net cash from operations to capital and surplus
  - Ratio of net cash from operations to premium income
  - Ratio of other cash provided (applied) to capital and surplus
  - Ratio of other cash provided (applied) to net cash from operations
  - Change in other cash provided (applied) from the prior year
  - Ratio of net transfers to or from separate accounts to capital and surplus
- For Health:
  - Ratio of net cash from operations to capital and surplus
  - Ratio of prior year net cash from operations to capital and surplus
  - Ratio of net cash from operations to premium income
  - Ratio of other cash provided (applied) to capital and surplus
  - Ratio of other cash provided (applied) to net cash from operations
  - Change in other cash provided (applied) from the prior year
  - Ratio of benefits and loss related payments to premiums collected net of reinsurance

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- When the time it takes to pay claims lengthens, the liability for unpaid claims generally increases. An analyst should consider also reviewing the health entity's liability for unpaid claims balances, since an understatement of these liabilities could overstate the results of other cash flow metrics, such as net cash from operations to capital and surplus, net cash from operations to net premium income, and change in other cash provided (applied) from the prior year. An increase in current liabilities increases the health entity's current cash requirements. A longer claims payment period could indicate the health entity is holding cash for other purposes.

- Average number of days of unpaid claims

Additional Review Considerations

- Review the cash flow from operations to determine the underlying cause of the negative cash flow.
- Review the trend in net cash from operations for the past five years and note any unusual fluctuations or negative trends between years.
- Describe any material commitments for capital expenditures as of the end of the reporting period indicating the purpose, anticipated source of funds, changes between equity and debt, and any off-balance sheet financing agreements.
- Compare cash flow from operations with the industry and peer group (Peer Financial Report) in order to identify significant deviations.
- Life/A&H: Review the trend in transfer to/from separate accounts for unusual fluctation, such as significant reliance on cash provided from separate accounts and significant trends in providing cash to separate accounts.
- Health: Review the sources, including the Management's Discussion and Analysis and the Asset Adequacy Analysis from the Statement of Actuarial Opinion (if required) to determine if concerns exist relating to cash flow and liquidity or asset adequacy.
  - An asset adequacy analysis is generally not required for a health entity; however, for companies filing the health blank that also write life business, this may be required.
- Health: Review changes in the average number of days of unpaid claims in past years for unusual fluctuations or negative trends between years.

Related Party Exposure in the Investment Portfolio

Determine related party exposure in the investment portfolio and assess any related liquidity risk.

Related parties are entities that have common interests as a result of ownership, control, affiliation or by contract as definited in *SSAP No. 25—Affiliates and Other Related Parties* (SSAP No. 25). Refer to the *Insurance Holding Company System Model Act* (Model #440) and SSAP No. 25 for a broader definition of "affiliate," "related party" and "control".

Related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the reporting entity or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny.

The anlayst should utilize the tools available in iSite+ to identify if the insurer has a material exposure to investments involving related parties, either on an asset category basis or in aggregate, and by the related party designation noted below. If a material exposure exists, further assessment of the [credit, market, liquidity] risk may be warranted. For example, what is the NAIC designation of investments involving related parties? Analysts may also consider the extent to which related parties are involved in securitizing or originating business for the insurer, and what differences may exist in how investments involving related parties are valued. If the role of the

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related party is that of a third-party advisor, factors to consider may include for example, the expertise of the related party advisor, any potential conflicts of interest, and if related parties are originating investments only for the insurer or also to the public, the latter being subject to SEC requirements. The analyst may consider utilizing suggested procedures in the "Additional Procedures" section on third-party advisors, if applicable.

Within the Annual Financial Statement investment Schedules B, BA, D, DA, DB, DL, and E (Part 2), all investments involving related parties must incude disclosure to ensure full transparency. This disclosure is in the column "Investments Involving Related Parites". It designates investments by the following roles:

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.
2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.
3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.
4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.
5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.
6. The investment does not involve a related party.

Procedures

- Review the Annual Financial Statement investment schedules, as disclosed in the column "Investments Involving Related Parties" and utilizing iSite+ tools, determine if the insurer has material related party exposures in its investment portfolio. This disclosure is included in Schedule B, Schedule BA, Schedule D, Schedule DA, Schedule DB, Schedule DL, and Schedule E, Part 2.
    - Consider exposure by asset class and in aggregate, and by the role of the related party in the investment as designed by the "Investments Involving Related Parties" disclosure.
- If concerns exist regarding a material related party exposure in the investment portfolio, assess the credit quality of those investments involving related parties by reviewing designations, assessing historical default experience, etc.
- If concerns exist regarding a material related party exposure in investment management or advisory services, consider the following:
    - Review the procedures in the "Additional Procedures" section below regarding Third Party Investment Advisors and consider their application to related party advisors in that role.
    - In addition to the additional analysis procedures regarding third party investment advisors, consider the following:
        - Review the insurer's investment policy guidelines and determine whether the related party investments follow the guidelines and are in compliance with regulatory requirements.

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- Review whether the fee structure for asset management is fair, reasonable, and appropriately recognized as investment expenses.
- If the related party asset manager also originates/securitizes investments held by the insurer, consider requesting additional information from the insurer to determine the following:
  - Whether the asset manager has adequate experience and knowledge in originating and managing the types of investments;
  - Whether the asset manager follows appropriate underwriting practices and applicable regulatory requirements in originating investments; and
  - Whether the fee structures embedded in securities (if applicable) are fair, reasonable, and appropriately account for potential duplication of fees or conflicts of interest.

Invested Asset Exposure to Climate Change, Transition and Asset Devaluation Risk

Identify and assess the potential exposure of the insurer's investment portfolio to the impact of material climate change and/or energy transition risks and asset devaluation risk. The insurer's investment portfolio is subject to prospective devaluation of the assets/changes in the asset return associated with its holdings of climate-affected assets. Transition risks refer to stresses on certain investment holdings arising from the shifts in policy, consumer and business sentiment, or technologies associated with the changes necessary to limit climate change. A few examples of investment holdings and sectors generally subject to greater levels of transition risk include, oil/gas, transportation, heavy manufacturing, and agriculture. In assessing an insurer's exposure to these risks, the analyst is encouraged to review information disclosed by the insurer in its responses to the NAIC's Climate Risk Disclosure Survey, U.S. Securities and Exchange Commission (SEC) filings, and/or the Own Risk and Solvency Assessment (ORSA) Summary Report filings. In addition, the analyst is encouraged to review the results of basic scenario analysis conducted by the NAIC using insurers' Annual Statement filings (U.S. Insurance Industry Climate Affected Investment Analysis) to identify potential concentrations in exposure.

Procedures

- Review information provided in the insurer's response to the NAIC's Climate Risk and Disclosure Survey (if available) on its exposure to material climate change/energy transition risk and related mitigation activity in this area.
- Review relevant information provided in the Own Risk and Solvency Assessment (ORSA) Summary Report, and/or U.S. Securities and Exchange Commission (SEC) 10-K or 10-Q filings (if available) that discusses the insurer's exposure to material climate change/energy transition risk and related mitigation activity in this area.
- Review information provided in the NAIC's U.S. Insurance Industry Climate Affected Investment Analysis to identify potential concentrations in insurer exposure.

Additional Review Considerations

- Review the insurer's investment policies and strategies to assess whether material climate change, transition and asset devaluation risk considerations have been appropriately implemented into the company's investment processes.
- Review the most recent examination report and summary review memorandum (SRM) for any findings regarding climate change/energy transition risks.
- If concerns exist, consider requesting information from the insurer regarding how the insurer manages its exposure to material climate change/energy transition risk, including how it identifies and estimates current and prospective exposures and the limits (if any) in place to avoid concentrations.

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Significant Assessments Against Policy Benefits (Fraternal Only)

Determine if the fraternal society has implemented assessments (i.e., liens) against policyholder benefits, which are generally used to increase surplus. If concerns exist, information should be gathered and assessed as to the nature and duration of the liens, and the use of the funds derived from the liens.

Procedures / Data:

- For fraternal societies, did the society report outstanding assessments in the form of liens against policy benefits that have increased surplus?
- Assess the materiality of outstanding assessments. Review the ratio of total liens as a percentage of total current year surplus
- Were new assessments imposed in the current year? Review any information the department has on the nature and duration of the liens. [Annual Financial Statement, General Interrogatories – Part 2 – #36.2]

ADDITIONAL PROCEDURES

Investment Policies and Strategy

To assess the insurer's investment strategy, consider requesting and reviewing a copy of their formal adopted investment plan. Evaluate the plan to determine if it aligns with the insurer's business, liquidity, and cash flow needs. Additionally, verify whether the insurer is adhering to the plan's guidelines for the following:

- *Investment Qualitfy and Diversification:* Evaluate the quality of investments, diversification standards (issuer, industry, duration, liquidity, geographic location), and exposure to climate-related risks.
- *Performance:* Compare expected and actual investment returns.
- *Investment Growth:* Analyze planned increases in investment types, sectors, and markets.
- *Asset-Liability Analysis:* Assess whether the investment plan aligns with the insurer's liability structure. This may involve reviewing asset adequacy analysis and discussing the insurer's plans with management.

Upon review of the investment plan, compare the plan to actual results to help determine if the insurer and its investment manager(s) appear to be adhering to the investment policies and guidelines in the investment plan.

Examination Findings

Consider reviewing the recent examination report, Summary Review Memorandum (SRM) and communication with the examination staff to identify if any findings regarding liquidity risks associated with:

- Asset liability matching and cash flow stress testing
- Investment returns
- Climate change, transition, and asset devaluationEffective management of the insurer's liquidity position
- Other-than-temporary impairment OTTI
- Investment valuation issues
- Adherence to investment policies and strategies
- Investment management, and use of and monitoring of external investment managers
- Determine if liquidity concerns identified during the last exam have been addressed

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If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

NAIC Capital Markets Bureau Analytical Assistance

Consider requesting the NAIC's Capital Markets Bureau (CMB) to assist with investment portfolio or investment management agreement analysis. The CMB has different levels of analysis that can be arranged to assist the state.

Third-Party Investment Advisors

Determine whether concerns exist regarding the use of third-party investment advisers. As investments and investment strategies grow in complexity, insurers may consider the use of unaffiliated third-party investment advisers to manage their investment strategy. Investment advisers may operate independently or as part of an investment company. Investment advisers and companies are subject to regulation by the SEC and/or by the states in which they operate, generally based on the size of their business. In certain situations, insurers may use a broker-dealer for investment advice. Broker-dealers are subject to regulation by the Financial Industry Regulatory Authority (FINRA). Regardless, most broker-dealers and investment advisers will register with the SEC and annually update a Form ADV–Uniform Application for Investment Adviser Registration and Report Form by Exempt Reporting Advisers, which provides extensive information about the nature of the organization's operations. To locate these forms, analysts can go to *https.//adviserinfo.sec.gov* and perform a search based on the company name.

Key information provided on a Form ADV includes:

a. Regulatory agencies and states in which the adviser/broker is registered.

b. Information about the advisory business including size of operations and types of customers (Item 5).

c. Information about whether the company provides custodial services (Item 9).

d. Information about disciplinary action and/or criminal records (Item 11).

e. A report of the independent public accountant verifying compliance if the investment advisor also acts as a custodian.

It is important to note that the information provided on Form ADV is self-reported and is subject to limited regulatory oversight. However, the information may be valuable to analysts in assessing the suitability and capability of investment advisers providing advisory services to insurers. In addition, although not expressly prohibited (as discussed at e. above), it is a best practice for the insurer to choose a national bank, state bank, trust company or broker/dealer which participates in a clearing corporation, other than its investment manager/advisor, to hold its assets in custody to promote segregation of duties. See additional guidance on custodial expectations in Section 1.III.F – Outsourcing of Critical Functions of the NAIC's Financial Condition Examiners Handbook.

Analysts should consider any significant risks identified in the most recent risk-focused examination and whether any follow-up procedures were recommended by the examiner. The examiner may have performed steps to determine the following; whether the investment adviser is suitable for the role (including whether he/she is registered and in good standing with the SEC and/or state securities regulators); whether the investment advisory agreements contain appropriate provisions; whether the adviser is acting in accordance with the agreement; and whether management/board oversight of the investment adviser is sufficient for the relationships in place.

Analysts should determine if changes have occurred in the insurer's use of investment advisers that may prospectively impact the insurer's investment strategy and overall management of the investment portfolio. If changes have occurred, analysts may consider asking the insurer for an explanation for the change in investment advisers and obtain a copy of the new adviser agreement to gain an understanding of the provisions including

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the advisor's authority, specific reference to compliance with the insurer's investment strategy and/or policy statements, as well as state investment laws; conficts of interest; fiduciary responsibilities; fees; and the insurer's review of the adviser's performance. Refer to the Financial Condition Examiners Handbook for further guidance and see V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for additional guidance on reviewing affiliated investment management agreements.

Analysts can determine if the investment advisor is in good standing with the SEC. The SEC does not officially use the term "good standing"; however, for this analysis, the term is used to mean a firm that is registered as an investment adviser with the SEC and does not report disciplinary actions or criminal records in Item 11 of the Form ADV.

If the insurer uses an external asset manager and if investments on Schedule BA Assets are invested in funds that are affiliated with the asset manager or are managed by that asset manager, analysts should consider several possible issues that may result from this scenario. A possible concern may exist when the asset manager is also managing other funds in addition to managing assets for the insurer and then invests the insurer's assets in those other funds that the asset manager manages. While those funds may be good investments, both in general and for the insurer, there are a few issues that may need to be considered. First, is the potential for a conflict of interest if the asset manager is using the insurer's available funds to provide seed money or fund the manager's other funds. Second, is if any concerns exist regarding the appropriateness of the fund for the insurer's investment portfolio and if the transactions would be considered on an arm's-length basis. Third, is the understanding that the insurer may be paying overlapping fees as the insurer would pay the asset manager a fee for the investment and then also pay a fee within the fund investment. There may be similar concerns with other complex investments such as structured securities that are originated by the asset manager or one of its affiliates/related parties. The fees associated with these investments could be considered arms-length and appropriate but would require further review and potentially additional support or documentation to make that determination.

- Assess and determine if any concerns exist regarding third party investment advisers and associated contractual arrangements.
    - Review Annual Financial Statement, General Interrogatories – Part 1 – #29.05. Does the insurer utilize third party investment advisors, broker/dealer or individuals acting on behalf of the insurer with access to their investment accounts?

        If "yes", consider the following procedures:

        - Verify that all affiliated and unaffiliated investment advisors the analyst is aware of are disclosed in the interrogatory, whether primary or sub-advisors.
            - Verify that Investment Management Agreements required to be filed with the department have been filed and consider requesting copies of agreements that have not been filed with the department for review.
            - Gain an understanding of the types of investments that are being managed by each of the advisors/sub-advisors disclosed in the interrogatory.
                - Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners. Did the examination identify any issues with regard to investment advisers and associated contractual arrangements that require follow-up analysis or communication with the insurer? If yes, document the follow-up work performed.
                - Compare Annual Financial Statement, General Interrogatories – Part 1 – #29.05 for the current year to the prior year to determine if there have been any changes in advisors.
                    - If "yes":

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- Consider obtaining an explanation for the change from the insurer.
- Consider obtaining a copy of the new investment advisor agreement and review it for appropriate provisions.

- Using the information reported in Annual Financial Statement, General Interrogatories, Part 1 – #29.05, obtain and review SEC Form ADV (if available), to determine if the investment advisor is in good standing with the SEC. If not in good standing, contact the insurer to request an explanation.
- If agreements with third party investment advisers are affiliated, have the appropriate Form D – Prior Notice of Transactions been filed and approved by the department? Were any concerns noted or follow-up monitoring recommended?
    - See additional guidance in V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for reviewing affiliated investment manager agreements.
- Request information from the insurer regarding the background and expertise in any complex or non-traditional assets (such as structured securities, mortgage loans, investment funds) of its investment advisors (in-house and/or contractual) and its analytical system capabilities. Determine whether the advisors and systems are adequate to allow the insurer to continuously monitor its investments.
- If the insurer uses an external asset manager, consider if there are any investments that may represent a potential for conflict. Examples of this are (1) if there are Investments Report on Schedule BA that are funds that are affiliated/related with the asset manager or are managed by that asset manager, (2) Structured Securities in which the asset manager or an affiliate/related party had a role in originating, or (3) direct investments in the asset manager or any of its affiliates/related parties. If the external asset manager qualifies as a related party, utilize guidance provided in the "Related Party Exposure in the Investment Portfolio" section above to assist in this review. Consider the following issues:
    - Have any potential conflicts of interest been reviewed and formally approved by the Board or Investment Committee.
    - If the investment is appropriate for the insurer's portfolio and is arm's-length.
    - If the insurer is paying overlapping fees.

Inquire of the Insurer

Consider requesting additional information from the insurer if liquidity risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of liquidity risk for specific topics where concerns have been identified.

- General Investment Inquiries
    - If management has adequately reviewed the investment portfolio and understand the yields, underlying collateral, cash flows and investment volatility.
    - Any additional concentration by collateral type.
    - Management's process for valuing securities to assist the analyst in assessing if the securities are valued appropriately.
    - Management's intended use of certain riskier investments and purpose within the insurer's portfolio.
    - If management has an appropriate level of knowledge and expertise with the type of securities being purchased/held.
    - If the insurer has controls implemented to mitigate the risks associated with this investment type.
    - Sources of liquidity, such as letters of credit (LOCs).

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- Information/explanation of guarantees or other commitments to PSA.
- Securities lending program (nature, size, reinvestment policies, etc.).
- Separate accounts plan descriptions and/or policy forms as they relate to its securities lending program (Life/A&H).

- Investment Diversification
  - Planned asset mix and diversification strategies.
- Mortgages
  - Handling of foreclosed mortgage loans.
- BA Assets
  - Information regarding the liquidity of non-traditional investments to ensure that limitations in this area are understood.
  - Current Audited Financial Statements and other documents (partnership agreements, etc.) necessary to support the value of the insurer's investment in partnerships and joint ventures.
  - Information necessary to support the value of significant other invested assets other than partnerships and joint ventures.
  - Current details on cash flows and returns for the different types of investments, especially hedge funds and private equity funds.
- Financial and Non-Financial Asset-Backed Securities
  - Percentage distribution and amounts of asset-backed securites (e.g. Agency RMBS/CMBS, Non-Agency RMBS/CMBS, CLO/CBO/CDO, Other ABS) held; planned amortization class (PAC), support bonds, interest only (IO) tranches, and principle only (PO) tranches to evaluate the level of prepayment risk in the portfolio.
  - Projected prepayment speeds on its RMBS portfolio and compare with historical prepayments, as well as the prepayment assumption at the time of purchase.

Own Risk and Solvency Assessment (ORSA)

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing risks faced by the insurer.

If the insurer is required to file an ORSA or is part of a group that is required to file an ORSA,

- Determine whether the ORSA Summary Report analysis conducted by the lead state indicate any liquidity risks that require further monitoring or follow-up.
- Determine whether the ORSA Summary Report analysis conducted by the lead state indicate any mitigating strategies for existing or prospective liquidity risks.
- For relevant business types, determine whether the ORSA Summary Report analysis conducted by the lead state indicate any liquidity risks regarding catastrophic exposure and related mitigating strategies.

Holding Company Analysis

Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

- Determine whether the Holding Company Analysis conducted by the lead state indicate any liquidity risks impacting the insurer that require further monitoring or follow-up.

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- Determine whether the Holding Company Analysis conducted by the lead state indicate any mitigating strategies for existing or prospective liquidity risks impacting the insurer.

Actuarial Filings, Including Asset Liability Matching (Life/A&H and Health)

- Review of the Statement of Actuarial Opinion or other actuarial filings for any concerns regarding the adequacy of asset liability matching, cash flow stress testing and the sufficiency of assets to meet the business obligations of the insurer.
- If concerns are identified regarding overall liquidity of the asset portfolio, request a copy of the insurer's asset-liability matching policy and/or liquidity stress testing/scenario analysis.

QUARTERLY LIQUIDITY RISK ASSESSMENT

The quarterly liquidity risk procedures are designed to identify the following. For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Insufficient Overall Liquidity (or Illiquid Assets are Significant)

Procedures / Data

- Analyze the insurer's liquidity position by reviewing the following metrics and data elements:
  - P/C: ratio of adjusted liabilities to liquid assets and the change from prior year
  - Life/A&H:
    - Ratio of capital and surplus plus AVR to total assets (excluding separate accounts)
    - Change in liquid assets from prior quarter-to-date or prior year-end
  - Health:
    - Ratio of liquid assets (excluding non-investment grade bonds) and receivables to current liabilities
    - Change in liquid assets from prior year-end
    - Ratio of working capital to total assets

Additional Procedures

- Review the liquidity ratio (P/C), liquidity (Life/A&H), and the ratio of total liabilities to liquid assets (Health) within the Financial Profile Report and document any unusual fluctuations over the last five years.
- If concerns are identified regarding overall liquidity of the asset portfolio, identify and assess other sources of liquidity available to the insurer. (Or request information from the insurer if necessary. See Additional Analysis and Follow-Up Procedures below).
- Assess the impact of market conditions through consideration of industry and economic events (i.e., news, industry analytics). Is the analyst aware of any market conditions that may threaten the liquidity of insurers' investment portfolios (e.g., market dislocation or other events that could affect liquidity of assets classes such as structured securities, structured notes, Schedule BA assets and non-investment grade bonds).

Exposure to Other Invested Assets (Schedule BA)

Determine whether there are concerns due to the level of investment in Schedule BA Assets.

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Procedures / Data

- Ratio of Schedule BA Assets owned to policyholders surplus (P/C) to net admitted assets (Life/A&H) and to capital and surplus (Health)
- Increase in Schedule BA Assets from the prior year-end, where the ratio of Schedule BA Assets to surplus is material

Liquidity of Reinvested Collateral within the Securities Lending Program (P/C and Life/A&H)

Determine if concerns exist regarding the materiality of securities lending activity and the nature of the reinvested collateral.

Procedures / Data

- Ratio of securities lending collateral reinvested to total assets
- Aggregate total collateral received

Additional Procedures

- Review the Quarterly Financial Statement General interrogatories, Part 1, #15 and Notes to the Financial Statements, Note #5 (if reported) to gain an understanding of the scope of the securities lending program and to understand how the cash collateral is reinvested.

Exposure to Affiliated Investments

Determine whether investments in affiliates are significant.

Procedures / Data

- Ratio of affiliated investments to policyholder surplus (P/C) and to capital and surplus (Life/A&H and Health)
- Change in total affiliated investments from the prior year
- Change in any category of affiliated investments from the prior year

Additional Procedures

- Review the results of the Holding Company Analysis completed by the lead state to determine if any concerns exist regarding affiliated entities.
- Review Quarterly Financial Statement, Notes to the Financial Statements, #10 and #14, if reported, to identify if the insurer is subject to any guarantees or other commitments to parent, subsidiaries, or affiliates (PSA). If the guarantee or commitment is material to the insurer, assess the nature of the agreement and the financial strength of the PSA.

Exposure to Other Less Liquid Receivables (Health)

Review and assess furniture, equipment, supplies, and EDP equipment.

Procedures / Data

- Ratio of admitted furniture, equipment and supplies to capital and surplus
- Change in the admitted balance of furniture, equipment and supplies from the prior year
- Ratio of admitted EDP equipment and software to capital and surplus

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- Change in admitted EDP equipment and software from the prior year

Negative (or Negative Trend in) Cash Flow from Operations

Review cash flow from operations and determine if any concerns exist.

Procedures / Data

- Property/Casualty:
  - Ratio of net cash from operations to policyholders surplus (P/C) and the change from prior year-to-date
- Life/A&H:
  - Ratio of net cash from operations to capital and surplus and the change from prior year-to-date
  - Ratio of net cash from operations to premium income
  - Ratio of other cash provided (applied) to capital and surplus
  - Ratio of other cash provided (applied) to net cash from operations
  - Change in other cash provided (applied)
  - Ratio of net transfers to or from separate accounts to capital and surplus and the change from the prior quarter-to-date
- Health:
  - Ratio of net cash from operations to capital and surplus and the change from prior year-to-date
  - Ratio of net cash from operations to premium income
  - Ratio of benefits and loss related payments to premiums collected net of reinsurance

Additional Review Considerations

- Review the cash flow from operations to determine the underlying cause of the negative cash flow.
- Review the trend in net cash from operations for the past five years and note any unusual fluctuations or negative trends between years.

Liquidity Strain of Surrender and Withdrawal Activity (Life/A&H)

Determine whether concerns exist regarding the insurer's surrender and withdrawal activity.

Procedures / Data

- Ratio of surrender benefits to net premiums
- Ratio of surrender benefits to capital and surplus
- Change in the ratio of surrender benefits to capital and surplus ratio

Additional Procedures

- Review Quarterly Financial Statement, Notes to Financial Statements, Note #32, if reported, to determine if the insurer has a material amount of annuity reserves withdrawable with minimal or no charge.
- Review the Quarterly Financial Profile Report to determine if there appears to be a negative trend in surrender activity over the past five quarters.

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- If concerns exist, review the insurer's plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy withdrawal features and surrender charges.

Significant Assessments Against Policy Benefits (Fraternal Societies Only)

Assess the materiality of a Fraternal Society's liens on policyholder benefits.

- For fraternal societies, did the society report outstanding assessments in the form of liens against policy benefits that have increased surplus? [General Interrogatories – Part 2 – #6.1]
- Review the ratio of total liens as a percentage of total current year surplus to assess the materiality of outstanding assessments.
- Determine if new assessments were imposed in the current year. Review any information the department has on the nature and duration of the liens [Quarterly Financial Statement, General Interrogatories – Part 2 – #6.2]

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MARKET RISK: Movement in market rates or prices (such as interest rates, foreign exchange rates or equity prices) adversely affect the reported and/or market value of investments.

The market risk assessment is focused primarily on exposure to market risk of investments and receivables. In analyzing market risk, the analyst may analyze specific types of investments and receivables held by insurers. An analyst's risk-focused assessment of market risk takes into consideration the following areas (but not be limited to):

- Diversification of assets subject to market risk
- Valuation of assets
- Economic/market impacts on asset value (e.g., real estate, etc.)
- Use of derivatives
- Investment turnover
- Capital gains and losses on investments
- Investment Income

Principles-Based Bond Definition (PBBD)

Beginning in 2025, investment schedules and certain other Notes to the Financial, General Interrogatories, 5-Year History, and related pages of the quarterly and annual financial statement were amended along with the implementation of the statutory accounting principles-based bond definition (PBBD) revisions.

Analysts should be aware that in some cases, changes between amounts reported on investment schedules and certain lines of the schedules may not be comparable to prior year (2024) or may vary from the prior year due to the bond definition change, in which an insurer may hold some securities that no longer meet the definition of a bond (or vice versa).

****Refer to the Credit Risk Assessment chapter of this Handbook for further information on the PBBD.***

ANNUAL MARKET RISK ASSESSMENT

Significant Investment Concentration by Asset Class

Determine whether the insurer's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by asset type, duration or issuer.

Various types of investments to total net admitted assets (excluding separate accounts for Life/A&H) are a measure of the diversity of the insurer's investment portfolio by type of investment. The results of these ratios may also provide some indication of the insurer's liquidity. In addition, the ratio of the investment in any one issuer to total net admitted assets (excluding separate accounts for Life/A&H) is a measure of the diversity of the insurer's investment portfolio by issuer.

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For foreign securites, market risk may include material exposures that could result in credit losses if those investments are affected by negative changes in geopolitical or foreign economic environments.

For mortgage loans, market risk may include the risk that the insurer is not properly identifying, handling and recording foreclosed mortgage loans.

Procedures/Data

- Consider evaluating the following assets classes in comparison to total admitted assets[i] to determine the level of concentration *(See also Credit Risk Assessment for diversification of other asset classes):*
  - Asset-Backed Securities.
  - Foreign bonds.
  - Common stocks.
  - Mortgage loans.
  - Real Estate (before encumbrances), including home office real estate.
  - Total derivatives (notional value).
  - Investment in affiliates.
  - Any one single investment in foreign bonds, common stock, real estate and derivatives (excluding afiliated investments) *(Note that single investments in financial asset-backed securities are considered within the Credit Risk Assessment).*

Additional Review Considerations

- Review the percentage distribution of assets for significant shifts in the mix of investments owned during the past five years.
- Compare the insurer's distribution of cash and invested assets to industry averages and peer averages on iSite+ to determine significant deviations from the industry averages. The comparison should focus on an appropriate peer group based on insurer type and asset size.
- If the insurer's investments include a significant amount of foreign bonds, review the Annual Supplemental Investment Risks Interrogatories (#4 through #11). Consider the insurer's potential foreign currency exposure from holding bonds denominated in a foreign currency.
- Review of the Annual Supplemental Investment Risks Interrogatories to identify any unusual items or areas and determine whether the insurer's investment portfolio is adequately diversified to avoid significant aggregate market risk.
- Review of the Legal Risk Assessment to determine whether the insurer's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws.
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.
- Inquire of the insurer its planned asset mix, and diversification strategies.

[i] For ratios in this asset concentration procedure, net admitted assets excludes separate accounts for Life/A&H.

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Valuation of Securities Not in Accordance with Standards, OR Economic Impact on Portfolio

Determine whether the securities owned by the insurer have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office (SVO) and Statutory Accounting Principles.

According to NAIC requirements, all securities purchased that are not filing exempt (FE) per the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) should be submitted to the SVO for valuation within 120 days of the purchase. In accordance with the NAIC *Annual Statement Instructions*, if the SVO provides an NAIC designation or price, that designation or price should be utilized. Insurers are required to complete the general interrogatory on compliance filing requirements of the P&P Manual and list exceptions as a component of the Annual Financial Statement. This interrogatory should indicate the following: 1) all prices or NAIC designations for the securities owned by the insurer that appear in the Valuation of Securities (VOS) product have been obtained directly from the SVO; 2) all securities previously valued by the insurer and identified with a "Z" suffix (which indicates that the security is not FE, does not appear in the SVO VOS product or has not been reviewed and approved in writing by the SVO) have either been submitted to the SVO for a valuation or disposed of; and 3) all necessary information on securities which have previously been designated NR (not rated due to lack of current information) by the SVO has been submitted to the SVO for a valuation or that the securities have been disposed.

Risks associated with valuation of securities may include:

- The securities reported on the balance sheet may not exist or may not be free of encumbrances.
- The insurer's investments reported on the balance sheet are incorrectly valued.
- The insurer's bonds, stocks and short-term investments that are considered hard-to-value, high-risk and/or subject to significant price variation are incorrectly valued.
- Portfolio value that is affected by volatility driven by economic changes/conditions.

Procedures

- Determine if the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office have been followed. Document any exceptions noted. [Annual Financial Statement, General Interrogatories, Part 1, #33.1 and #33.2]

Additional Review Considerations

- Assess the impact of market conditions:
    - Through consideration of industry and economic events (i.e., news and industry analytics), determine if there are any market conditions that may threaten the value of the insurers' investment portfolios.
    - Determine if the insurer is aware of any market conditions that could threaten the value of its investment portfolio through correspondence with the insurer.
- Determine if the insurer has complied with the requirement to submit securities that are not filing exempt to the Securities Valuation Office (SVO) for a valuation (i.e., there are securities which were acquired prior to the current year with a "Z" suffix after the NAIC designation and/or there is a significant number of securities which were acquired during the current year with a "Z" suffix after the NAIC designation) [Annual Financial Statement, Schedule D – Part 1, Section 1 and 2 and Schedule D – Part 2, Section 1 and 2].
    - If securities with a "Z" suffix after the designation do not qualify as filing exempt, compare the price or designation actually received from the SVO to that included in the Annual Financial Statement for

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significant increases. [Annual Financial Statement, Schedule D – Part 1, Section 1 and 2 or Schedule D – Part 2, Section 1 and 2]

- Consider requesting verification from the insurer that the securities are FE or have been submitted to, and subsequently valued by, the SVO and compare the price or designation subsequently received from the SVO to that included in the Annual Financial Statement for significant securities.

- Determine if all bonds with an NAIC designation of 3, 4, 5, 6 (non-investment grade bonds) have been valued at the lesser of book/adjusted carrying value or fair value and all other bonds have been valued at book/adjusted carrying value. [Annual Financial Statement, Schedule D – Part 1, Section 1 and 2]
    - Review Annual Financial Statement, Schedule D – Part 1, Section 1 and 2 to determine whether all bonds with an NAIC designation of 6—bonds in or near default—have been valued at the lower of cost or fair value and all other bonds have been valued at amortized cost value in accordance with the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual).
- Determine if sinking fund preferred stocks have been valued at their cost and all other stocks have been valued at their fair value. [Annual Financial Statement, Schedule D – Part 2]
- For each of the securities listed in Annual Financial Statement, Schedule D – Part 1, Schedule D – Part 2 and Schedule DA – Part 1, compare the CUSIP number, NAIC designation, and fair value included in the Annual Financial Statement to information on the NAIC Valuation of Securities (VOS) master file using Jumpstart Reports for investment analysis. Contact the insurer to follow up on any exceptions noted.
- Determine if any unusual valuation methods were noted on the Annual Financial Statement Summary Investment Schedule.

Valuation of Bond and Sinking Fund Preferred Stock Significantly Greater than Fair Value

Determine whether the statement value of bonds and sinking fund preferred stocks is significantly greater than fair value. Annual Financial Statement, General Interrogatories, Part 1, #31 shows the aggregate statement value and the aggregate fair value of issuer credit obligations, asset-backed securities and preferred stocks owned and requires the insurer to indicate how the fair values were determined. If the statement value of bonds and sinking fund preferred stocks is significantly greater than fair value, the insurer could realize significant losses if it were forced to sell these investments to cover unexpected cash flow needs due to larger than anticipated policy surrenders or claims. In determining whether there is a concern regarding the excess of the statement value of bonds or sinking fund preferred stocks over fair value, the analyst should also consider the insurer's interest maintenance reserve (Life and Fraternal only) and the results of its cash flow testing.

Procedures/Data

- Determine whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value.
    - Compare the aggregate excess of the statement value over the fair value of bonds and preferred stocks to the statement value of bonds and preferred stocks owned [Annual Financial Statement, General Interrogatories, Part 1, #31]
    - Compare the aggregate excess of the statement value over the fair value of bonds and preferred stocks owned to surplus (P/C), or to capital and surplus plus asset valuation reserve (AVR) (for Life/A&H), or to capital and surplus (Health)

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Additional Review Considerations

- Review available information from actuarial reporting on asset/liability matching (ALM) and cash flow testing to determine if there are any concerns regarding:
  - The impact of interest rate changes (or prolonged low interest rate environment, if applicable) on long duration bonds and the potential for prospective liquidity risk to result in market risk.
  - Asset/liability matching based on the asset composition, based on the duration and maturity profile of the bond portfolio.
  - For this procedure, the analyst may choose to seek the assistance of an in-house actuary.
- Review Annual Financial Statement, Schedule D – Part 1 and Schedule D – Part 2 or request additional information from the insurer to determine which individual securities have a book/adjusted carrying value significantly in excess of their fair value. The analyst should be aware that the value for those securities with an "AV" (amortized value) designation in the rate used to obtain the value column in Schedule D does not represent a true fair value for the securities. For those securities:
  - Verify the NAIC designation assigned and, if not filing exempt, determine whether it has been updated recently by the SVO.
  - If filing exempt, determine the current rating by a Credit Rating Provider (CRP) (e.g., Moody's Investors Service, Standard & Poor's, A.M. Best or Fitch Ratings).
  - Determine whether there has been an other-than-temporary impairment recognized.
- For bonds and sinking fund preferred stocks with other-than-temporary declines, consider whether the investment should be written down to its fair value to properly reflect the value of the investment.
- If the insurer has experienced negative cash flows or has other liquidity problems, consider requesting information from the insurer regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

Valuation of Common Stock,

OR

Volatility of Common Stock

Determine whether the fair value of common stock is significantly greater than or less than the actual cost. Review the Annual Financial Statement, Schedule D – Part 2 – Section 2, to compare the aggregate fair value position to the aggregate actual cost of common stock. Also review individual stock issues to determine if the fair value is significantly above or below actual cost. If the fair value of a stock issue is significantly below cost (unrealized loss), the insurer may incur a loss upon disposition. If the fair value of an individual stock issue is significantly greater than actual cost (unrealized gain), the insurer may be reflecting an unrealized gain that will not be realized at disposition.

Procedures/Data

- Determine if the fair value of common stock is significantly greater than or less than the cost [Annual Financial Statement, Schedule D – Part 2 – Section 2].
  - Determine if the aggregate fair value of common stocks is below the actual cost and if the difference is greater than 10% of surplus (P/C) or capital and surplus (Life/A&H, Health).
  - Determine if the aggregate actual cost of common stocks is below the fair value and if the difference is greater than 10% of surplus (P/C) or capital and surplus (Life/A&H, Health).

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- Determine the fair value to actual cost, when an investment in one issue of common stock is greater than 5% of invested assets.

Additional Review Considerations

- If concerns about sector concentration of common stocks, review Annual Financial Statement, Schedule D – Part 2 – Section 2 and consider requesting the NAIC Capital Markets Bureau to perform an analysis of the portfolio focusing on sector risk.
- Review Annual Financial Statement, Schedule D – Part 2 – Section 2, or request additional information from the insurer to determine which individual common stocks have a cost significantly in excess of their fair value. For those securities:
  - If the stock is listed on a market or an exchange (designated by the symbol "L" or "U") - such as the New York Stock Exchange, American Stock Exchange, NASDAQ National Market System, or a foreign exchange - verify the price and total market value.
  - Determine whether the stock is listed on a national exchange and verify the price per stock and the total fair value listed in the statement. If the NAIC designation of the stock is "A" (unit price of the share of privately held common stock is determined analytically by the SVO), review the date that the price per share was last analyzed by the SVO.
  - Consider whether the common stock has had an other-than-temporary decline in its value.
- Request the Audited Financial Statement and other documents from the insurer necessary to support the value of the common stock.
- Request information from the insurer regarding investment strategies and short-term cash flow needs to determine whether common stock with a cost significantly in excess of its fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

Exposure to Real Estate (or Real Estate Backed Assets)

Determine whether concerns exist due to the value of investment in real estate. There may be concerns regarding the fair value of the real estate, whether it is the underlying investment or the collateral for a mortgage loan. Real estate in certain parts of the country has experienced significant declines in fair values from time to time. High exposure to mortgage loans, real estate and non-agency mortgage-backed assets could result in credit losses in the event of a housing and/or commercial real estate market downturn. These investments are less liquid than many other types of investments. Investments in real estate have some similarities to investments in common stock and mortgages since they involve credit risk and the risk of default.

Determine whether there are concerns due to the level or quality of investment in real estate.

Procedures/Data

- Ratio of real estate to surplus (P/C), or to capital and surplus plus asset valuation reserve (AVR) (Life/A&H), or capital and surplus (Health).
- Increase in total real estate over the prior year, where the ratio of total real estate to surplus (P/C), or to capital and surplus plus asset valuation reserve (AVR) (Life/A&H), or capital and surplus (Health) is material
- Determine if the insurer owns any securities of a real estate holding company or otherwise holds real estate indirectly [Annual Financial Statements, General Interrogatories, Part 1, #12.1].

Additional Review Considerations

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- If there are concerns regarding real estate owned, review the Annual Financial Statement, Schedule A – Part 1 to determine whether updated appraisals should be obtained for any of the properties owned, based on the location of the property, the book/adjusted carrying value and reported fair value of the property, and the year of the last appraisal.
    - Consider benchmarking against the National Council of Real Estate Investment Fiduciaries (NCREIF) index number, keeping in mind that the NCREIF is a national benchmark for all property types.
- In addition, for those properties with book/adjusted carrying values in excess of fair value; consider whether the asset should be written down. [Annual Financial Statement, Schedule A – Part 1]
- For instances where a property has a book/adjusted carrying value in excess of its cost, request information from the insurer regarding any increases in book/adjusted carrying value during the year. [Annual Financial Statement, Schedule A – Part 1] Review Schedule A – Part 1 to identify if real estate owned is concentrated in one or a few geographical areas. Utilize postal code and property type information along with the city and state location information in Schedule A and Schedule B to identify geographic concentrations and to identify differences in volatility based on the property type and geographic location.
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.

Valuation of Schedule BA Assets, OR Adequacy of Collateral of BA Assets

Determine whether concerns exist due to the level of investment in other invested assets (Schedule BA). Volatility of underlying assets (example: certain hedge funds) may result in underlying assets that are not adequate.

Procedures/Data

- Determine the ratio of Schedule BA assets to surplus (P/C), or to capital and surplus plus asset valuation reserve (AVR) (Life/A&H), or capital and surplus (Health).
- Determine the increase in Schedule BA assets from the prior year when the ratio of Schedule BA assets to surplus (P/C), or to capital and surplus plus asset valuation reserve (AVR) (Life/A&H), or capital and surplus (Health) is material.

Additional Review Considerations

- Review Annual Financial Statement, Schedule BA – Part 1 to determine the amount and types of other invested assets owned and identify if the insurer's exposure to certain classes of Schedule BA assets are significant (e.g., hedge funds and private equity funds).
- Request current audited financial statements and other documents (e.g., partnership agreements, etc.) necessary to support the book/adjusted carrying value of the insurer's investment in partnerships and joint ventures and information to support the book/adjusted carrying value of significant other invested assets (e.g., other than partnerships and joint ventures).
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.
- Review Schedule BA to determine if a significant amount of BA assets have NAIC ratings of 3, 4, 5 or 6 or have a "Z" designation.
- Inquire of the insurer:

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- Request information necessary to determine the fair value of collateral to the amount loaned to ensure the loan is adequately collateralized
- Information to support significant increases by adjustment in book/adjusted carrying value during the year
- Current Audited Financial Statements and other documents (partnership agreements, etc.) necessary to support the value of the insurer's investment in partnerships and joint ventures
- Information necessary to support the value of significant other invested assets other than partnerships and joint ventures
- Current details on cash flows and returns for the different types of investments, especially hedge funds and private equity funds

Exposure to and Valuation of Collateral Loans (Life/A&H/Fraternal Only)

Determine whether concerns exist due to the level of investment in collateral loans. Review Annual Financial Statement, Schedule BA, Part 1 and Schedule DA – Part 1. In most states, collateral loans are required to be secured or collateralized by assets which have a value in excess of the amount of the loan, and which are considered admitted assets for an insurer.

Procedures

- Determine whether there are concerns regarding investment in collateral loans.
  - Compare the value of the collateral to the amount loaned thereon to determine whether the loan is adequately collateralized [Annual Financial Statements, Five-Year Historical Data].
  - In those instances where the underlying collateral is comprised of securities, verify the rate used to obtain the fair value of the securities held as collateral for the loans by reference to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*.

Exposure to and Valuation of Affiliated Investments, OR Financial Solvency Risk of PSA

Determine whether investments in parents, subsidiaries, affiliates (PSA) are significant and are properly valued. When investments in affiliates are significant, it is important to review and understand the underlying financial statements of the affiliates. It is only through this process that substantially overvalued investments can be detected. Review the level of return on the investment in the affiliate, including the source of the investment income (e.g., cash or merely an increase in the accrual). Be alert to the level of investments in the affiliate and the level of accrued interest relating to investments in the affiliate. Note also that if a PSA becomes insolvent, it may result in a significant drop in value, which could lead to other risks including liquidity issues.

Procedures/Data

- Total of all investments in affiliates to surplus (P/C), or capital and surplus (Life/A&H, Health) [Annual Financial Statement, Five-Year Historical Data].
- Change in total of all investments in affiliates from the prior year-end.
- Change in any category of affiliated investments from the prior year-end.

Additional Review Considerations

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- Review the results of the Holding Company analysis completed by the lead state and note any concerns regarding exposure to (see diversification procedure above) or valuation of affiliated investments.
- If investments in common stocks of PSAs involve publicly traded securities, determine if the investment is valued on a basis other than market valuation.
- If investments in PSA do not involve publicly traded securities, determine if the investment is valued on a basis other than the Statutory Equity or GAAP Equity methods.
- Review the components of investment income reflected on the Annual Financial Statement, Exhibit of Net Investment Income and the Exhibit of Capital Gains (Losses).
    - Calculate the return on investment for current and prior years.
    - Review the components of investment income and determine whether the source is cash or merely an increase in accrued interest income.
    - If a substantial portion of investment income relates to an increase in the accrual, determine whether such revenue recognition is legitimate and reasonable.
    - Determine whether accrued interest on investments in affiliates have grown to a significant level.
- Review details of affiliated investments as reported in Annual Financial Statement, Schedule A, Schedule B, Schedule BA and Schedule D, and compare with prior years. Review the trend in the value of affiliated investments to identify any negative trends that may continue in future.
- If concerns exist regarding an affiliate investment(s), consider the following (note that some of this information may be available in the Holding Company analysis completed by the lead state):
    - Obtain an understanding of the primary business activity of the affiliate and determine that such an investment complies with regulatory requirements.
    - Obtain and review the Audited Financial Statement, Annual Financial Statement, and Statement of Actuarial Opinion of the affiliate, if available.
    - Determine the current ratings of the affiliate from the credit rating agencies, if available.
    - Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.
    - Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate. Also review iSite+ data on the reinsurer (i.e., financial statements, Regulatory Information Retrieval System [RIRS] and Global Receivership Information Database [GRID]).
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.

Exposure to Derivative Investments, OR Hedge Effectiveness of Derivatives Portfolio

Determine whether concerns exist due to the value of investment in derivative instruments. A derivative instrument is a financial market instrument which has a price, performance, value, or cash flow based primarily on the actual or expected price, performance, value, or cash flow of one or more underlying interests. Derivative instruments (which consist of options, caps, floors, collars, swaps, forwards, swaptions and futures) are used by some insurers to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to its assets, liabilities, or anticipated future cash flows. A market risk may include that insurer's derivatives strategy may not meet hedge effectiveness for mitigating risk. If an insurer invests in

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derivative instruments, it is important for the analyst to understand the impact that these derivative instruments have on the risk return profile of the insurer's cash market investment portfolio under different scenarios. For insurers with significant investments in derivative investments, this will probably require the analyst to obtain the assistance of an actuary.

Refer to IV. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations for general information and a primer on derivatives.

Procedures/Data

- Determine whether there are concerns due to the use of derivitive instruments.
    - Determine if the insurer is engaged in derivative activity [Annual Financial Statement, Notes to Financial Statements, Note #1 and Note #8; General Interrogatories, Part 1, #27; the write-ins for assets and liabilities; Exhibit of Net Investment Income, Line 7; Exhibit of Capital Gains and Losses, Line 7; Schedule DB - all parts; the MD&A; and the Audited Financial Report]
- If yes,
    - Determine whether derivative holdings at year-end are significant. Review the ratio of total **book/adjusted carrying value** at year-end to surplus (P/C) or to capital and surplus plus AVR (Life/A&H), or capital and surplus (Health). [Annual Financial Statement, Schedule DB, Part A, Part B and Part C, Section 1]

      Total **book/adjusted carrying value** and percentage of surplus (P/C) or to capital and surplus plus AVR (Life/A&H), or capital and surplus (Health) for:

        - Hedging effective
        - Hedging other
        - Replication
        - Income generation
        - Other
        - Total derivative transactions
    - Determine whether derivative holdings at year-end are significant. Review the ratio of total **fair value** at year-end to surplus (P/C) or to capital and surplus plus AVR (Life/A&H). [Annual Financial Statement, Schedule DB, Part A, Part B and Part C, Section 1]

      Total **fair value** and percentage of surplus (P/C) or to capital and surplus plus AVR (Life/A&H) for:

        - Hedging effective
        - Hedging other
        - Replication
        - Income generation
        - Other
        - Total derivative transactions
    - Ratio of total off balance sheet exposure to surplus (P/C) or to capital and surplus plus AVR (Life/A&H) [Annual Financial Statement, Schedule DB – Part D]
- If questions or concerns are noted (Life/A&H):

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- Is the initial cost (original value) of call and put options, warrants, caps, floors, collars, swaps, swaptions and forwards acquired or opened during the year greater than 150% of the initial cost (original value) of derivatives owned or open at prior year-end? [Annual Financial Statement, Schedule DB – Part A – Section 1]
- Is the current year statement value of futures contracts greater than 150% of the book adjusted carrying value at prior year-end? [Annual Financial Statement – Schedule DB – Part B – Verification]

Additional Review Considerations

- Review Annual Financial Statement, Notes to Financial Statement, Note #5 for any information regarding possible collateral calls and assess the materiality exposure to the insurer if the collateral calls were to come due.
- Review the Annual Financial Statement, Schedule DB and for significant derivative instruments that are open at year-end, request the following information from the insurer:
  - A description of the methodology used to verify the continued effectiveness of the hedge provided.
  - A description of the methodology to determine the fair value.
  - A description of the determination of the book/adjusted carrying value.
- Consider having the insurer's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.
- Inquire of the insurer:
  - Request a derivatives use plan and consider obtaining a comprehensive description of the insurer's hedge program in order to obtain an understanding of the insurer's use of derivative instruments to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to the insurer's assets, liabilities, or expected cash flows. Analysis of hedging programs should include consideration of the company's hedge effectiveness analysis. (See Strategic Risk Assessment for further guidance.)
  - Information on how the insurer will manage any material collateral calls if they come due
  - Review the Annual Financial Statement, Schedule DB for significant derivative instruments that are open at year-end, request the following information from the insurer:
    - A description of the methodology used to verify the continued effectiveness of the hedge provided
    - A description of the methodology to determine the fair value
    - A description of the determination of the book/adjusted carrying value
  - Consider having the insurer's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.

Negative Results Generated from Exposure to Derivatives Market

Derivative market volatility could have a negative impact on derivative returns and generate capital losses. Determine whether there are concerns regarding investment income and captial gains(losses) on the investment in derivatives.

Procedures/Data

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- Ratio of gross derivative investment income to net investment income. [Annual Financial Statement, Exhibit of Net Investment Income, Line 7]
- Ratio of realized capital loss attributed to derivatives to surplus (P/C), or to capital and surplus plus AVR (Life/A&H), or capital and surplus (Health). [Annual Financial Statement, Exhibit of Capital Gains (Losses), Line 7]
- Aggregate net losses on derivatives to surplus (P/C), or to capital and surplus plus AVR (Life/A&H), or capital and surplus (Health). [Annual Financial Statement, Schedule DB – Part A – Section 2, columns 22, 23, and 24, and Schedule DB – Part B – Section 2, columns 16, 17, and 18. If material to surplus, review and document amount and percent of surplus for the following:
    - Recognized gains/losses of derivatives
    - Derivatives used to adjust basis of hedging items
    - Deferred gains or losses on derivatives

High Investment Portfolio Turnover

Determine whether concerns exist due to the level of investment turnover of long-term bonds, preferred stocks, or common stocks during the year. Identify significant turnover by reviewing Annual Financial Statement, Schedule D – Part 4 and Schedule D – Part 5. The turnover ratio represents the degree of trading activity in long-term bonds, preferred and common stock investments that has occurred during the year. Investment turnover is an indication of whether a buy-and-hold or sell based on short-term fluctuation strategy is utilized. High turnover ratios may be an indication of unusual activity in the management of the investment portfolio. High turnover in the portfolio may be driven by economic/market conditions, resulting in the need to make changes to the portfolio. High turnover in the portfolio may indicate a change in investment strategy. A high turnover of investments generally leads to greater transaction costs, operating expenses and the acceleration of realized capital gains and should be justified by more active management that may or may not be appropriate given the liabilities recorded. Sales result from securities reaching a price objective, anticipated changes in interest rates, changes in credit worthiness of issuers or general financial or market developments. High turnover ratios may raise questions that investments are being sold at a loss, possibly creating high capital losses.

Procedures/Data

- Long-term bond turnover ratio.
- Stock turnover ratio.
- Total long-term bond and stock turnover ratio.

Additional Review Considerations

- Review the Annual Financial Statement, Schedule D – Part 3, Schedule D – Part 4 and Schedule D – Part 5 to determine the amount and types of securities purchased and sold during the current year. This information can also assist the analyst in determining the types of securities sold and acquired, the length of time each security was held and the quality of the security.
- Review Annual Financial Statement, Schedule D – Part 3 to determine the quality of bonds acquired, noting any “Z” rated (not rated by the SVO) securities. Also note any NAIC designations of 3, 4, 5, or 6 (non-investment grade bonds).
- Review Annual Financial Statement, Schedule D – Part 3 to determine the quality of preferred and common stocks acquired. Evaluate any “U” (unlisted) or “A” (analytically determined) rated stocks.

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- Review realized capital gains from the sale of securities to determine any reliance on these gains to increase surplus, as opposed to unrealized gains and losses.
- Consider having a specialist (i.e., NAIC's Capital Markets Bureau (CMB)) review the insurer's investment program.
- Review the Statement of Actuarial Opinion to determine whether any concerns regarding investment turnover are noted.
- In light of the level of portfolio turnover identified, inquire of the insurer regarding any changes in investment strategy or philosophy, or changes in investment managers. Assess the impact of any strategic changes on the insurer's prospective exposure to market risk.

Realized and Unrealized Capital Gains and Losses

Review the Annual Financial Statement, Notes to the Financial Statements, Exhibit of Capital Gains (Losses) and Investment Schedules to determine the amount of other-than-temporary impairments (OTTI) that have been taken in the current period and to determine if OTTI appear to be in compliance with statutory accounting guidelines.

Procedures/Data

- Ratio of net unrealized capital gains/(losses) to prior year-end surplus.
- Ratio of net realized capital gains to net income, where the absolute value of net realized capital gains or losses is material surplus.

Additional Review Considerations

- Review Annual Financial Statement, Notes to Financial Statements, the Exhibit of Capital Gains (Losses) and Investment Schedules to assess the amount of OTTI have been taken in the current period for reasonableness.
- If concerns exist that OTTI are not properly written down, request information on the insurer's investment policy for recording OTTI to determine if it aligns with statutory accounting requirements

Negative Market Impact on Investment Income/Returns, OR Narrowing or Low Interest Rate Spreads [Life/A&H], OR Investment Results Actual to Projected Variance

Review investment yields, interest rate spreads and trends in investment returns. Determine if the investment returns appear adequate to meet the business plans of the insurer. Economic conditions, such as a low interest rate environment or change in investment markets, may result in a reduced returns on investments compared to expectations. Additionally, the insurer's actual investment portfolio and/or portfolio performance may vary significantly from projections if the insurer is not adhering to the strategy in place (i.e., higher actual credit, market or liquidity risk compared to the plan).

Procedures/Data

- Investment yield ratio
- Adequacy of investment income ratio (IRIS Ratio #4 – Life/A&H only)

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- Interest Margin (Life/A&H only). Determine if Investment spread results for life and annuity business is narrowing or worsening.

Additional Review Considerations

- Review the detail of investment income in the Annual Financial Statement, Exhibit of Net Investment Income and the detail of realized gains or (losses) in the Exhibit of Capital Gains (Losses) for reasonableness.
- Review the investment yield ratio for unusual fluctuations and trends between years. [iSite+]
- Calculate and review the investment yield ratio by asset class.
- Compare the ratio of investment income to cash and invested assets to the industry average investment yield to determine any significant deviation from the industry average. [iSite+]
- [Life/A&H Only]: If interest margin (spreads) are negative and issues are identified, consider using available information from the actuarial filings and the Annual Financial Statement and, if necessary, contacting the insurer (see below), to assist in the following:
    - Gaining an understanding of the liquidity requirements and the adequacy of ALM for the insurer's mix of business, including interest rate guarantees on products.
    - Gaining an understanding of the investment portfolio and strategy underlying the investment income returns, specifically understanding what factors are driving the investment yields year-over-year (YOY).
    - Review actual investment performance against projections from the insurer.
    - Gaining an understanding of trends and whether investment returns or guaranteed rates are driving the spread results.
    - Reviewing the Actuarial Memorandum and Regulatory Asset Adequacy Issues Summary (RAAIS) stress testing results (e.g., for prolonged low interest rate) and booking of additional ALM reserves.
        - Consider talking to the Company's appointed actuary to understand his or her perspective on the ALM testing and his or her comfort level.
    - Gaining an understanding of prospective strategic plans to manage this risk for prolonged low interest rate, including any changes in investment strategy, impacts of other factors including market volatility, changes in guaranteed rates on policies, and additional reserving.
    - If the negative margin result cannot be explained by other transactions that skew the ratio, gain an understanding of what actions the company is taking or should take to resolve or mitigate the risk.

Related Party Exposure in the Investment Portfolio

Determine related party exposure in the investment portfolio and assess any related credit [market, liquidity, operational] risk.

Related parties are entities that have common interests as a result of ownership, control, affiliation or by contract as definited in *SSAP No. 25—Affiliates and Other Related Parties* (SSAP No. 25). Refer to the *Insurance Holding Company System Model Act* (Model #440) and SSAP No. 25 for a broader definition of "affiliate," "related party" and "control".

Related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the reporting entity or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny.

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Utilize the tools available in iSite+ to identify if the insurer has a material exposure to investments involving related parties, either on an asset category basis or in aggregate, and by the related party designation noted below. If a material exposure exists, further assessment of the [credit, market, liquidity] risk may be warranted. For example, what is the NAIC designation of investments involving related parties? Consider the extent to which related parties are involved in securitizing or originating business for the insurer, and what differences may exist in how investments involving related parties are valued. If the role of the related party is that of a third-party advisor, factors to consider may include for example, the expertise of the related party advisor, any potential conflicts of interest, and if related parties are originating investments only for the insurer or also to the public, the latter being subject to SEC requirements. Consider utilizing suggested procedures in the "Additional Procedures" section of the repository on third-party advisors, if applicable.

Within the Annual Financial Statement investment Schedules B, BA, D, DA, DB, DL, and E (Part 2), all investments involving related parties must incude disclosure to ensure full transparency. This disclosure is in the column "Investments Involving Related Parites". It designates investments by the following roles:

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.
2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.
3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.
4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.
5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.
6. The investment does not involve a related party.

Procedures

- Assess related party exposure in investment portfolio.
    - Review the Annual Financial Statement investment schedules, as disclosed in the column "Investments Involving Related Parties" and utilizing iSite+ tools, determine if the insurer has material related party exposures in its investment portfolio. This disclosure is located in:
        - Schedule B
        - Schedule BA
        - Schedule D
        - Schedule DA
        - Schedule DB
        - Schedule DL
        - Schedule E, Part 2

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- Consider exposure by asset class and in aggregate, and by the role of the related party in the investment as designed by the "Investments Involving Related Parties" disclosure.
- If concerns exist regarding a material related party exposure in the investment portfolio, assess the credit quality of those investments involving related parties by reviewing designations, assessing historical default experience, etc.
- If concerns exist regarding a material related party exposure in investment management or advisory services, consider the following:
    - Review the procedures in the "Additional Procedures" section below regarding Third Party Investment Advisors and consider their application to related party advisors in that role.
    - In addition to the additional analysis procedures regarding third party investment advisors, consider the following:
        - Review the insurer's investment policy guidelines and determine whether the related party investments follow the guidelines and are in compliance with regulatory requirements.
        - Review whether the fee structure for asset management is fair, reasonable, and appropriately recognized as investment expenses.
        - If the related party asset manager also originates/securitizes investments held by the insurer, consider requesting additional information from the insurer to determine the following:
            - Whether the asset manager has adequate experience and knowledge in originating and managing the types of investments.
            - Whether the asset manager follows appropriate underwriting practices and applicable regulatory requirements in originating investments.
            - Whether the fee structures embedded in securities (if applicable) are fair, reasonable, and appropriately account for potential duplication of fees or conflicts of interest.
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.

Invested Asset Exposure to Climate Change, Transition and Asset Devaluation Risk

Identify and assess the potential exposure of the insurer's investment portfolio to the impact of material climate change and/or energy transition risks. The insurer's investment portfolio may be subject to prospective devaluation of the assets/changes in the asset return associated with its holdings of climate-affected assets. Transition risks refer to stresses on certain investment holdings arising from the shifts in policy, consumer and business sentiment, or technologies associated with the changes necessary to limit climate change. A few examples of investment holdings and sectors generally subject to greater levels of transition risk include oil/gas, transportation, heavy manufacturing, and agriculture. In assessing an insurer's exposure to these risks, review information disclosed by the insurer in its responses to the NAIC's Climate Risk Disclosure Survey, U.S. Securities and Exchange Commission (SEC) filings, and/or the Own Risk and Solvency Assessment (ORSA) Summary Report filings. In addition, review the results of basic scenario analysis conducted by the NAIC using insurers' Annual Statement filings (U.S. Insurance Industry Climate Affected Investment Analysis) to identify potential concentrations in exposure.

Procedures

- Review information provided in the insurer's response to the NAIC's Climate Risk and Disclosure Survey (if available) on its exposure to material climate change/energy transition risk and related mitigation activity in this area.

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- Review relevant information provided in the Own Risk and Solvency Assessment (ORSA) Summary Report, and/or U.S. Securities and Exchange Commission (SEC) 10-K or 10-Q filings (if available) that discusses the insurer's exposure to material climate change/energy transition risk and related mitigation activity in this area.
- Review information provided in the NAIC's U.S. Insurance Industry Climate Affected Investment Analysis to identify potential concentrations in insurer exposure.

Additional Review Considerations

- Review the insurer's investment policies and strategies to assess whether material climate change, transition and asset devaluation risk considerations have been appropriately implemented into the company's investment processes.
- Review the most recent examination report and summary review memorandum (SRM) for any findings regarding climate change/energy transition risks.
- If concerns exist, consider requesting information from the insurer regarding how the insurer manages its exposure to material climate change/energy transition risk, including how it identifies and estimates current and prospective exposures and the limits (if any) in place to avoid concentrations.

ADDITIONAL PROCEDURES

Investment Strategy

Consider requesting and reviewing a copy of the insurer's formal adopted investment plan to determine if it is appropriately structured to support its ongoing business plan. If an insurer's investment strategy is not structured to support the business plan, it could indicate the strategy enjoys higher credit, market and liquidity risks than are appropriate for the liabilities of the insurer and may lead to financial concerns in the future. This should be evaluated to determine if the plan appears to result in investments that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs and to determine whether the insurer appears to be adhering to its plan. For example, the insurer's plan for investing in noninvestment-grade bonds should be reviewed for guidelines regarding the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location. Experience in execution of an investment strategy can also be a concern with more volatile and complex markets. The use of external investment managers can raise a host of other issues. (see additional guidance below)

- Review the guidelines outlined in the plan for:
    - Quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, geographic location, and issues/sectors exposed to material climate change, transition, and asset devaluation risks.
    - Expected rate of returns on investments (projected investment income) compared to actual results.
    - Planned increases in investment types, sectors and markets, etc.
    - Appropriateness of the investment plan for the liability structure of the insurer. (This may require a review of asset adequacy analysis for asset liability matching and discussion with the insurer's management to better understand its plan.)
- Upon review of the investment plan, compare the plan to actual results. Does the insurer and its investment manager(s) appear to be adhering to the investment policies and guidelines in the investment plan?

Examination Findings

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Consider a review of the most recent examination report, summary review memorandum and communication with the examination staff to identify if any market risk issues were discovered during the examination such as:

- Asset liability matching
- Adherence to investment policies and strategies
- Investment management, and use of and monitoring of external investment managers

If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

NAIC Capital Markets Bureau Analytical Assistance

Consider requesting the NAIC's CMB to assist with analytical review of the insurer's investment portfolio or investment management agreement. The CMB has different levels of analysis that can be arranged to assist the state.

Third-Party Investment Advisors

Determine whether concerns exist regarding the use of third-party investment advisers. As investments and investment strategies grow in complexity, insurers may consider the use of unaffiliated third-party investment advisers to manage their investment strategy. Investment advisers may operate independently or as part of an investment company. Investment advisers and companies are subject to regulation by the U.S. Securities and Exchange Commission (SEC) and/or by the states in which they operate, generally based on the size of their business. In certain situations, insurers may use a broker-dealer for investment advice. Broker-dealers are subject to regulation by the Financial Industry Regulatory Authority (FINRA). Regardless, most broker dealers and investment advisers will register with the SEC and annually update a Form ADV–Uniform Application for Investment Adviser Registration and Report Form by Exempt Reporting Advisers, which provides extensive information about the nature of the organization's operations. To locate these forms, the analyst can go to *www.adviserinfo.sec.gov* and perform a search based on the company name.

Key information provided on a Form ADV includes:

a. Regulatory agencies and states in which the adviser/broker is registered

b. Information about the advisory business including size of operations and types of customers (Item 5)

c. Information about whether the company provides custodial services (Item 9)

d. Information about disciplinary action and/or criminal records (Item 11)

e. A report of the independent public accountant verifying compliance if the investment advisor also acts as a custodian.

It is important to note that the information provided on Form ADV is self-reported and is subject to limited regulatory oversight. However, the information may be valuable to analysts in assessing the suitability and capability of investment advisers providing advisory services to insurers. In addition, although not expressly prohibited (as discussed at e. above), it is a best practice for the insurer to choose a national bank, state bank, trust company or broker/dealer which participates in a clearing corporation, other than its investment manager/advisor, to hold its assets in custody to promote segregation of duties. See additional guidance on custodial expectations in Section 1.F – Outsourcing of Critical Functions of the NAIC's Financial Condition Examiners Handbook.

Consider any significant risks identified in the most recent risk-focused examination and whether any follow-up procedures were recommended by the examiner. The examiner may have performed steps to determine the following; whether the investment adviser is suitable for the role (including whether he/she registered and in good standing with the SEC and/or state securities regulators); whether the investment advisory agreements

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contain appropriate provisions; whether the adviser is acting in accordance with the agreement; and whether management/board oversight of the investment adviser is sufficient for the relationships in place.

Determine if changes have occurred in the insurer's use of investment advisers that may prospectively impact the insurer's investment strategy and overall management of the investment portfolio. If changes have occurred consider asking the insurer for an explanation for the change in investment advisers and obtain a copy of the new adviser agreement to gain an understanding of the provisions including the advisor's authority, specific reference to compliance with the insurer's investment strategy and/or policy statements, as well as state investment laws; conflicts of interest; fiduciary responsibilities; fees; and the insurer's review of the adviser's performance. (Refer to the *Financial Condition Examiners Handbook* for further guidance.) and see V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for additional guidance on reviewing affiliated investment management agreements.

Determine if the investment advisor is in good standing with the SEC. The SEC does not officially use the term "good standing;" however, for this analysis, the term is used to mean a firm that is registered as an investment adviser with the SEC and does not report disciplinary actions or criminal records in Item 11 of the Form ADV.

If the insurer uses an external asset manager and if investments on Schedule BA assets are invested in funds that are affiliated with the asset manager or are managed by that asset manager, the analyst should consider several possible issues that may result from this scenario. A possible concern may exist when the asset manager is also managing other funds in addition to managing assets for the insurer and then invests the insurer's assets in those other funds that the asset manager manages. While those funds may be good investments, both in general and for the insurer, there are a few issues that may need to be considered. First is the potential for a conflict of interest if the asset manager is using the insurer's available funds to provide seed money or fund the manager's other funds. Second is if any concerns exist regarding the appropriateness of the fund for the insurer's investment portfolio and if the transactions would be considered on an arm's-length basis. Third is the understanding that the insurer may be paying overlapping fees as the insurer would pay the asset manager a fee for the investment and then also pay a fee within the fund investment. There may be similar concerns with other complex investments such as structured securities that are originated by the asset manager or one of its affiliates/related parties. The fees associated with these investments could be considered arms-length and appropriate but would require further review and potentially additional support or documentation to make that determination.

Assess and determine if any concerns exist regarding third party investment advisers and associated contractual arrangements.

- Review Annual Financial Statement, General Interrogatories, Part 1, #29.05 and determine if the insurer utilizes third party investment advisors, broker/dealer or individuals acting on behalf of the insurer with access to their investment accounts.

If "yes," consider the following procedures:

- Verify that all affiliated and unaffiliated investment advisors the analyst is aware of are disclosed in the interrogatory, whether primary or sub-advisors.
    - Verify that Investment Management Agreements required to be filed with the department have been filed and consider requesting copies of agreements that have not been filed with the department for review.
    - Gain an understanding of the types of investments that are being managed by each of the advisors/sub-advisors disclosed in the interrogatory.
- Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners and determine if the examination identified any issues with regard to investment advisers and associated contractual arrangements that require follow-up analysis or communication with the insurer. If "yes," document the follow-up work performed.

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- Compare Annual Financial Statement, General Interrogatories, Part 1, #29.05 for the current year to the prior year to determine if there have been any changes in advisors.
    - If there has been changes in advisors, consider obtaining an explanation for the change from the insurer.
    - If there has been changes in advisors, consider obtaining a copy of the new investment advisor agreement and review it for appropriate provisions.
- Using the information reported in Annual Financial Statement, General Interrogatories, Part 1, #29.05, obtain and review SEC Form ADV (if available), to determine if the investment advisor is in good standing with the SEC. If not in good standing, contact the insurer to request an explanation.
- Determine if agreements with third party investment advisers are affiliated, have the appropriate Form D – Prior Notice of Transactions been filed and approved by the department and note any concerns or follow-up recommended.
    - See additional guidance in V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for reviewing affiliated investment manager agreements.
- Request information from the insurer regarding the background and expertise in any complex or non-traditional assets (such as structured securities, mortgage loans, investment funds) of its investment advisors (in-house and/or contractual) and its analytical system capabilities. Determine whether the advisors and systems are adequate to allow the insurer to continuously monitor its investments.
- If the insurer uses an external asset manager, consider if there are any investments that may represent a potential conflict. Examples of this are: (1) if there are investments reported on Schedule BA that are funds that are affiliated/related with the asset manager or are managed by that asset manager, (2) structured securities in which the asset manager or an affiliate/related party had a role in originating, or (3) direct investments in the asset manager or any of its affiliates/related parties. If the external asset manager qualifies as a related party, utilize guidance provided in the "Related Party Exposure in the Investment Portfolio" section above to assist in this review. Consider the following issues:
    - If any potential conflicts of interest have been reviewed and formally approved by the Board or Investment Committee.
    - If the investment is appropriate for the insurer's portfolio and is arm's-length.
    - If the insurer is paying overlapping fees.

Inquire of the Insurer

If concerns exist, consider requesting additional information from the insurer if market risk concerns exist in a specific area.

General Investment Inquiries

- If management has adequately reviewed the investment portfolio and understands the yields, underlying collateral, cash flows and investment volatility
- Any additional concentration by collateral type
- Management's process for valuing securities so as to assist analysts in assessing if the securities are valued appropriately
- Management's intended use of certain riskier investments and purpose within the insurer's portfolio
- If management has an appropriate level of knowledge and expertise with the type of securities being purchased/held

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- If the insurer has controls implemented to mitigate the risks associated with this investment type
- Sources of liquidity, such as letters of credit (LOCs)
- Investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements

Asset-Backed Securities

- Percentage distribution and amounts of each type of asset-backed securities held; planned amortization class (PAC), support bonds, interest only (IO) tranches, and principle only (PO) tranches to evaluate the level of prepayment risk in the portfolio
- Projected prepayment speeds on its RMBS portfolio and compare with historical prepayments, as well as the prepayment assumption at the time of purchase

Own Risk and Solvency Assessment (ORSA)

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing risks faced by the insurer.

- Did the ORSA Summary Report analysis conducted by the lead state indicate any market risks that require further monitoring or follow-up?
- Did the ORSA Summary Report analysis conducted by the lead state indicate any mitigating strategies for existing or prospective market risks?

Holding Company Analysis

Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

- Did the Holding Company analysis conducted by the lead state indicate any market risks impacting the insurer that require further monitoring or follow-up?
- Did the Holding Company analysis conducted by the lead state indicate any mitigating strategies for existing or prospective market risks impacting the insurer?

Actuarial Filings, Including Asset Liability Matching (Life/A&H, Health)

Did the review of the Statement of Actuarial Opinion or other actuarial filings indicate any concerns regarding:

- The adequacy of asset/liability matching and the sufficiency of assets to meet the business obligations of the insurer
- Exposure to certain asset classes
- Investment turnover
- Interest rate spreads

QUARTERLY MARKET RISK ASSESSMENT

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The quarterly market risk procedures are designed to identify the following. For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Significant Investment Concentration by Asset Class

Determine whether the insurer's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue. See also Credit Risk Assessment for diversification of other asset classes.

Procedures/Data

- Common stocks owned as a percent of total net admitted assets[ii].
- Mortgage loans owned as a percent of total net admitted assets.
- Real estate (before encumbrances), including home office real estate owned as a percent of total net admitted assets.
- Investments in affiliates owned as a percent of total net admitted assets.

Additional Procedures

- Review iSite+ for significant shifts in the mix of investments owned over the last five years.

Increased Exposure to Volatility, OR Valuation Risk by Asset Class

Determine if concerns exist due to the change in certain asset classes from the prior year-end.

Procedures/Data

- Increase in real estate from the prior year-end, where the ratio of total real estate to surplus (P/C), or cash and invested assets (Life/A&H), or capital and surplus (Health) is material.
- Increase in mortgage loans from the prior year-end, where the ratio of total mortgage loans estate to surplus (P/C), or cash and invested assets (Life/A&H), or capital and surplus (Health) is material.
- Increase in affiliated investments from the prior year-end, where the ratio affiliated investments estate to surplus (P/C), or cash and invested assets (Life/A&H), or capital and surplus (Health) is material.
- Increase in BA assets from the prior year-end, where the ratio of BA assets estate to surplus (P/C), or cash and invested assets (Life/A&H), or capital and surplus (Health) is material.

Valuation of Securities

Determine if concerns exist with the valuation of securities.

Procedures/Data

- Determine if the insurer has followed the filing requirements of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* [Quarterly Financial Statement, General Interrogatories, Part 1, #18.1 and #18.2].

Additional Procedures

[ii] For ratios in this asset concentration procedure, net admitted assets excludes separate accounts for Life/A&H, and Health.

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- Assess the impact of market conditions.
  - Through consideration of industry and economic events (i.e., news and industry analytics), determine if there are any market conditions that may threaten the value of insurers' investment portfolios.
  - Through correspondence with the insurer, determine if there are any market conditions that could threaten the value of its investment portfolio.

Valuation of Affiliated Investments

Determine if concerns with the level of exposure to investments in affiliates and valuation of the investments.

Procedures/Data

- Total of all investments in affiliates to surplus (P/C), or capital and surplus (Life/A&H, Health) [Quarterly Financial Statement, General Interrogatories Part 1, #13].
- Change in total of all investments in affiliates from the prior year-end.
- Change in any category of affiliated investments from the prior year-end.

Additional Procedures

- Review the results of the Holding Company analysis completed by the lead state. Note any concerns regarding exposure to (see diversification procedure above) or valuation of affiliated investments.
- If investments in common stocks of parents, subsidiaries, and affiliates (PSA) involve publicly traded securities, determine if the investment is valued on a basis other than market valuation.
- If investments in common stocks of PSA do not involve publicly traded securities, determine if the investment is valued on a basis other than the statutory equity or generally accepted accounting principles (GAAP) equity methods.
- If concerns exist regarding an affiliate investment(s) and/or material changes have occurred since the prior period analysis, consider the following (note that some of this information may be available in the Holding Company analysis completed by the lead state):
  - Obtain an understanding of the primary business activity of the affiliate and determine that such an investment complies with regulatory requirements.
  - Obtain and review the Audited Financial Statement, Annual Financial Statement and Statement of Actuarial Opinion of the affiliate, if available.
  - Determine the current ratings of the affiliate from the major rating agencies, if available.
  - Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.
  - Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate. Also, review iSite+ data on the reinsurer (i.e., financial statements, Regulatory Information Retrieval System [RIRS] and Global Receivership Information Database [GRID]).

Exposure to Derivative Investments

Determine if there are concerns due to the use of derivative instruments.

Procedures/Data

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- Determine whether derivative holdings are significant. Review the ratio of total **book/adjusted carrying value** to surplus [Quarterly Financial Statement, Schedule DB, Part A and Part B, Section 1].

  Total **book/adjusted carrying value** and percentage of surplus (P/C), or capital and surplus plus AVR (Life/A&H), or capital and surplus (Health) for:

  - Hedging effective
  - Hedging other
  - Replication
  - Income generation
  - Other
  - Total derivative transactions

- Determine whether derivative holdings are significant. Review the ratio of total **fair value** at quarter-end to surplus (P/C), or capital and surplus plus AVR (Life/A&H) [Quarterly Financial Statement Schedule DB, Part A and Part B, Section 1].

  Total **fair value** and percentage of surplus for:

  - Hedging effective
  - Hedging other
  - Replication
  - Income generation
  - Other
  - Total derivative transactions

- Increase in derivative investments over the prior year-end where the ratio of potential exposure on futures contracts and options, caps, floors, collars, swaps and forwards to surplus (P/C), or capital and surplus plus AVR (Life/A&H) is material. [Quarterly Financial Statement, Schedule DB, Part A and Part B, Section 1].

Additional Procedures

- Review detail provided in Quarterly Financial Statement, Schedule DB columns for Description of Item(s) Hedged, Used for Income Generation, or Replicated and Type(s) of Risk(s) to determine if the insurer's detailed use of derivatives appears to be consistent with the overall strategy that the reporting entity has described elsewhere. Where the detail reported in Schedule DB differs from other information provided by the insurer, request further clarifying information from the reporting entity.
- Review detail provided in Quarterly Financial Statement, Schedule DB columns for Hedge Effectiveness at Inception and at Quarter-End. Note anything unusual or any variances from the insurer's current hedging program description.

Realized and Unrealized Capital Gains and Losses

Assess if concerns exisit with realized and unrealized capital gains (losses), including other-than-temporary impariments (OTTI).

Procedures/Data

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- Ratio of net unrealized capital gains/(losses) to prior year-end surplus (P/C), or capital and surplus (Life/A&H, Health).
- Ratio of net realized capital gains to net income, where the absolute value of net realized capital gains or losses material to surplus (P/C), or capital and surplus (Life/A&H, Health).

Additional Procedures

- Review the iSite+ for significant changes or trends in capital gains (losses) by quarter over the last five years.

Negative Market Impact on Investment Income/Returns

Determine if concerns exist regarding the adequacy of net investment income.

Procedures/Data

- Ratio of investment income to cash and invested assets (rolling year).

Additional Procedures

- Review iSite+ for significant changes or trends in investment income by quarter over the last five years.

For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

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OPERATIONAL RISK: The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events.

The Operational Risk Assessment is focused on risks inherent in the company's daily operations. As such, although operational risk encompasses overall profitability, other risks in this area may not be identified through traditional financial statement review. Therefore, analysts may require additional investigation and information requests to understand and assess the potential impact of these risks. For example, analysts may need additional information to assess the insurer's exposure to cybersecurity risks. In addition, information presented in the Enterprise Risk Report (Form F) and Own Risk and Solvency Assessment (ORSA) Summary Report (if available), which are reviewed and risks documented by the lead state, may assist analysts in identifying and assessing the insurer's exposure to operational risks.

Analysts' risk-focused assessment of operational risk should take into consideration the following areas (but not be limited to):

- Statement of income and operating performance
- Corporate governance practices
- Changes in officers and directors
- Investment operations (purchases and sales)
- Use of investment advisors
- Changes in corporate structure
- Related party transactions
- Use of managing general agents (MGAs) and third-party administrators (TPAs)
- Separate accounts (Life only)
- Risk transfer arrangements other than reinsurance (Health only)
- Provider liabilities (Health only)

ANNUAL OPERATIONAL RISK ASSESSMENT

Poor (or Declining) Operating Performance For P/C Insurers

Determine whether concerns exist regarding the insurer's operating performance.

In evaluating the insurer's operating performance, analyze the combined ratio as a key indicator of underwriting profitability. Identify and assess potential concerns such as elevated losses, decreased premiums, or increased underwriting expenses. Delve into the underlying causes of these issues to gain deeper insights. High commission and expense ratios may indicate a high expense structure that may make it difficult for the insurer to attract new business, compete with other insurers and fulfill its strategic plan.

While the combined ratio solely focuses on underwriting performance, the two-year overall operating ratio (Insurance Regulatory Information System (IRIS) ratio #5) and return on surplus offer a broader perspective on

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overall profitability. The two-year operating ratio reflects the insurer's financial performance relative to underwriting and investment activities over a two-year period. Conversely, return on surplus measures net income and unrealized gains (losses) as a percentage of two-year average surplus.

In addition to analyzing the current year results, analysts should also examine trends in these metrics over the past five years. Continued trends in expense ratio, combined ratio and overall profitability may indicate ongoing solvency risks. Additionally, benchmarking certain metrics against industry averages can highlight outliers and potential areas of concern.

Procedures/Data

- Analyze the current year's performance, changes from the prior year and trends over past five years in the following metrics to assess the insurer's operating performance:
  - Combined ratio
  - Loss ratio (direct, assumed, gross, ceded, and net)
  - Expense ratio
  - Commissions and brokerage ratios
  - Change in individual income and expense line items (i.e., net premium earned, inclured losses and loss adjustment expenses, expenses and commissions)
  - Net income
  - Return on surplus ratio
  - Two-year operating ratio (IRIS ratio #5)
  - Ratio of other income to net income, when the absolute value of other income is material to surplus

Additional Review Considerations

- Compare the entity's actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
- Compare the metrics and data above for operating performance to industry averages to determine any significant deviations.
- Review the components of other income in the Annual Financial Statement, Statement of Income, including write-ins for miscellaneous income, for reasonableness.
- Describe any known trends that have had or that the insurer reasonably expects will have a material favorable or unfavorable impact on net revenues or net income. If the insurer knows of events that will cause a material change in the relationship between benefits, losses, and expenses, the change in the relationship should be disclosed.
- Review the Annual Statement Blank, Insurance Expense Exhibit (IEE), to identify any expense allocation concerns or unusual operating results by line of business. The (IEE) is a supplemental P/C schedule filed by April 1. The IEE includes an interrogatories section and three major parts. Part I shows, for each expense line item included in the Annual Financial Statement, the allocation to five expense groups: 1) loss adjustment expense; 2) acquisition, field supervision, and collection expenses; 3) general expenses; 4) taxes, licenses and fees; and 5) investment expenses. Part II shows major categories of expenses and the allocation to each line of business. Part III is similar to Part II except that premiums are reflected on a direct basis. While the IEE is not a primary source of information for solvency analysis, it does provide meaningful information for evaluating an insurer's operations and overall profitability. In addition, the IEE may be used in the rate-making process or for evaluating an insurer's performance by line of business.

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  - Investigate unusual items, especially situations where expenses were allocated to lines of business using methods not defined in the Annual Statement Instructions. The Annual Statement Instructions are included in the Supplements section and additional guidance in this regard is included in the *Financial Condition Examiners Handbook*.

- Review IEE, Part 1:
  - Investigate significant fluctuations in expenses by expense groups between years
  - Compare expenses by expense group for the insurer with the industry averages
- Review the IEE , Part II and Part III:
  - Investigate significant fluctuations in expenses by lines of business between years
  - Compare expenses by line of business with industry averages
  - Determine whether the totals agree with financial statement line items included in the Annual Financial Statement
- Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses.
- Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations.
- In conjunction with review of reinsurance program(s) (within Strategic Risk), consider the impact of reinsurance program(s) on the insurer's operating performance. This could include assessing whether there are any risk limiting features or insufficient ceding commission rates that could be a significant additional drain on operating earnings when insurers utilize reinsurance for RBC or premium leverage considerations.

Poor (Or Declining) Operating Performance for Life/A&H Insurers

Determining whether concerns exist regarding the insurer's Summary of Operations or operating performance.

One of the most common measures of overall profitability and operating performance for an A&H insurer is the IRIS ratio of net income to total income (including realized capital gains and losses). Six principal factors affect the insurer's net gain, as reflected in this ratio: 1) mortality and morbidity experience; 2) adequacy of investment income; 3) commissions and expenses; 4) reinsurance transactions; 5) the relationship of statutory reserve requirements to prevailing interest and mortality rates; and 6) realized capital gains and losses. This ratio is an indicator of the insurer's overall profitability and operating performance without consideration of realized gains and losses. Another important measure of the insurer's operating performance is the return on capital and surplus, which considers net income as a percentage of capital and surplus. All of these metrics are intended to assist analysts in determining whether the operating performance and profitability of the insurer may represent a current or prospective operating risk to be evaluated and assessed.

Additional steps may include reviewing the summary of the individual income and expense items for the past five years for unusual fluctuations or trends between years. In addition, analysts might compare the ratio of return on capital and surplus to industry average results to determine any significant deviation from the industry average. By reviewing the Analysis of Operations by Lines of Business in the Annual Financial Statement, analysts could determine which lines of business had significant surrender activity during the year, which lines of business were profitable, and which lines of business generated a loss, and whether commissions and expenses on any lines of business appear excessive, based on the volume of premiums and deposit-type funds. If the ratio of commissions and expenses to premiums appears high or if the ratio of investment yield appears unusual, analysts should consider: 1) reviewing these ratio results for the past five years for unusual fluctuations or trends between years; and 2) comparing the ratio results to industry averages to determine any significant deviations from the industry averages. If write-ins for miscellaneous income or deductions are significant, analysts should consider reviewing the individual components of these amounts for reasonableness.

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Procedures/Data

Determine whether concerns exist regarding the insurer's income statement or operating performance.

- Review the net income/(loss) and related ratios:
  - Net Loss in the current year, or in two or more of the past three years.
  - Change in net income/(loss) if the value of net income is material to capital and surplus.
  - Ratio of net income to total income (including realized capital gains and losses) (IRIS ratio #3).
  - Ratio of net gain from operations (before realized capital gains and losses) to total income.
- Ratio of return on capital and surplus.
- Ratio of commissions and administrative expenses to gross premiums for non-life insurers, and five-year trend.
- Accident and health (A&H) loss ratio, and five-year trend.
- Ratio of aggregate write-ins for miscellaneous income to net income when aggregate write-ins for miscellaneous income is material to capital and surplus.
- Ratio of aggregate write-ins for deductions to net income when aggregate write-ins for deductions are material to capital and surplus.
- Change in material individual income and expense categories, and five-year trend.
- Compare the following measures of operating performance to the industry average to determine any significant deviations:
  - Return on capital and surplus ratio
  - Commissions and administrative expenses to premiums ratio
- Review the lines of business information from the Analysis of Operations by Lines of Business and determine:
  - Income/(Loss) by lines of business in the current year, or negative trend in profitability over the past five years.
  - Whether commissions and expenses on any lines of business appear excessive based on the volume of premiums.

Additional Review Considerations

- Compare the entity's actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
- Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on the net revenues or net income, or a material impact on the relationship between benefits, losses, and expenses.
- Review the components of the aggregate write-ins for miscellaneous income and aggregate write-ins for deductions for reasonableness.
- If concerns exist regarding operating performance, consider the following procedures:
  - Review Exhibit 2 – General Expenses to identify concerns or unusual items to identify any expense allocation concerns or unusual operating results by line of business to assist in identifying areas for follow-up and investigation with the insurer.

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  - Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses.
  - Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations.

- Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses. This procedure can assist analysts in further understanding the cause of poor operating performance and assess whether it is likely to continue going forward.
- Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations. This procedure can assist analysts in evaluating the insurer's plans and mitigation strategies for addressing the poor operating performance.
- If the insurer writes Medicare Part D business, obtain and review supporting documents if concerns are identified related to the operating performance of Medicare Part D business. Supporting documents may include information on contracted benefits, premium and cost sharing with the CMS, and support for reserve, utilization and benefit cost assumptions projected in the development of the contract.

Poor (or Declining) Operating Performance for Health Insurers

Determine whether concerns exist regarding the insurer's Statement of Revenue and Expenses or operating performance.

Each of the ratios provided in this procedure is designed to provide analysts with an overall assessment of the health entity's profitability. The profit margins in the health insurance industry have traditionally been fairly low. As a result, the threshold for this ratio is established at less than 0% or greater than 10%. A profit margin ratio of less than 0% indicates the health entity has experienced a net loss and operating problems may exist. With continued losses, the health entity's capital cushion to support the business is likely to be diminished. Conversely, a profit margin greater than 10% is unusual in the health insurance industry and should be investigated.

Another ratio that provides an assessment of a health entity's profitability is the combined ratio. The threshold for the combined ratio is set at greater than 100%. A health entity with a combined ratio of 100% should have investment income for profit. The combined ratio consists of the medical loss and the administrative expense ratios. The administrative expense ratio includes administrative expenses as well as claims adjustment expenses. Claims adjustment expenses are the costs incurred relating to reported and unreported claims and are considered to be administrative in nature. The threshold for the medical loss ratio is set at greater than 85% and the administrative expense ratio is set at greater than 15%. These thresholds are based upon a typical relationship between the combined, medical loss, and administrative expense ratios. Some health entities may have a higher medical loss ratio but a lower administrative expense ratio. Some view this relationship as positive because more benefits are provided to the consumer. Other health entities may have a lower medical loss ratio and a higher administrative expense ratio. In some cases, this relationship may be positive because sometimes this is indicative of a health entity with lower operating leverage. Also, the medical loss ratio measures the direct cost of business as related to premiums earned and should have a consistent trend, while the administrative expense ratio which measures indirect expenses as related to premiums earned should decrease as the company becomes more efficient over a period of time. Typically, premium increases are driven by claim cost trends that exceed general inflation, which drives administrative costs. On the other hand, in situations where general inflation is less than medical cost trends, administrative cost ratios may actually increase since administrative trends will be higher than premium trends. As previously mentioned, analysts should also be familiar with the health entity's primary lines of business in order to evaluate their operating performance. This includes lines with business risk (ASO/ASC) but no underwriting risk, which report fees as a reduction of expenses, instead of as premium.

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In addition to providing information on the current year's operating performance, this procedure also provides information on changes from the prior year. As previously mentioned, an increase in a health entity's medical loss ratio may indicate a loss of control in the health entity's underwriting or pricing processes. An increase in the administrative expense ratio may indicate escalating costs or an expense structure that no longer supports the health entity's premium volume. Changes may also be the result of a change in the health entity's business mix. As previously mentioned, a health entity's entrance into new lines of business or sales regions might result in financial problems if the health entity does not have expertise in these new lines of business or regions. All of these items should be further investigated to further assess the risk to the health entity.

All of these metrics are intended to assist analysts in determining whether the operating performance and profitability of the insurer may represent a current or prospective operating risk to be evaluated and assessed. In addition, analysts are encouraged to review data and metrics provided and presented in the Annual Financial Profile Report over a five-year period to identify trends and areas of concern. Analysts are also encouraged to compare results in certain areas against industry averages to identify outliers and areas of concern. Finally, review the Analysis of Operations by Line of Business and the Statement of Revenues and Expenses line item aggregate write-ins to understand results, recognize trends and identify items for follow-up with the insurer.

Procedures/Data

Determine whether concerns exist regarding the insurer's income statement or operating performance.

- Net income (loss)
  - Current year net loss
  - Change in net income when net income is material to surplus
  - Net loss in two or more of the past five years
- Review the components of the Statement of Revenues and Expenses line item aggregate write-ins for other health care related revenues, other income or expenses for reasonableness.
- Profit margin ratio, change from the prior year and, or negative trend over the past five years.
- Return on capital and surplus ratio
- Combined ratio, change from the prior year and, negative trend over the past five years
- Medical loss ratio, change from the prior year and, negative trend over the past five years
- Administrative expense ratio, change from the prior year and, negative trend over the past five years
- Combined ratio for any line of business
- Determine if combined, medical loss, and administrative expense ratios appear reasonable.
- Losses incurred from ASO/ASC plans [Annual Financial Statement, Notes to Financial Statements, Note #18]
- Review the five-year trend with the Annual Financial Profile Report for the following measures of operating performance, and note any unusual fluctuations or trends between years for each ratio:
  - Ratios by line of business
  - Change in material individual income and expense categories
- Review the Analysis of Operations by Line of Business to determine which lines of business generated a loss.
- Compare the following measures of operating performance to the industry average to determine any significant deviations
  - Combined ratio
  - Return on capital and surplus

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Additional Review Considerations

- Compare the insurer's actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
- Describe any known trends that have had or that the insurer reasonably expects will have a material favorable or unfavorable impact on net revenues or net income or a material impact on the relationship between benefits, losses and expenses.
    - Consider if the insurer is dependent upon investment income.
    - If the insurer knows of events that will cause a material change in the relationship between benefits, losses, and expenses, the change in relationship should be disclosed.
- Review the Supplemental Health Care Exhibit (SHCE) to identify concerns or unusual items for further analysis. This procedure can help analysts determine what specific areas of operations or lines of business may be the source of poor operating performance.
    - Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses. This procedure can assist analysts in understanding the cause of poor operating performance and assess whether it is likely to continue going forward.
    - Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations. This procedure can assist analysts in evaluating the insurer's plans and mitigation strategies for addressing the poor operating performance.
- If the insurer writes Medicare Part D business, obtain and review supporting documents if concerns are identified related to the operating performance of Medicare Part D business. Supporting documents may include information on contracted benefits, premium and cost sharing with the CMS, and support for reserve, utilization and benefit cost assumptions projected in the development of the contract.

Lack of Effective Corporate Governance/Oversight of Operations

The lack of an effective governance function to oversee operations may make it difficult for the insurer to fulfill its strategic plan and achieve desired outcomes.

Procedures

Determine whether corporate governance practices of the insurer provide effective oversight of operations.

- Review the Corporate Governance Annual Disclosure (CGAD) filing (if filed on an insurance entity basis) to identify and assess the governance practices in place at the insurer. If the CGAD is filed on a group basis, rely on the information provided in the GPS or provided by the lead state if material risks are only relevant to specific insurance entities.
    - Identify and follow up on any issues noted that could affect the insurer's ability to adequately oversee operations.
- If your state is the lead state, document information and risks from the CGAD in the Group Profile Summary (GPS) (Refer to the procedures in chapter VI.D. Corporate Governance Disclosure Procedures of the Handbook.)
    - Identify and follow up on any issues noted that could affect the group's ability to adequately oversee operations.
    - If material risk relates only to an insurance entity, contact the domestic state in a timely manner.

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- If your state is not the lead state and the CGAD is filed to the lead state, review the corporate governance assessment included in the lead state's GPS and contact the lead state with any questions, concerns or follow-ups. Upon the receipt of any additional information, the non-lead state should document any material concerns regarding corporate governance that could impact the financial condition (e.g., operations, policyholder surplus or capital position) of the domestic insurer.
- Review the results of the corporate governance assessment conducted during the last on-site examination, other examination documentation or summaries, communication with the examiner-in-charge, or the most recent communication with the insurer, to identify issues or concerns to be considered or addressed.
- If concerns are identified, request a copy of recent board minutes to determine if the board of directors has taken any significant actions that may result in changes in operations, business structure, or management that may result in a material financial impact on the insurer.
- Consider reviewing internal resources on file related to the following, and if not on file, request the following information from the insurer:
    - For the board of directors and each committee established by the board of directors request a copy of the charter/policy, the business ethic policy, code of conduct policy, and conflict of interest policy
    - The most recent conflict of interest statement, or its equivalent, for each member of the board of directors and committees established by the board of directors including an explanation of any conflicts reported
    - Financial expertise or statutory accounting principles expertise of the audit committee
    - Reporting structure of the internal audit function
    - Copy of the company's by-laws currently in effect
    - If part of a holding company system, discussion on the level of oversight the parent company maintains over the insurer
    - Discussion of compliance with corporate governance statutes
    - Discussion of compensation policies, bonus/incentive programs, and management performance and assessment programs
    - Discussion of the board of directors' and management's responsibilities and authority
- Contact the insurer regarding actions taken to address the concerns identified.
- Based on the above procedures, determine if the board of directors and management provide a sufficient level of oversight and support.

Risks of Change in Operations,

OR

Turnover in Key Board or Sr. Management Positions

Evaluate the effects of changes in officers or directors on the operations of the insurer. A significant change in operations resulting from turnover or changes in key board of directors and/or senior management positions may increase operational risk and should be evaluated for their potential impact on the current and prospective solvency of the insurer.

Procedures

- Review any changes in officers, directors or trustees and any concerns noted during a review of biographical affidavits to assess suitability. Determine if:

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- new directors and officers have the required knowledge, experience and training to perform their duties. Document any concerns.
- new board of directors' members sufficiently independent from management and adequately engaged in performing their duties.
- there has been significant turnover in management in the current year or a pattern of turnover in the past five years. If so, document the reasons.
- new directors and officers have ever been officers, directors, trustees, key employees or controlling stockholders of an insurance company that, while they occupied any such position or served in any such capacity with respect to it:
  - Been placed in supervision, conservation, rehabilitation, or liquidation.
  - Been enjoined from, or ordered to cease and desist from, violating any securities or insurance law regulation.
  - Suffered the suspension or revocation of their certificate of authority or license to do business in any state.
  - If so, request and review the insurer's policies and procedures regarding performance of background checks on new management.

- If a significant amount of turnover and/or changes in key positions are identified, gain an understanding and evaluate the impact of such changes on the insurer's operations.
- Request updated business plans, hold in-person meetings, conduct conference calls, and take other steps to understand and address significant changes.
- Determine if there have been significant operational or business changes that have resulted in significant changes in staffing levels, consolidations of operations with affiliates, outsourcing of key functions, or placing blocks of business into run-off (closed) blocks.
- Review and evaluate the insurer's human capital and succession planning processes and controls.
  - Evaluate the insurer's management and personnel to identify directors, executives, or key employees that may be approaching retirement and discuss the steps taken by the company to plan for succession for any individuals identified.
  - Determine whether the insurer is overly reliant on any one individual to produce its business or manage its operations and discuss succession plans for any individuals identified.
  - Describe the insurer's processes to identify, appoint, train, evaluate, and compensate directors, executives, and key members of personnel.

Lack of Control over Purchases, Sales, and Investment Operations

Determine whether concerns exist related to investment operations, including purchases and sales of securities and control of assets. Assets not under the full control of the insurer may not be available to fulfill policyholder obligations. Assets that are not under the insurer's control might not meet the state's requirements to be considered net admitted assets.

Procedures/Data

- Ratio of payable for securities to total invested assets.
- Ratio of receivable for securities to total invested assets.

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- Review Annual Financial Statement, General Interrogatories, Part 1, #16 to determine if the purchase or sale of any investments have not been approved by the board of directors or a subordinate comettee thereof.
- Review the Annual Financial Statement, General Interrogatories, Part 1, #25.01 and #25.02 to determine:
  - if any stocks, bonds and other securities owned, over which the insurer has exclusive control, not in the actual possession of the insurer, other than securities lending programs.
  - the reason the securities are not in the entity's possession and who holds the securities in order to evaluate whether they qualify as net admitted assets of the entity under the state insurance laws or whether there are concerns regarding the entity's ability to have access to the securities when needed.
- Review Annual Financial Statement, General Interrogatories, Part 1, #26.1 and #26.21 to determine:
  - if any stocks, bonds or other assets owned by the insurer not exclusively under the control of the insurer.
  - why are the assets not under the entity's exclusive control (e.g., loaned to others, subject to repurchase or reverse purchase agreements, pledged as collateral, placed under option agreements).
- Review Annual Financial Statement, General Interrogatories, Part 1, #21.1 and #21.21 to determine
  - if any assets were reported subject to a contractual obligation to transfer to another party without the liability for such obligation being reported.
  - the purpose and the amount.

Additional Review Considerations

- Request a copy of the insurer's investment plan to determine who is authorized to purchase and sell investments and what approvals are required for investment transactions.

Questionable Investment Activities

Analysts should also consider if the insurer's investment performance or risks in its investment portfolio may be masked due to questionable investment activities (e.g., wash sales, window dressing, etc.).

Procedures

- Review the Annual Financial Statement, Schedule D – Part 3 and Schedule D – Part 5, to determine:
  - if significant amounts of bonds or stocks purchased near the beginning or the end of the year.
  - types of securities purchased and the vendors used for those purchases.
- Review the Annual Financial Statement, Schedule D – Part 4 and Schedule D – Part 5, to determine:
  - if significant amounts of bonds or stocks disposed of near the beginning or the end of the year.
  - types of securities sold and the purchasers of those securities.
- Review Annual Financial Statement, Schedule D – Part 5 to determine
  - if significant amounts of bonds or stocks acquired near the beginning of the year and disposed of near the end of the year
  - types of securities purchased, the vendors used for those purchases and the purchasers of those securities.
- Based on the results of the two previous questions, determine whether the insurer might have engaged in "window dressing" of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end).

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Concerns with Third-Party Investment Advisors

Determine whether any concerns exist regarding third-party investment advisors, associated contractual arrangements, and related party exposure in the investment portfolio. Heavy reliance on unqualified investment advisors or lack of effective oversight may lead to excessive risk taking and increases in fraud and investment reporting risks.

As investments and investment strategies grow in complexity, insurers may consider the use of unaffiliated third-party investment advisers to manage their investment strategy. Investment advisers may operate independently or as part of an investment company. Investment advisers and companies are subject to regulation by the U.S. Securities and Exchange Commission (SEC) and/or by the states in which they operate, generally based on the size of their business. In certain situations insurers may use a broker-dealer for investment advice. Broker dealers are subject to regulation by the Financial Industry Regulatory Authority (FINRA). Regardless, most broker dealers and investment advisers will register with the SEC and annually update a Form ADV-Uniform Application for Investment Adviser Registration and Report Form by Exempt Reporting Advisers which provides extensive information about the nature of the organization's operations. To locate these forms, analysts can go to *www.adviserinfo.sec.gov* and perform a search based on the company name.

Key Information provided on a Form ADV includes:

a. Regulatory agencies and states in which the adviser/broker is registered

b. Information about the advisory business including size of operation and types of customers (Item 5)

c. Information about whether the company provides custodial services (Item 9)

d. Information about disciplinary action and/or criminal records (Item 11)

e. A report of the independent public accountant verifying compliance if the investment advisor also acts as custodian

It is important to note that the information provided on Form ADV is self-reported and is subject to limited regulatory oversight. However, the information may be valuable to analysts in assessing the suitability and capability of investment advisers providing advisory services to insurers. Note that the SEC does not officially use the term "good standing"; however, for this analysis, the term is used to mean a firm that is registered as an investment adviser with the SEC and does not report disciplinary actions or criminal records in Item 11 of the form ADV.

Procedures

- Review the Annual Financial Statement, General Interrogatories, Part 1, #29.05 to determine if the insurer utilizes third party investment advisors, broker-dealers or individuals acting on behalf of the insurer with access to its investment accounts.
- If yes, consider the following procedures:
  - Verify that all affiliated and unaffiliated investment advisors the analyst is aware of are disclosed in the interrogatory, whether primary or sub-advisors.
    - Verify that Investment Management Agreements required to be filed with the department have been filed and consider requesting copies of agreements that have not been filed with the department for review.
    - Gain an understanding of the types of investments that are being managed by each of the advisors/sub-advisors disclosed in the interrogatory.
  - Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners. Determine if the examination identified any issues with regard to investment advisors and associated contractual

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arrangements that require follow-up analysis or communication with the insurer. If yes, document the follow-up performed.

- Note: The examiner may have performed steps to determine the following: 1) whether the investment adviser is suitable for the role (including whether he/she registered and in good standing with the SEC and/or state securities regulators); 2) whether the investment advisory agreements contain appropriate provisions; 3) whether the adviser is acting in accordance with the agreement; and 4) whether management/board oversight of the investment adviser is sufficient for the relationships in place.

- Compare Annual Financial Statement, General Interrogatories, Part 1, #29.05 for the current year to the prior year to determine if there have been any changes in advisors that may prospectively impact the insurer's investment strategy and overall management of the investment portfolio. If yes, consider obtaining:
  - An explanation for the change from the insurer
  - A copy of the new investment advisor agreement and review it for appropriate provisions, to gain an understanding of the provisions including the adviser's authority, specific reference to compliance with the insurer's investment strategy and/or policy statements, as well as state investment laws; conflicts of interest; fiduciary responsibilities; fees; and the insurer's review of the adviser's performance. (Refer to the *Financial Condition Examiners Handbook* for further guidance.)
- Using the information reported in Annual Financial Statement, General Interrogatories, Part 1, #29.05, obtain and review SEC Form ADV (if available), to determine if the investment advisor is in good standing with the SEC. If not, contact the insurer to request an explanation.
  - See additional guidance in V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for reviewing affiliated investment manager agreements.
- If agreements with third party investment advisors are affiliated, has the appropriate form D-Prior Notice of Transaction been filed and approved by the department? Were any concerns noted or follow-up monitoring recommended?
- Request information from the insurer regarding the background and expertise in any complex or non-traditional assets (such as structured securities, mortgage loans, investment funds) of its investment advisors (in-house and/or contractual) and its analytical systems capabilities. Determine whether the advisors and systems are adequate to allow the entity to continuously monitor its investments.
- If the insurer uses an external asset manager, consider if there are any investments that may represent a potential for conflict. Examples of this are (1) if there are Investments Report on Schedule BA that are funds that are affiliated/related with the asset manager or are managed by that asset manager, (2) Structured Securities in which the asset manager or an affiliate/related party had a role in originating, or (3) direct investments in the asset manager or any of its affiliates/related parties. If the external asset manager qualifies as a related party, utilize guidance provided in the "Related Party Exposure in the Investment Portfolio" section above to assist in this review. Consider the following issues:
  - Have any potential conflicts of interest been reviewed and formally approved by the Board or Investment Committee.
  - If the investment is appropriate for the insurer's portfolio and is arm's-length.
  - If the insurer is paying overlapping fees.

Related Party Exposure in Investment Portfolio

Determine related party exposure in the investment portfolio and assess any related market risk.

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Related parties are entities that have common interests as a result of ownership, control, affiliation or by contract as definited in *SSAP No. 25—Affiliates and Other Related Parties* (SSAP No. 25). Refer to the *Insurance Holding Company System Model Act* (Model #440) and SSAP No. 25 for a broader definition of "affiliate," "related party" and "control".

Related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the reporting entity or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny.

Procedures

- Review the Annual Financial Statement investment schedules B, BA, D, DA, DB, DL, and E (Part 2), as disclosed in the column "Investments Involving Related Parties" and Utilize the tools available in iSite+ to identify if the insurer has a material exposure to investments involving related parties, either on an asset category basis or in aggregate, and by the related party designation noted below. All investments involving related parties must include disclosure to ensure full transparency which is located in the column previously noted. It designates investments by the following roles:
    1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.
    2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.
    3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.
    4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.
    5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.
    6. The investment does not involve a related party.
- If a material exposure exists, further assessment of the [credit, market, liquidity] risk may be warranted to assess the credit quality of those investments by reviewing designations, assessing historical default experience, etc. Also consider the extent to which related parties are involved in securitizing or originating business for the insurer, and what differences may exist in how investments involving related parties are valued. If the role of the related party is that of a third-party advisor, factors to consider may include for example, the expertise of the related party advisor, any potential conflicts of interest, and if related parties are originating investments only for the insurer or also to the public, the latter being subject to SEC requirements.
- Review the insurer's investment policy guidelines and determine whether the related party investments follow the guidelines and are in compliance with regulatory requirements.
- Review whether the fee structure for asset management is fair, reasonable, and appropriately recognized as investment expenses.

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- If the related party assets manager also originates/securitizes investments held by the insurer, consider requesting additional information from the insurer to determine the following:
    - Whether the assets manager has adequate experienceand knowledge in originating and manging the types of investments;
    - Whether the assets manager follows appropriate underwriting practices and applicable regulatory requirements in originating investments; and
    - Whether the fee structures embedded in securities (if applicable) are fair, reasonable, and appropriately account for potential duplication of fees or conflicts of interest.

Changes in Corporate Structure

Determine whether any concerns exist regarding changes in the insurer's corporate structure.

Significant changes in corporate structure may materially impact the entity's future financial condition and generally require prior regulatory approval. Analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure in which the insurer operates, future problems may be avoided. For example, a common corporate structure involves a holding company whose only significant asset is the stock of the insurance entity. The holding company may have financed the acquisition of the insurer through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the insurer. This type of corporate structure warrants close attention to ensure that dividends are valid and in compliance with your state's applicable dividend restrictions, and that any other payments by the insurer to the holding company are legitimate, rather than dividends in disguise. Analysts should also be alert to a corporate structure that includes affiliated brokers or intermediaries that may be recording unusual or significant levels of commissions and fees. When a corporate structure is involved that includes multiple tiers of affiliates where significant levels of surplus are comprised of investments in affiliates, focus on the level of surplus that exists on a consolidated basis.

Additional steps may be performed if the insurer's corporate structure elevates concerns about transactions with affiliates. The primary objective is to understand the financial position of the parent company. By understanding the financial commitments of the parent, analysts will be able to better understand the parent's motivation for entering into transactions with the insurer or other affiliates. Financial statements of affiliates may reveal unauthorized transactions in progress.

The following procedures for the review of corporate structure and transactions with affiliates should consider any analysis already completed or anticipated to be completed with regard to the Holding Company Analysis performed by the lead state, review of the Form B – Registration Statement and any review of Form D – Material Transactions to avoid duplication of analysis.

Procedures

- Review the Annual Financial Statement, Schedule Y – Part 1 and additional information provided in Form B, for the current and prior year to determine:
    - if there any significant changes to the corporate structure during the year (e.g., acquisitions, divestitures, mergers).
        - If the answer is yes, and the change involved ownership of the insurer or a transaction with an affiliate, determine if the insurer failed to receive proper regulatory approval.
    - if there are any indications that the corporate structure may include a holding company whose primary asset is the stock of an insurance company.
    - if the insurer has an agency or brokerage subsidiary.

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Risks Associated with Significant and Complex Services and Transactions with Affiliates

Several types of transactions with affiliates are reported in the Annual Financial Statement, Schedule Y – Part 2, and explanatory comments are provided in the Annual Financial Statement, Notes to Financial Statements, #10. In addition, information is made available in Note #13, as well as in holding company filings (Form B and Form D) that are received from insurance holding company systems throughout the year. Refer to all of these sources of information in order to develop an understanding and assessment of the underlying transactions with affiliates.

Risks of Affiliated Transactions—Economic-Based and In Compliance

The primary objective in this area is to understand the substance of the transactions and to determine whether the transactions are economic-based and in compliance with regulatory guidelines. Review the extent of transactions with officers and directors to ensure that the transactions are at arm's length and are not detrimental to the financial condition of the insurer. Significant services and transactions with affiliates can alter financial performance and increase risks related to cost sharing, contingent liabilities, unauthorized dividends, etc.

Risk of Unauthorized Dividends,

OR

Risks Related to Capital Contributions

The following briefly describes the key concerns for several of the major transactions with affiliates. For shareholder dividends, the major concern relates to whether the level of dividends is within the regulatory guidelines and whether the dividends should be considered extraordinary and therefore requires prior regulatory approval.

For capital contributions from the insurer to another affiliate, analysts should determine that such contributions do not substantially impact the financial condition of the insurer.

For non-cash capital contributions to the insurer, analysts should determine that the infusion is recorded at fair value so as to not arbitrarily inflate surplus. In the case of purchases, sales or exchanges of loans, securities, real estate, mortgage loans, or other investments, the concern to analysts is primarily one of valuation. These types of transfers should be at arm's length and recorded at fair value.

Also, be alert to possible abuses regarding the transfer of assets between property/casualty and life/health affiliates merely to impact the RBC calculation of the affiliates. For management agreements and service contracts, the main concerns relate to the type of service being performed and the reasonableness of the cost. This is a common area for abuse when parent companies desire to withdraw funds from the insurer but do not want to or would not be permitted to classify it as a shareholder dividend. Understand why the parties were motivated to enter into such contracts and particularly, the benefit to the insurer. For those services provided by an affiliate where a market already exists (such as data processing, actuarial, or investment management), an effective way to determine whether an arm's length transaction exists is to contact one of the vendors and request a proposal or fee estimate for a similar service.

In understanding and evaluating these transactions, identify any discrepancies in reporting across the various information sources. In addition, verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.

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Procedures/Data

- Review the ratio of management fees paid to affiliates to total expenses incurred. (P/C Annual Financial Statement, Underwriting and Investment Income Exhibit, Part 3), (L/A&H Annual Financial Statement, Exhibit 2 General Expenses, Footnote (a)), or (Health Annual Financial Statement, Underwriting and Investment Exhibit, Part 3).
- Review the Annual Financial Statement, Schedule Y – Part 2, Notes to Financial Statement – Note #10 and Note #13, and additional information provided in Form B and D:
    - Determine whether any unusual items were noted, such as significant new transactions with affiliates or modified intercompany agreements from the prior year or significant increases in transaction amounts.
    - Determine whether the insurer has forwarded to any affiliate funds greater than 15% of the insurer's surplus.
    - Determine whether affiliated undertakings resulting in a contingent liability to the insurer involve financial exposure greater than 25% of surplus.
    - Review the description of management agreements and service contracts. Determine if an allocation basis involved other than one designed to estimate actual cost.
- Review the Annual Financial Statement, Schedule Y – Part 2 and the Notes to Financial Statements – Note #10 to identify any discrepancies in reporting between the two disclosures.
- Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved (e.g., Dividends – Note #13 and Structured Settlements – Note #27).
- Did capital contributions from the insurer to another affiliate substantially impact the financial condition of the insurer?
    - Were non-cash capital contributions into the insurer not recorded at fair value?
    - Were purchases, sales, or exchanges of loans, securities, real estate, mortgage loans, or other investments, not at arms-length or not recorded at fair value?
    - Did any transfer of assets between insurance affiliates impact the risk-based capital calculation?
- **Risk Retention Groups:** Summarize the insurer's level of reliance on captive managers, TPAs, or MGAs to run its business operations (e.g., underwriting, claims, records, and reporting).
    - If significant reliance exists, describe the services provided, and additional relationships, whether the expense ratio is in line with industry standards, and whether those parties service other insurers.

Additional Review Considerations

Take additional steps if concerns regarding the economic substance of an affliated transaction are identified. Such steps include independent appraisals, comparisons to third-party services/bids, detailed review of contracts, review of the financial condition of the affiliate, reviewing collection, etc. In addition, the analyst should consider recommending procedures for the next examination (targeted or full-scope) to verify information reported on transactions with affiliates and to further evaluate the fairness and reasonableness of charges. In so doing, consider additional guidance regarding criteria to be considered in determining whether an agreement with affiliates merits review during an onsite examination at section V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide (Form D - Prior Notice of a Transaction).

- If there is a concern related to the fair value of a transaction with affiliates:
    - Obtain and review an appraisal of the asset transferred.
    - Consider consulting an independent appraiser.

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- If the concern involves a management agreement or service contract:
  - Obtain and review the supporting contract and compare against Form D filing previously submitted to the department (if applicable).
  - Determine whether the amounts involved are reasonable approximations of actual costs.
  - Determine whether the actual amounts paid are in agreement with the supporting contact.
  - For any arrangement based on a cost-plus formula or percent of premiums formula, request justification from the insurer for amounts in excess of the actual costs of providing the service.
  - For those services being performed by/for an affiliate and that are also provided by unrelated third-party vendors (e.g., data processing, actuarial, investment management), contact such vendors or review vendor pricing schedules in order to determine the reasonableness of the intercompany transfer pricing level.
  - Evaluate whether any portion of such fees in substance dividends should be evaluated in the contact of dividend regulations.
  - Determine if agreements received appropriate regulatory approval in conformity with regulatory requirements.
  - Consider whether additional examination procedures should be recommended to verify/validate information regarding transactions and services with affiliates or to further consider whether the expense allocations continue to be fair and reasonable.
  - See additional guidance regarding criteria to be considered in determining whether an agreement with affiliates merits review during an onsite examination at section V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide (Form D - Prior Notice of a Transaction).

Risk of Affiliated Transactions—Not Legitimate or Not Properly Accounted For

Determine whether other transactions with affiliates are legitimate and properly accounted for.

Exposure to Collectability Risk

Closely monitor other transactions with affiliates to ensure that the insurer is not exposed to significant collectability risk. For example, if the insurer is included in a consolidated federal income tax return and a significant asset for federal income tax recoverable is recorded on the financial statements of the insurer, Closely review the financial statements of the parent to determine the parent's ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectability risk to the insurer. When the amounts of structured settlements are significant, analysts should review and understand the financial statements of the life insurance affiliate.

Procedures/Data

- Review the following ratios to determine the level of affiliated transactions:
  - Affiliated receivables to policyholder surplus.
  - Affiliated payables to policyholder surplus.
  - Federal income tax recoverables to policyholder surplus (P&C) or to capital and surplus (Life/A&H, and Health).
  - Health: Non-current balances [Health Annual Financial Statement, Exhibit 6]
  - Health: Ratio of payments made to affiliated providers to total payments

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- Determine if any foreign entity controls 10% or more of the insurer, either directly or indirectly, through a holding company system. [Annual Financial Statement, General Interrogatories, Part 1, #7.1 and #7.2.].
    - If so, determine if the insurer properly disclosed the investment in Schedule Y, Part 1.
- Review the Annual Financial Statement, General Interrogatories, Part 1, #20.1 and #20.2 to assess the exposure to loans to directors, officers, and other stakeholders:
    - Ratio of total amount loaned to directors, other officers, or stockholders to net income.
    - Ratio of total amount of loans outstanding at the end of the year to directors, other officers, or stockholders to policyholder surplus.
- Determine if the insurer has failed to establish a conflict-of-interest disclosure policy [Annual Financial Statement, General Interrogatories, Part 1, #18].
    - If so, is there any evidence that activities of directors, officers or shareholders were in violation of state statutes?

Additional Review Considerations

- Review Annual Financial Statement, Schedule E – Part 1:
    - Determine if any open depositories are a parent, subsidiary, or affiliate.
    - Based upon a review of the holding company financial statements (as filed with the Annual Holding Company Registration Statement Form B), determine if any holding company lenders reported that also appear as open depositories of the insurer.
    - If holding company lenders also appear as open depositories of the insurer, verify this is properly disclosed on Schedule Y – Part 1
    - Determine if there is any evidence that activities directors, officers and shareholders were in violation of state statutes
- Review the Annual Financial Statement, Notes to Financial Statements, Note #9:
    - If the insurer is included in a consolidation federal income tax return, note any concerns relating to how taxes are allocated to the insurer.
    - Review the tax-sharing agreement and verify whether the terms are being followed.
    - Obtain and review the financial statements of the parent of affiliate and evaluate any collectability to the insurer.
    - Verify whether the amount recoverable from the prior year-end has been collected/recovered.
    - If federal income tax recoverables are greater material to surplus and if there are federal income tax recoverables due from an affiliate.
    - If the concern relates to federal tax recoverables from a parent or affiliate:
        - Obtain and review the financial statements of the parent or affiliate, and evaluate any collectability risk to the insurer
        - Review the tax-sharing agreement, and verify that terms of the tax-sharing agreement are being followed
        - Verify that the amount recoverable from the prior year-end has been paid
- Review the Annual Financial Statement, Notes to Financial Statements, Note #27:
    - Determine if the insurer has acquired structured settlements from an affiliated life insurance company.

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- If so, determine if the amount of loss reserved eliminated by annuities greater material to surplus.
- Determine the current rating of the affiliates from the major rating agencies, if available.
- Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.
- Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.
- Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.

- Review the Annual Financial Statement, General Interrogatories, Part 2, #5. In case of reciprocal exchange:
  - Check for any unusual items noted regarding compensation of the attorney-in-fact.
  - If there is an approved agreement on file with the insurance department, review the Articles of Agreement.
- If unusual items were noted, determine if the insurer properly disclosed the investment on the Annual Financial Statement, Schedule Y – Part 2. If not properly disclosed in Schedule Y – Part 2, determine if any evidence exists that activities of directors, other officers, or shareholders were in violation of state statutes.
- Are there any financial guarantees in place, in any form between the insurer and any member of the holding company system?
- Review the Annual Financial Statement, Schedule SIS to determine if there are any unusual items noted regarding transactions with, or compensation to directors and officers.
- Assemble a list of all affiliated and other related parties and summarize the financial impact of each transaction. Identify any other unusual transactions and investigate for reasonableness.

Health Only:

- If concern exists regarding downstream risk with affiliated provider intermediaries:
  - Obtain and review the Audited Financial Report and Annual Financial Statement of the affiliate, if available.
  - Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups, if available.
  - Obtain and review the actuarial opinion of the affiliate, if available.
  - Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.
- Review the Annual Financial Statement, Exhibit 5.
  - Are there any balances over 90 days which are admitted?
  - Does the exhibit otherwise suggest that the insurer may have collectability issues with its affiliates?
  - Are any of the receivable balances from an affiliate which the insurer also reports a payable balance on Exhibit 6 and could therefore net the balances on the face of the balance sheet if the requirements of SSAP 64 were met?
  - Is the analyst aware of any receivable balances from an affiliate which has experienced some financial problems?
  - Are there any affiliated receivable balances from medical providers or intermediaries included on Exhibit 5?

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- Review the Annual Financial Statement, Exhibit 6. Are any of the balances unusually large for the description or are any of the descriptions unusual?
- Review the Annual Financial Statement, Exhibit 7 – Part 1. Has there been any indication that the amount charged by the affiliated provider is non-economic or non-arms-length?

Significant Reliance on MGAs and TPAs,

OR

Concerns with MGAs and TPAs

Determine whether concerns exist due to a significant amount of the insurer's direct premiums being written through MGAs and TPAs.

While the amount of direct premiums written by MGAs and TPAs is not necessarily an indication of a problem or concern, this procedure provides an indication of the insurer's exposure to potential abuse by MGAs and TPAs. MGAs and TPAs who had been delegated significant authority without insurer oversight have played a major role in the insolvency of several large insurers.

Perform additional steps if there are concerns regarding the insurer's use of MGAs and TPAs. Consider reviewing the information in the Annual Financial Statement, Notes to Financial Statements, Note #19 to determine which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the insurer), the types and amount of direct premium written by each, and the types of authority granted to each by the insurer.

For the more significant MGAs and TPAs, consider requesting information from the insurer to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether the MGA or TPA arranged for that reinsurance. If the MGA or TPA arranged for the reinsurance, consider determining whether the MGA or TPA is affiliated with the reinsurer. In addition, consider reviewing the reinsurance agreements to determine whether the terms are reasonable. For the more significant MGAs and TPAs, consider requesting information from the insurer regarding commission rates and any other amounts paid to the MGAs and TPAs, reviewing that information for reasonableness and comparing the commission rates to those paid by the insurer to other agents. Any arrangement involving sliding-scale commissions based on loss ratios or a sharing of interim profits on business, where the MGA or TPA establishes claim liabilities or controls claim payments, should be reviewed closely to determine if there is potential for abuse by the MGA or TPA. In addition, consider determining whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid Certificates of Authority.

The more authority that is delegated to an MGA or TPA, the more important it is for the insurer to provide active, ongoing oversight into the MGA's or TPA's operations. To evaluate the insurer's oversight of significant MGAs and TPAs, consider requesting from the insurer copies of its contracts with the MGAs and TPAs to determine compliance with the minimum contract provisions per the MGA Act and the TPA Guideline and/or the applicable provisions of the insurance code. Also consider requesting from the insurer copies of financial statements for the significant MGAs and TPAs and documentation supporting the insurer's periodic (at least semi-annual) review of the underwriting and claims processing systems. If there are concerns regarding the business placed with the insurer by an MGA or TPA, analysts should consider determining if other insurers are utilizing the same MGA or TPA and comparing the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates).

Procedures/Data

Determine whether concerns exist due to a significant amount of the insurer's direct premiums being written through managing general agents (MGAs) and third-party administrators (TPAs).

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- Determine if any agent, general agent, broker, sales representative, non-affiliated sales/service organization, or any combination thereof under common control (other than salaried employees of the insurer) received credit or commissions for or control a substantial part of either the sale of new business or renewals. [Annual Financial Statement, General Interrogatories, Part 1, #4.1 and #4.2].
- Determine if the aggregate amount of direct premiums written through MGAs and TPAs to total direct premiums written were material. [Annual Financial Statements, Note #19]. Health: Ratio of Aggregate direct premiums written through MGAs and TPAs to capital and surplus.
- Health: Ratio of direct medical expense payments made to intermediaries to total medical expense payments.

Additional Review Considerations

- Review the Annual Financial Statement, Notes to Financial Statements, Note #19 (which lists all individual MGAs and TPAs whose direct writings are greater than 5% of surplus), determine the following:
  - Which MGAs and TPAs are being utilized and whether any are affiliated with the insurer.
  - The types and amount of direct business written by MGAs and TPAs.
  - The types of authority granted to the MGAs and TPAs by the insurer.
- Determine whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid certificates of authority. In some states, an insurer may utilize an MGA who is not licensed if biographical questionnaires have been submitted for each individual owning more than 10% of the MGA. If this provision is applicable and the MGA is not licensed, verify that the required biographical questionnaires have been submitted.

For the more significant MGAs and TPAs, if further concerns exist request the following information from the insurer to evaluate:

- P&C: The comparability of the incurred loss and LAE ratios on the business written by the MGA and TPA with that written directly by the insurer (for the lines of business in which significant, but not all, direct business is written through the MGA/TPA).
- Whether the business produced by the MGA and TPA is ceded to a particular reinsurer and, if so, whether that reinsurance was arranged by the MGA or TPA. If the MGA or TPA arranged for the reinsurance, determine whether the MGA or TPA is affiliated with the reinsurer, and consider reviewing the reinsurance agreements to determine whether the terms are reasonable.
- Commission rates and any other amounts paid to the MGA and TPA. Review the information for reasonableness and compare the commission rates to those paid by the insurer to other agents.
- Whether the contracts between the insurer and MGA include minimum required provisions per Section 4 of the NAIC *Managing General Agents Act* (#225) and/or the applicable sections of the insurance code.
- Whether the contracts between the insurer and TPA include minimum required provisions per Sections 2,4,6,7 and 8 of the NAIC *Registration and Regulation of Third-Party Administrators* (#1090) and/or the applicable sections of the insurance code.
- The most recent independent CPA audit or annual report of the MGA or TPA (or IPA for Health Entities).
- For P&C: If the MGA establishes loss reserves, the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA.
- Documentation supporting the insurer's periodic (at least semi-annual) on-site review of the MGA's underwriting and claims processing operations.

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- Documentation supporting the insurer's periodic (at least semi-annual) review of the underwriting and claims processing operations of the TPA (or IPA for Health Entities). (Model #225 requires at least one of the semi-annual reviews to be an on-site audit of the operations of the TPA.)
- For Health Entities, consider requesting from the insurer:
    - A listing of significant TPAs and IPAs that pre-authorize, or process claims for the insurer, by line of health business (e.g., pharmacy, vision, mental health) and/or provider types (Hospitals, Physicians).
    - Whether the TPAs and IPAs utilized by the insurer are properly licensed to process, preauthorize or otherwise administrator claims.
    - Contracts between the insurer and the TPA or IPA to determine whether the contracts include minimum provisions.
- For Health Entities, review analyst notes or exam reports for the other companies using the same intermediaries if there is reason to believe problems exist with those entities.
- For Health Entities, if, with respect to business produced by the TPA or IPA, the TPA or IPA provides the insurer with claim reserve and/or claim adjustment expense reserve estimates that are incorporated into the insurer's financial statement, an opinion from an actuary employed or retained by the TPA or IPA attesting to the adequacy of such reserves.
- For Health Entities, if the TPA or IPA provides paid claims data that is used by the insurer in establishing claim reserves, determine whether the insurer or the actuary providing the insurer's claim reserve certification tested data provided by the TPA or IPA.

If there are concerns regarding the business placed with the insurer by an MGA or TPA, consider determining if other insurers are utilizing the same MGA or TPA and perform the following:

- Compare the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether the contracts are similar (e.g., contain the same commission rates).
- Compare the insurer's loss and LAE ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer may be receiving a disproportionate amount of "bad" business from the MGA or TPA.

Risks With Management of Separate Accounts (Life/A&H)

Determine whether concerns exist regarding the appropriateness of business being placed within separate accounts or regarding transactions between the general account and the separate account. Challenges in properly managing and reporting separate account business and transactions with the general account may mask true financial performance and/or understate liabilities due to the separate account.

Criteria for qualifying for separate account classification under GAAP are outlined in *Statement of Statutory Accounting Principles (*SSAP*) No. 56—Separate Accounts*. A separate account product must meet four conditions as defined in Separate Accounts Annual Financial Statement, General Interrogatories, #8.2 in order to receive separate account classification: 1) legal recognition; 2) legal insulation; 3) investment directive; and 4) investment performance. If an insurer reports any products that do not meet these criteria, analysts should review the conditions listed in Separate Accounts Annual Financial Statement, General Interrogatories, #8.3 and further review the details of the separate account disclosures, as this is an indication the insurer includes products in its separate account that are not true separate account products.

Some insurers may include non-variable (non-unit linked) products in the separate account. Separate Accounts Annual Financial Statement, General Interrogatories, #8.3 may assist analysts in determining if such products are included. Analysts should gain an understanding of the reasons why non-variable products are included in the

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separate account. Analysts may need to contact the policy form unit within the insurance department to obtain information about the policy form application and approval to help gain such understanding of the products included in the separate account. Analysts may need to contact the insurer to request additional information about the policies included in the separate account. Considerations may include: What investment guidelines apply to these products? Outside of product guarantees, does the general account have any responsibilities for funding the reserve liabilities?

If the insurer filed a non-insulated separate accounts statement, *Procedure #10.b.* assists analysts in gaining an understanding of the insurer's non-insulated products.

All separate accounts activity reaches the Separate Accounts Annual Financial Statement through the General Account Annual Financial Statement. Premiums are recorded in the general account and then "transferred to" the Separate Accounts Annual Financial Statement through the item Net Transfers to or from Separate Accounts (referred to as "above the line" activity). Once the premiums have been moved to the separate accounts, all direct investment activity and reserve changes are recorded on the Separate Accounts Annual Financial Statement. Seed money is "contributed to or withdrawn from" the Separate Accounts Annual Financial Statement through the item Surplus (contributed to) withdrawn from Separate Accounts during the period (referred to as "below the line" activity).

Additional procedures assist analysts in determining that the accounting for activity between the separate accounts and the general accounts is proper. The primary concern here is to properly classify such activity as to "above the line" (i.e., recorded on the Net Transfers to or (from) Separate Accounts line on the general account) or "below the line" activity (i.e., recorded on the Change in Surplus in Separate Accounts Statement on the general account). An additional area analysts should investigate in this regard is the level of investment management fees charged to the separate accounts. The SEC has set maximums for the level of such fees. Common industry practice is for this fee to range between 125 and 140 basis points on separate accounts assets.

Procedures/Data

Determine whether concerns exist regarding the appropriateness of business being placed within separate accounts or regarding transactions between the general account and the separate account.

- Determine if the insurer reported any separate account products that do not meet separate account GAAP classification? If so, review in detail the products and conditions listed. [Separate Accounts Financial Statement, General Interrogatory #8.3]
- Determine if the insurer filed a non-insulated separate accounts statement. Identify and document any concerns regarding the inclusion of non-insulated products in the separate account.
- Portion of capital and surplus funds of the insurer covered by assets in the Separate Accounts Financial Statement greater than capital and surplus
- Portion of capital and surplus not distributable from the separate accounts to the general account for use by the general account. [Annual Financial Statement, General Interrogatories, Part 2, #3.3]
- Compare the amounts recorded on page 4, line 20 of the Separate Accounts Financial Statement, contributed surplus, to Page 4, line 46 of the General Account Financial Statement, surplus (contributed to) withdrawn from separate accounts during period and verify the amounts reconcile.
- Determine if other changes in surplus in the Separate Accounts Financial Statement are greater than capital and surplus.

Additional Review Considerations

- Determine if any non-variable (non-unit linked) products were reported in the Separate Account. If so:

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  - Review the specific product information to determine and understand the reasons for including non-variable products in the separate accounts.
  - Identify and document any concerns regarding the non-variable products' inclusion in the separate accounts.
- Request additional information from the insurer of any unusual or non-variable (non-unit linked) products included in the separate accounts.
- Review the Annual Financial Statement, Notes to Financial Statements, Note #35 – Separate Accounts.
  - Determine if the amounts transferred between the general account and separate accounts statement(s) reconcile.
  - Determine if any recording adjustments are noted.
  - Determine if the net amount of all reconciling items is material to statutory net income.
- Assess and determine if any additional concerns exist regarding separate accounts reporting.
- Review the Separate Accounts Annual Financial Statement and the General Account Annual Financial Statement and:
  - Verify that the separate accounts gain from operations is properly recorded in the capital and surplus section of the General Account Summary of Operations.
  - Verify that all other premium and benefits activity is properly recorded on the net transfers to or (from) separate accounts line of the General Account Summary of Operations.
  - Review the Separate Accounts Summary of Operations and surplus account in order to identify potential misclassifications as to "above the line" and "below the line" classifications.
- Review the level of investment management fees charged to the separate accounts to determine that they are in the generally accepted range of 125 to 140 basis points on separate accounts assets.
- Review the insurer's response to Annual Financial Statement, General Interrogatories, Part 2, #3.3. Assess if any concerns exist regarding the portion of capital and surplus funds of the insurer covered by assets in the Separate Accounts Financial Statements that are not currently distributable from the separate accounts to the general account for use by the general account.

Risk Transfer Agreements Other Than Reinsurance (Health)

Determine whether experience rating arrangements are significant, reasonable and paid on a timely basis.

Concerns with Experience Rated Arrangements

The materiality of experience rated arrangements is determined by comparing the amount due from groups (from write-in for other than invested assets) and the amount due to groups (from reserve for rate credits or experience rating refunds on the Annual Financial Statement, Underwriting and Investment Exhibit, Part 2D, Line 4) to total hospital and medical benefits paid. If experience rating arrangements are significant, analysts should determine whether amounts are reasonable and settled on a timely basis by comparing to prior year balances and inquiring of the company, if necessary.

Procedures/Data

- Determine if experience rating arrangements are significant, reasonable, and settled on a timely basis.
  - Compare reserve for rate credits or experience rating refunds to total hospital and medical expenses. Determine if the insurer reported reserve for rate credits or experienced rating refunds to be collected

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from the prior year. If not settled on a timely manner, inquire with the insurer for any balances outstanding. [Annual Financial Statement, Underwriting and Investment Exhibit – Part 2D, Line 4]

- Compare amounts due from experience rating arrangements from the write-in for other than invested assets to total hospital and medical expenses. Determine if the insurer reported amounts due from experience rating arrangements.
- Determine whether the insurer has reported appropriate reserves. Determine if a premium stabilization reserve been included in the reserve for rate credits or experience rating refunds. [Annual Financial Statement, Underwriting and Investment Exhibit – Part 2D, Line 4]

Concerns with Capitation Agreements and Payments

Determine whether capitation payments with providers are material and whether risks exist with providers' or intermediaries' ability to meet capitation agreement obligations. The significance of capitation payments is determined by comparing their total to hospital and medical benefits paid. Also, the percent of capitation being paid to intermediaries or "other providers" is reviewed to determine if there is a disproportionate amount being paid to these entities and the proportion of bonuses and withhold payments is reviewed for appropriateness. If capitation payments are material, analysts are asked to review whether provider agreements have been filed with the department and if the arrangements are properly reflected in RBC reporting. If an intermediary (TPA or Individual Practice Associations (IPA)) is involved in capitation payments, analysts are encouraged to request audited financial statements for the intermediary (to verify financial position) and to consider obtaining and reviewing an actuarial opinion on the reserves established for claims incurred and outstanding on business produced by the intermediary.

Determine if capitation payments with providers are material and if so, whether risks exist with providers' or intermediaries' ability to meet capitation agreement obligations.

Procedures/Data

- Compare total capitation payments to intermediaries to total hospital and medical expenses [Annual Financial Statement, Exhibit 7 – Part 1]
- Health care receivables to capital and surplus.
- Percentage of members covered by capitated arrangements based on capitation payments to total payments.

Additional Review Considerations

- Determine if the insurer has completed Annual Financial Statement, Exhibit 7 – Part 1.
- Determine if the insurer has capitation agreements with providers.
  - Determine if there are copies of provider agreements with domiciliary jurisdiction.
  - If the insurer has capitation arrangements with providers, ensure the appropriate information has been entered in the RBC filing (worksheet XR017).
- Determine if capitation to groups or intermediaries reported in Annual Financial Statement, Exhibit 7 is actually disbursed or withheld by the insurer for future payment of claims as they are submitted.
- Determine if the insurer pays or processes claims for the participating providers of a capitated intermediary.
- Request the most recent independent audited report of the intermediary (TPA or IPA). If not available, request the most recent annual report.

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- Obtain the opinion of an actuary attesting to the adequacy of claim reserves and claim adjustment expenses established for claims incurred and outstanding on business produced by the intermediaries, if available.
- Review analyst notes or exam reports for the other companies using the same intermediaries if there is reason to believe problems exist with those entities.

Concerns with Special Payment Arrangements

Determine whether special payment arrangements (i.e., bonuses and withholds) with providers are material, reasonable and reported correctly. The significance of special payment arrangements is determined by comparing their total to hospital and medical benefits paid. Also, the percent of bonus/withhold to intermediaries or "other providers" is reviewed to determine if there is a disproportionate amount being paid to these entities and/or if the level paid is appropriate.

Determine if the health entity's use of bonus and withhold arrangements are significant. Since health entities use these arrangements to different degrees, it is important to determine the significance of their use by the health entity under review. These procedures determine if the amount of bonus and withhold liabilities and expenses compared to the total hospital and medical expense is significant.

Determine the significance of the liabilities outstanding for bonuses and withholds. While these procedures focus on materiality, there are very few tests that can be made to verify that provider liabilities are appropriate. Provider contracts often change dramatically from year to year, limiting the value of year-over-year comparisons. These liabilities build up over the contract period and then are paid, decreasing the liability to zero. Contract periods for different providers may cover different periods so that wide fluctuations can be seen from period to period. Therefore, analysts are encouraged to perform other qualitative procedures to evaluate provider liabilities such as reviewing the Statement of Actuarial Opinion, reviewing provisions in provider contracts and obtaining the detailed calculation supporting the liabilities.

Verify that information that is reported in the financial statement for the health entity is consistent with what is reported in the health entity's RBC filing. Since withholds and bonuses are reported both in the Annual Financial Statement and in the RBC filing, they should not appear in one and not the other. This procedure also assists analysts in determining if a significant amount of the prior year's withholds and bonuses available were not paid during that reporting year. Withholds and Bonuses Available represent the total amount that could have been paid in withholds and bonuses. (This information is provided in the RBC filing on page XR016.) The amount paid compared to the amount available provides analysts with a rough indication of how well provider groups were able to meet their contract goals. Further analysis may be necessary in order to determine whether the provider group is able to meet its financial or operational goals in its contracts with the health entity, currently and going forward. Provider groups not being able to meet their financial and operational goals and thus not earning all of their withholds in one year can result in higher claims costs than anticipated and/or less favorable contracts in the next contracting cycle.

Additional procedures may be performed if there are concerns regarding the amount of prior year withholds and if bonuses available not paid were significant. If the level of these arrangements is significant, it is important to determine if any actual risk is being transferred. Potentially, these arrangements could be used to create the appearance of capitated risk transfer when in fact the bonus and withholds result in no actual risk transfer. Since these arrangements reduce RBC, capital requirements could be understated. Some health entities have many types of contracts with providers, but it is possible to request that a health entity provide the primary contracts with its largest contracting providers.

It is also important to determine if these arrangements are concentrated within a few providers. If there is a concentration, any financial weakness of the providers could result in them not being able to fulfill their part of the risk transfer contract. Standards published by the Actuarial Standards Board of the American Academy of Actuaries (Actuarial Standard of Practice 16) requires that the actuarial opinion disclose the actuary's knowledge

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of the health entity's capitated risk contracts indicating if the actuary evaluated the financial position of the contracting providers. The actuarial opinion should be reviewed to determine if the capitated risk contracts, as well as the financial strength of the contracting providers were or were not reviewed by the opining actuary. It may be necessary to contact the qualified actuary to discuss his or her review and potential concerns.

It is possible that the contracting provider is actually an affiliate of the health entity. This can be the case where hospitals own HMOs that then contract back to the parent hospital. These arrangements should be understood for potential impact of the financial weakness of any of the participants.

Determine whether the insurer's special payment arrangements (i.e., bonus and withold arrangements) with providers are material, reasonable, and reported correctly.

Procedures/Data

- Compare total bonus/withhold arrangement payments to total hospital and medical benefits.
- Compare pool/withhold arrangement payments to total bonus/withhold accrual.
- Bonus/withhold payments and prior year underwriting losses.
- Liability for accrued medical incentive pool and bonus payments to total hospital and medical expense.
- Liability for amounts withheld from paid claims and capitations to total hospital and medical expense.
- Incentive pool and withhold adjustments expense to total hospital and medical expense.
- Change in bonus/withhold accrual from prior year to current year.

Additional Review Considerations

- Review the Annual Financial Statement, General Interrogatories, Part 2. Determine if the insurer reported bonus/withhold arrangements with providers.
- Determine if risk transfer arrangements with providers have had a negative impact on utilization. Review the Exhibit of Premiums, Enrollment, and Utilization in the Annual Financial Statement and compare to prior years. Determine if utilization compared to membership increased.
- Determine if the insurer failed to comply with state-specific laws, regulations, or guidelines regarding arrangements for risk transfer other than reinsurance.
- Request a listing of provider groups contracting with the insurer.
- Review the Statement of Actuarial Opinion to determine if capitation arrangements were reviewed.
- Review the Statement of Actuarial Opinion to determine if:
    - The financial strength of contracting provider groups was or was not reviewed or excluded by the opining actuary.
    - Provider insolvencies were considered when determining the reserves and liabilities.
- Evaluate the financial condition of the largest contracting provider groups.
- Contact the qualified actuary who signed the insurer's actuarial opinion to discuss the nature and scope of the review of the provider contracts.
- Review bonus/withhold provisions of the provider contracts.
- Obtain detailed calculation of direct bonus and withhold payments, and accruals and those covering capitated arrangements.

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- Request information concerning the specific contract provisions of the primary bonuses and withhold arrangements that the insurer is using.
- Request withheld and bonus liability amounts (included in "Accrued medical incentive pool and bonus payments" from Page 3, Column 3, Line 2) for the top five provider groups.
- Evaluate the appropriateness of withhold distributions or bonus payments made to providers relative to contract provisions and the insurer's underwriting results.
- Determine whether the insurer is compliant with RBC filing requirements and verify that amounts reported for bonuses and withholds in the insurer's Risk-Based Capital (RBC) filing are consistent with what is reported in the Annual Financial Statement filing.
    - Determine if there is an amount entered in accrued medical incentive pool and bonus Payments on Page 3, Column 3, Line 2, even though the RBC filing on worksheet XR017.
    - Column 2, Lines 3 and 4, indicates that no business is subject to withholds or bonuses
    - Determine if there is no amount entered in accrued medical incentive pool and bonus payments on Page 3, Column 3, Line 2, even though the RBC filing on worksheet XR017 Column 2, Lines 3 and 4, indicates that some business is subject to withholds or bonuses.
    - Determine if the prior year withholds and bonuses paid differed by more than 40% from prior year withholds and bonuses available from RBC worksheet XR017 in the RBC filing. (XR018: ABS (Line 18 - Line 19)/(Line 18)).
    - If amounts reported for bonuses and withholds in the insurer's RBC filing appear to be potentially inconsistent with what is reported in the annual statement filing, request that the insurer provide an explanation. If further analysis indicates that there is a disconnect between the two filings, request that the insurer amend whichever filing is incorrect.

Exposure to Cybersecurity Risk,

OR

Ineffective Mitigation of Cybersecurity Risk

Determine whether concerns exist regarding the insurer's exposure to and mitigation of cybersecurity risk.

Cybersecurity is defined as a set of technologies and processes that protect a company's information system as well as information stored on the system. An insurer's exposure to cybersecurity risk may be influenced by its size and complexity, the nature and scope of its activities, and the sensitivity of non-public information used by the insurer or in the insurer's possession, custody or control. These potential cyber risks may directly lead to financial loss and/or reputational risk. As cybersecurity events become more prevalent, there are additional pressures for insurers to enhance their information security program to protect personal and sensitive information. Therefore, the NAIC adopted the *Insurance Data Security Model Law* (#668) in October 2017 to outline requirements for insurers in addressing cybersecurity risks. States are expected to adopt the model in the coming years, which should result in more consistency and authority for state insurance regulators in this area. However, in the meantime, analysts may consider discussing, reviewing and assessing risks in this area on a more frequent basis than the routine examination schedule. As cybersecurity activities and controls are commonly conducted at the group level, efforts may need to be coordinated with the lead state.

Procedures

- Gain an understanding of and evaluate the company's exposure to and mitigation of cybersecurity risk by reviewing recent exam results and findings, company documentation, and other relevant information. Considerations may include whether the company's information security program appropriately identifies,

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prevents, detects and responds/recovers from cybersecurity events. Concern may be heightened in the event of companies with planned mergers or acquisitions (and the resulting system integration), system updates, and/or significant unresolved findings from financial exam or other third-party security audits. If the analyst's level of concern merits additional analysis, consider performing the following procedures:

- Obtain and review information on the cybersecurity insurance coverage maintained by the insurer to limit exposure to cybersecurity events.
- Inquire on recent adjustments made to the company's information security program to address emerging threats and vulnerabilities.

- If material risk warrants further investigation, or more technical analysis, the analyst should consider seeking the expertise of a cybersecurity expert (e.g., internal examination staff or external consultants) to conduct additional risk analysis and/or target examination in this area. If the cybersecurity expert's level of concern merits additional analysis, consider performing the following procedures in the scope of the work to be performed by the expert:
  - Obtain and review results of recent vulnerability assessments and/or penetration tests to identify weaknesses in the existing security framework.
  - Obtain and review results of external/internal security audits, including those performed by other regulatory agencies–e.g., Office of Management and Budget (OMB) or Federal Reserve (FRB)–and corresponding changes to the company's security techniques (e.g., firewalls or intrusion detections, logical access controls (e.g., user access rights or authentication mechanisms) and disaster recovery processes).
- If the state has passed the NAIC's *Insurance Data Security Model Law* (#668), consider:
  - Obtaining and reviewing any changes to the company's information security program to ensure compliance with the law's provisions, which notably include sections on oversight by board of directors and oversight of third-party service provider arrangements.
  - Ensuring the company has submitted an "Annual Certification to Commissioner of Domiciliary State," which is a new requirement under the Model #668 whereby an insurance company asserts compliance with Section 4 of the model law (i.e., risk assessment, risk management, oversight by board of directors, etc.).
  - Reviewing any recent notifications of a cybersecurity event provided by the company in accordance with Section 6 of Model #668.
    - Gain an understanding of the nature and extent of any cybersecurity event and its expected impact on the company's reputation and financial standing.
    - For each cybersecurity event, determine whether the company took appropriate steps to remediate, including timely reporting to impacted stakeholders, protection of policyholders against identity theft and/or corrective actions to address identified weaknesses in IT security.
- If the state has not passed Model #668, consider obtaining and reviewing information regarding any cybersecurity events the company has detected over the past 12 months.
  - Gain an understanding of the nature and extent of any cybersecurity event and its expected impact on the company's reputation and financial standing.
  - For each cybersecurity event, determine whether the company took appropriate steps to remediate, including timely reporting to impacted stakeholders, protection of policyholders against identity theft and/or corrective actions to address identified weaknesses in IT security.

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ADDITIONAL PROCEDURES

Examination Findings

Consider a review of the recent examination report, summary review memorandum and communication with the examination staff to identify if any operational risk issues were discovered during the examination with any of the following:

- Operating Performance
- Information Technology (IT) Systems
- Cybersecurity
- Fraud
- Internal Controls
- Disaster Recovery
- Transactions and services with affiliates

If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

Own Risk and Solvency Assessment (ORSA)

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing risks faced by the insurer.

If the insurer is required to file an ORSA or is part of a group that is required to file an ORSA:

- Determine if the ORSA Summary Report analysis conducted by the lead state indicates any operational risks that require further monitoring or follow-up.
- Determine if the ORSA Summary Report analysis conducted by the lead state indicates any mitigating strategies for existing or prospective operational risks.

Holding Company Analysis

Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing operational risks that could impact the insurer.

- Determine if the Holding Company analysis conducted by the lead state indicates any operational risks impacting the insurer that require further monitoring or follow-up.
- Determine if the Holding Company analysis conducted by the lead state indicates any mitigating strategies for existing or prospective operational risks impacting the insurer.

Enterprise Risk Management – Pandemic (Health)

Consider conducting additional procedures if concerns exist regarding the insurer's preparedness and ability to respond to a pandemic outbreak event. A pandemic is defined as an epidemic of infectious disease that has spread through human populations across a large region. The effects a pandemic may have on an insurer include, but are not limited to, significant increases in claims volume, increased loss costs and liquidity demands. Therefore, it is important to understand the processes and strategies put in place by health insurers to limit the effect of a pandemic on an insurer's operations and ongoing solvency, including the results of stress testing performed to assess and quantify the impact on an insurer. Such procedures may include gaining an

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understanding of the company's plans and processes for dealing with such an event and evaluating whether they address increased utilization, liquidity needs and impact on workforce.

QUARTERLY OPERATIONAL RISK ASSESSMENT

The quarterly operational risk procedures are designed to identify the following. For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Poor (or Declining) Operating Performance

Analyze the currant year-to-date performance and trends in the following items to determine whether concerns exist regarding the insurer's operating performance.

Procedures/Data

- Review the Statement of Income and operating performance.
  - Net Loss (current year-to-date, and five-year trend).
  - Change in net income (loss) from prior year-to-date when absolute value of net income (loss) is material to surplus.
  - P/C: Profitability Ratios (current quarter, change from prior year-to-date, and five-year trend).
    - Combined ratio and its components.
      - Change in net premiums earned from prior year-to-date.
      - Change in net incurred losses from prior year-to-date.
    - Net loss ratio (direct, assumed, gross, ceded, and net).
    - Pure loss ratio.
    - Pure loss adjustment expense (LAE) ratio.
    - Expense ratio.
    - Dividend ratio.
    - Ratio of other income to net income when the absolute value of other income is material to surplus.
  - Life/A&H: Profitability Ratios (current quarter, change from prior year-to-date, and five-year trend)
    - Net income/total revenue (ROR).
    - Annualized net income/total assets (ROA).
    - Annualized net income/capital & surplus (ROE).
    - Ratio of commissions and administrative expenses to premiums and deposits.
    - Ratio of aggregate write-ins for miscellaneous income to net income when aggregate write-ins for miscellaneous income are materials to capital and surplus.
    - Ratio of aggregate write-ins for deductions to net income when aggregate write-ins for deductions are material to capital and surplus.
  - Health: Profitability Ratios (current quarter, change from prior year-to-date or year-end, and five-year trend)
    - Profit margin ratio.

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- Combined ratio.
- Medical loss ratio (MLR).
- Administrative expense ratio.

Additional Review Considerations

- Review the components of other income in the Quarterly Financial Statement, Statement of Income, including write-ins for miscellaneous income, for reasonableness.
- Describe any known trends that have had or that the insurer reasonably expects will have a material favorable or unfavorable impact on net revenues or net income. If the insurer knows of events that will cause a material change in the relationship between benefits, losses and expenses, the change in the relationship should be disclosed.
- If concerns exist regarding operating performance, consider the following procedures:
  - Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses.
  - Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations.

Risks with Investment Operations

Determine whether all securities owned are under the control of the insurer and in the insurer's possession.

Procedures/Data

- Determine if any of the assets of the insurer loaned, placed under option agreements, or otherwise made available for use by another person (excluding securities under securities lending agreements)? If so, determine if there are any concerns regarding these assets. [Quarterly Financial Statement, General Interrogatories, Part 1, #11.1 and #11.2]

Exposure to Affiliated/Related Party Transactions

Note: The following procedures for the review of Corporate Structure and Affiliated Transactions should consider any analysis already completed or anticipated to be completed with regard to the Holding Company Analysis performed by the lead state, review of the Form B – Registration Statement and any review of Form D – Material Transactions to avoid duplication of analysis.

Procedures/Data

Determine whether the insurer is a member of a holding company group and whether the corporate structure elevates concerns about affiliated transactions.

- Determine if the insurer is part of a holding company system. [Quarterly Financial Statement, General Interrogatories, Part 1, #3.1]
- Determine if there have been substantial changes in the organizational chart since the prior quarter end. [Quarterly Financial Statement, General Interrogatories, Part 1, #3.2]

Additional Review Considerations

- If there have been substantial changes and the change involved ownership of the insurer or a transaction with an affiliate, determine if the insurer received proper regulatory approvals.

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- Determine if there any indications that the corporate structure may include a holding company whose primary asset is the stock of the insurance company.
- Determine if the insurer has an agency or brokerage subsidiary.

Procedures/Data

Identify whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.

- Determine if there have been changes to any management agreement, including third-party administrators (TPAs) and managing general agents (MGAs) in terms of the agreement or principals involved. [Quarterly Financial Statement, General Interrogatories, Part 1, #5].

Additional Review Considerations

- Review Quarterly Financial Statement, Schedule A – Part 2 and Part 3 and Schedule BA – Part 2 and Part 3:
  - Determine if any such acquisitions or disposition involve an affiliate or other related party.
  - Determine if the amount of the transaction was material to surplus?
  - Determine if there is any reason to believe that the acquisition was recorded on a basis other than fair value.

Concerns with Separate Accounts (Life/A&H)

Determine whether concerns exist regarding the insurer's separate accounts.

Procedures/Data

- Determine whether the insurer maintains Separate Accounts. Review the Quarterly Financial Statement, Balance Sheet asset and liability items relating to separate accounts business. Determine if there are balances in either of these categories

If not, do not proceed with the remaining Separate Accounts procedures.

- Change in separate account assets or liabilities from the prior year-end.
- Review the Quarterly Financial Statement, Capital and Surplus Account Statement page.
  - Determine if the line item, "Other changes in surplus in the Separate Accounts Statement," is greater than capital and surplus.
  - Change in line item, "Other changes in surplus in the Separate Accounts Statement," from the prior year, same quarter.
- Review the Quarterly Financial Statement, Summary of Operations page.
  - Change in line item, "Net transfers to or (from) separate accounts," from the prior year, same quarter.
  - Determine if the insurer reported a net loss in the line item, "Separate accounts net gain from operations excluding unrealized gains or losses," whose absolute value material to the general account capital and surplus.

Significant Bonus and Withholding Arrangements (Health)

Determine whether the insurer's use of bonus and withhold arrangements are significant.

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Procedures/Data

- Ratio of Liability for accrued medical incentive pool and bonus payments to annualized total hospital and medical expenses.
- Ratio of Incentive pool and withhold adjustments to total hospital and medical expense.

For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

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PRICING/UNDERWRITING RISK: Pricing and underwriting practices are inadequate to provide for risks assumed.

The Pricing/Underwriting Risk Assessment is focused primarily on risks inherent in writing business and premium production. Although pricing and underwriting risk is a component of overall profitability and operations, it is reviewed separately from other operational risks. Analysts may require additional investigation and information requests to understand and assess the potential impact of these risks. For example, analysts may need additional information to assess the insurer's capacity for growth and plans for expansion.

An analyst's risk-focused assessment of pricing and underwriting risk should take into consideration, the following areas (but not be limited to):

- Underwriting performance
- Premium production
- Premium concentration
- Writings leverage
- Financial impact of the federal Affordable Care Act (ACA) (Life/A&H, Health)

ANNUAL PRICING/UNDERWRITING RISK ASSESSMENT – PROPERTY/ CASUALTY

Poor Overall Underwriting Performance – P/C

Determine whether concerns exist regarding the insurer's underwriting performance including the impacts of premium revenue, incurred losses, loss adjustment expenses and commissions expenses.

Key ratios and procedures for assessing underwriting performance are as follows. Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums written may be an indication of an insurer's entrance into new lines of business or sales territories that might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses. Significant increases in incurred loss ratios may indicate premium pricing errors or reserve strengthening due to prior reserve understatements, whereas significant decreases in incurred loss ratios may be indicative of current reserve redundancies.

Procedures/Data

- Consider the following metrics to determine whether concerns exist regarding the insurer's underwriting performance:
  - Change in net premiums earned
  - Change in net incurred losses and loss adjustment expense (LAE)

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- Other underwriting expense ratio
- Net loss ratio
- Change in net loss ratio
- Direct commissions to direct premiums ratio

Additional Review Considerations

- Review the five-year trend with the Financial Profile Report and/or the Management Discussion and Analysis (MD&A), for the following measures of operating performance, and note any unusual fluctuations, events (e.g., catastrophes) or trends between years for each ratio:
  - Loss ratios for direct, assumed and ceded business
  - Incurred loss and LAE by line of business
- Compare, by line of business, the pure net loss ratio to the industry averages in the Financial Profile Report to determine any significant deviations.
- Review each line of business included in the Annual Financial Statement, Schedule P, for trends in accident year loss ratios, on both a gross and net basis, that may indicate a deterioration in underwriting results.
- If concerns exist regarding underwriting results, consider requesting from the insurer the following for review:
  - Additional information from the insurer on the causes of poor underwriting performance.
  - Explanations for unusually high loss and combined ratios.
  - Plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
  - Rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.
  - Descriptions of underwriting practices and policies, including any exposure limits established by the insurer.
  - Descriptions of pricing practices (e.g., frequency of review) and policies.
  - Status of recent and pending rate increase requests.
- Review the write-ins for underwriting deductions in the Annual Financial Statement, Statement of Income and the Financial Profile Report and note any unusual fluctuations or trends.

Concerns over Premium Production, Concentration and Writings Leverage – P/C

The following are examples of risks that may be identified related to premium production.

- **Concerns over Changes in Premium Production—**See below.
- **Concentration of Writings**—See below.
- **High Writings Leverage [or Trend]**—A high writings leverage trend may indicate concentrations, overexposure to certain insurance risks and/or a lack of support from ownership/parent. See below.
- **Lack of Underwriting Expertise** —A lack of underwriting expertise may result in underpricing or faulty risk acceptance if the insurer is not experienced in underwriting a new line of business
- **Lack of Sufficient Underwriting Standards** —A lack of sufficient underwriting policies and procedures may results in underpricing, acceptance of unknown/excessive risks, etc.

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- **Negative Variance on Projected Premium/Sales to Actual** —Actual premium volume or new sales results vary materially from projections, leading to an inability to fulfill the strategic plan
- **Rapid Expansion/Growth** —Rapid growth or expansion into new geographic areas or new states may result in a higher-than-expected strain on surplus.
- **Declining Premium Volume** —Declines in premium volume may result in insufficient revenue to sustain current operations.
- **Lack of Clear Underwriting/Marketing Strategy** —Failure to define and update the underwriting/marketing strategy of the insurer may lead to inconsistent results, inappropriate risk acceptance, etc.

Determine whether concerns exist regarding changes in the volume of premiums written or changes in the insurer's mix of business (lines of business and/or geographic location) and changes in writing leverage. Significant increases or decreases in premiums written may indicate a lack of stability in the insurer's operations. In addition, a significant increase in premiums written may be an indication of the insurer's entrance into new lines of business or sales territories, which might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums written might also be an indication that the insurer is engaging in cash flow underwriting. Cash flow underwriting is the practice of writing a significant amount of business in order to invest and earn a greater investment return than the costs associated with potentially underpriced business. Cash flow underwriting can be a serious concern if it is accompanied by a shift in business written from short-tail property lines of business to long-tail liability lines.

Analysts should consider reviewing premiums written by line of business to determine which lines increased or decreased significantly and whether any new lines of business are being written. Analysts should also consider verifying that the insurer is authorized to write all lines of business being written. If new lines of business are being written, or if premiums are being written in new states, analysts should consider determining whether the insurer has expertise in the new lines of business or new sales territories. This would include expertise in distribution, underwriting, claims, and reserving. There is no information in the Annual Financial Statement to assist analysts in making this determination. However, there may be helpful information in the insurer's Management's Discussion and Analysis (MD&A). Otherwise, information may be requested from the insurer.

Within several lines of business and policy types (most notably commercial property), property/casualty insurers may be exposed to losses resulting from acts of terrorism. Following the September 11, 2001, attacks on the New York World Trade Center and the U.S. Pentagon, terrorism coverage became prohibitively expensive, if offered at all. In response, the U.S. Congress passed the Terrorism Risk Insurance Act (TRIA) of 2002. TRIA was initially created as a temporary three-year federal program that required insurers to offer commercial policyholders with terrorism coverage, while allowing the Federal Government to share monetary losses with insurers on commercial property/casualty losses from a terrorist attack. Since then, it has been renewed four times and is due to expire on December 31, 2027. Before this backstop can be accessed, several stipulations and limits are applied, many of which have been adjusted under subsequent extensions of the Act to limit the support available to insurers. Analysts should assess the insurer's exposure to losses related to acts of terrorism and consider any mitigation by TRIA.

The procedure also assists analysts in determining whether the insurer is excessively leveraged due to the volume of premiums written. Surplus can be considered as underwriting capacity, and the ratios of gross and net writings leverage measure the extent to which that capacity is being utilized and the adequacy of the insurer's surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross writings leverage ratio result greater than 900% may indicate that the insurer is excessively leveraged, and special attention should be given to the adequacy of the insurer's reinsurance protection and the quality of the reinsurers. A net writings leverage ratio greater than 300% may also indicate that the insurer is excessively leveraged and lacks sufficient surplus to finance the business currently being written. In evaluating these ratios, analysts should also consider the nature of the insurer's business. For example, an insurer that has historically written primarily

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short-tail property lines of business might not be considered excessively leveraged even though it has higher ratio results, because the risk of significant underpricing or adverse underwriting results is less than that of an insurer that writes primarily volatile long-tail liability lines of business such as medical professional liability.

Analysts should consider reviewing the net premiums written by line to determine which lines of business are being written. An insurer that writes primarily short-tail property lines may be able to write at higher levels of premiums to surplus than an insurer that writes primarily long-tail liability lines, because the risk of underpricing and significant adverse underwriting results is less with the short-tail property lines of business. Analysts should also consider comparing the ratios of gross and net writings leverage to industry averages to help evaluate the insurer's leverage. If the insurer is a member of an affiliated group of insurers, analysts might want to compute the net and gross writings leverage ratios on a consolidated basis to help evaluate whether the affiliated group of insurers is excessively leveraged. If the net and gross writings leverage ratios results are high, analysts should consider determining whether the insurer has adequate reinsurance protection against large losses and catastrophes and that the reinsurers are of high quality.

Procedures/Data

- Consider the following metrics to assess materiality of exposure to premium production, concentration, and writings leverage:
  - Change in gross premiums written
  - Change in net premiums written
  - Change in direct premiums written (DPW) for any line of business
  - Ratio of DPW for any new lines to total DPW
  - Change in DPW in any one state when DPW is greater than 10% of total DPW in either the current or prior year-end
  - Ratio of DPW in a new state to total DPW
  - Gross premiums written to surplus [IRIS ratio #1]
  - Net premiums written to surplus [IRIS ratio #2]

Additional Review Considerations

- If significant changes in premium volume are identified, consider the following procedures:
  - Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.
  - Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.
- Review, by line of business, premiums written by year in the Financial Profile Report for shifts in the mix of business between years and to gain an understanding of lines of business written.
- Determine whether the insurer has material exposure to losses resulting from acts of terrorism. If concerns are identified, consider the following procedures:
  - Request additional data/information from the insurer to gain an understanding of its exposure to terrorism risk.
  - If the insurer is subject to ORSA reporting, review information provided on terrorism exposure and risk assessment in the ORSA Summary Report or obtain the lead state's review (if applicable).
  - Gain an understanding of the insurer's mitigation of terrorism risk through TRIA coverage.

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- Assess the reasonableness of the ultimate exposure based on the insurer's business strategy and capital position.
- Consider the reasonableness of the insurer's plan to limit exposures, such as policy limits, policy exclusions, location of risks, pricing modifications, non-renewal of certain policies, plans for diversification, or other risk mitigation strategies.

- Review the Five-Year Historical Data of the Annual Financial Statement. Determine whether there has been a shift in the mix of gross premiums written or net premiums written from property lines to liability lines within the past five years. If so, evaluate the underwriting/marketing strategy of the insurer and its expertise in writing liability lines of business.
- Review Annual Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.
- Review Annual Financial Statement, Schedule T and the writings section in the Financial Profile Report to evaluate the top states in terms of direct premiums and the percentage of total DPW in those states. Based on the lines of business written, determine whether large concentrations of premiums are written in areas prone to catastrophic events.
- Determine whether the company is diversified in terms of product lines and geographical exposure. If not, request and review information from the insurer regarding:
  - Mitigation strategies to limit exposure concentrations.
  - Explanations for significant shifts in geographic concentrations, lines of business, amounts of premiums written, high leverage positions, etc.
- Review the insurer's underwriting/marketing strategy included in its business plan.
  - If the change in DPW in any one state is greater than 10% of total DPW in either the current or prior year-end, evaluate the insurer's marketing and expansion plans in that state.
  - Determine whether the insurer is planning expansion into new states or premium growth in the future.
  - Determine whether the insurer has applied for or received new licenses in other states.
  - Determine whether the insurer has reported that it has ceased writing new business, a line of business or writing in a certain geographical location.
  - Determine whether the insurer has any closed block operations.
  - Ascertain whether the insurer's marketing strategy and projected premium growth match actual results reported in the current period. If materially different, evaluate the reasons why, or ask the insurer for an explanation.
- Determine whether the insurer has expertise (e.g., distribution network, underwriting, claims, and reserving) in the lines of business written. Consider reviewing the insurer's MD&A, business plan and/or additional information from the insurer to determine the expertise in the lines of business written.
- Review the insurer's gross and net writings leverage positions to assist in evaluating risk exposure. Consider the following specific procedures in this area:
  - Compare the gross writings leverage and net writings leverage ratios to the industry averages and determine any significant variances.
  - If the insurer is a member of a group, compute the gross premiums written to surplus ratio and the net premiums written to surplus ratio on a consolidated basis to determine if the group appears to be excessively leveraged.
  - Obtain an explanation from the insurer for unusual results for P/C IRIS ratios #1 and #2.

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- Inquire of the insurer:
  - Marketing strategy, including distribution channels/networks, planned growth or cessation of business, expansion into new states or regions, management of closed block operations, etc.
  - Financial projections for expected premium/sales.

Exposure to Catastrophic Events – P/C

Identify and assess the insurer's current and prospective exposure to catastrophic events as well as the risk management practices of insurers writing a significant percentage of their business in products and geographic areas that are exposed to severe loss events. These types of catastrophic risk exposures have frequently been the cause or contributing factor in insurer insolvencies. Various steps included in this procedure assist in identifying the potential concentrations of exposure through a review of information provided in the annual statement as well as additional information provided within the RBC filing regarding modeled catastrophic risk exposures.

The Catastrophe Risk Charge in RBC (RCAT or PR027) is required to be completed by all insurers filing on the Property/Casualty blank unless they are exempted from filing due to limited exposure to property lines or coverage in catastrophe-prone areas. Insurers that are not exempted from this charge are required to provide modeled loss outputs from an approved catastrophe model for the worst year in 50, 100, 250, and 500, using the insurance company's own insured property exposure information as inputs to the model. Insurers are not required to utilize any prescribed set of modeling assumptions but are expected to use the same exposure data, modeling, and assumptions used in its own internal catastrophe risk management process.

If the analyst identifies potentially significant concentrations or exposures in writings or modeled losses, the analyst should gain an understanding of the risk mitigation practices in place to identify, monitor and mitigate significant exposures. An understanding could be gained through a review of existing information available to the analyst through company responses to the NAIC Climate Risk Disclosure Survey, ORSA Summary Report filings, or public information sources such as SEC 10K or 10Q filings. If these existing information sources are not available or do not provide adequate details of exposures and risk management practices, the analyst is encouraged to reach out to the company to request and review additional information.

In reviewing the insurer's exposure to catastrophic losses, it is important to consider both the current and prospective nature of the exposures. Increases in weather-related catastrophic losses may result from noticeable changes in climate that have been recorded over an extended period, including rising sea levels, changes in temperatures, precipitation, and/or wind patterns. The concern is that climate change or change in weather patterns may increase the severity and frequency of future weather events including, but not limited to: thunderstorms, including severe hail and strong winds; tornadoes; hurricanes; windstorms; floods; heat waves; drought; and wildfires. If the insurer is exposed to significant catastrophic losses that could be the result of climate change, the analyst should take steps to gain an understanding of and evaluate the potential impact on the company's business and underwriting strategy over medium and longer-term time horizons.

Consider evaluating the following items to determine whether concerns exist regarding the insurer's exposure to catastrophic events.

Procedures

- Review Annual Financial Statement, Schedule T and the writings section in the Financial Profile Report (or the Mix of Business Dashboard) to evaluate the top states in terms of direct premiums and the percentage of total DPW in those states. Based on the lines of business written, determine whether there is a material concentration of premiums written in areas prone to catastrophic events.
- Review information provided by the insurer in the RCAT (PR027) section of its Risk Based Capital filing to identify and assess the insurer's current exposure to catastrophic events at modeled worst year in 50, 100,

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250, and 500 levels on both a gross (direct and assumed) and net basis (after reinsurance). Evaluate the potential impact of the company's modeled loss results on its capital and surplus and RBC position.

- Review the Interrogatory on Catastrophe Risk Reinsurance Program RCAT (PR027) section of the insurer's Risk Based Capital filing. If necessary, request additional information or clarification from the insurer to gain a comprehensive understanding of its catastrophe reinsurance program and any recent changes in coverage due to market conditions.
    - Evaluate the adequacy of reinsurance protection; for example, evaluate the impact that multiple, smaller events could have on the insurer's financial position if they fall below retention levels.
    - Identify any exclusions in the reinsurance treaties that could leave the insurer exposed to unexpected losses.
    - Assess the financial strength and creditworthiness of the reinsurers involved. Assess any potential concentration risk where the insurer relies heavily on one reinsurer.
    - Review the insurer's claims handling practices for catastrophe events, including factors such as reserving adequacy, loss adjustment expenses, and reinsurance recoveries.
- Review information provided in the insurer's response to the NAIC's Climate Risk and Disclosure Survey (if available) on its exposure to physical losses impacted by climate change, as well as its related mitigation activity.
    - Determine whether any of the company's responses require further investigation and inquiry.
- Review information provided in the ORSA Summary Report and/or SEC 10K or 10Q filings (if available) regarding the insurer's exposure to physical losses impacted by climate change, as well as its related mitigation activity.
- Utilize the information gathered and/or request additional information as necessary to assess the insurer's exposure to climate/catastrophic risks, as well as processes and strategies in place to limit exposures.
    - Gain an understanding of how the company incorporates catastrophe modeling results into its underwriting processes (e.g., assessment of risk appetite or determination of net retained risk) and the insurer's oversight of the process.
    - Use of modeled results to set underwriting exposure limits and refine underwriting guideline.
    - Gain an understanding of and evaluate the potential impact of climate change on the company's business and underwriting strategy over medium and longer-term time horizons.
    - Determine whether there are any concerns regarding the company's risk management processes in regard to climate change, both currently and prospectively.

ANNUAL PRICING/UNDERWRITING RISK ASSESSMENT – LIFE, ACCIDENT & HEALTH (A&H)

Poor Overall Underwriting Performance – Life/A&H

Review the annual financial statement, summary of operations and determine whether concerns exist regarding the insurer's underwriting performance including the impacts of net gain from operations before realized capital gains to total revenue, operating loss trends, loss ratio and commissions expenses.

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Procedures/Data

- Consider evaluating the following items to determine whether concerns exist regarding the insurer's underwriting performance:
  - Ratio of net gain from operations (before realized capital gains and losses) to total income.
  - Determine whether there have been operating losses in two or more of the past three years.
  - A&H loss ratio.
  - Direct commissions to direct premium ratio.

Additional Review Considerations

- Review the five-year trend with the Annual Statement Summary of Operations, Annual Financial Profile Report, and Management Discussion and Analysis (MD&A) for the following measures of operating performance, and note any unusual fluctuations, events or trends between years for each:
  - Operating income.
  - A&H loss ratio.
  - Commissions to premiums ratio.
- Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on net revenues or net income, or a material impact on the relationship between benefits, losses, and expenses.
- Review the Annual Financial Statement, Analysis of Operations by Lines of Business and the Financial Profile Report and:
  - Determine which lines of business were profitable for the insurer and which lines of business generated a loss.
  - Determine if any lines of business indicate a negative trend in profitability over the past five years.
  - Determine whether commissions on any lines of business appear excessive based on the volume of premiums.
- If concerns exist regarding underwriting results, consider inquiring of the insurer for the following, for review:
  - Additional information from the insurer on the causes of poor underwriting performance.
  - Plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
  - Rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.
  - Descriptions of underwriting practices and policies.
  - Descriptions of pricing practices (e.g., frequency of review) and policies
- Review the components of the Annual Financial Statement, Summary of Operations line items Aggregate Write-ins for Miscellaneous Income and Aggregate Write-ins for Deductions for reasonableness.

Poor Underwriting Performance on Medicare Part D Coverage – Life/A&H

Review the annual financial statement, Medicare Part D Coverage Supplement and determine whether concerns exist regarding the insurer's underwriting performance of the Medicare Part D Prescription Drug coverage. The

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procedures utilize data in the Annual Financial Statement, Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, analysts should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated when the contract was made. If the insurer is reporting unusual results, analysts should consider if any delays in payments from the federal Centers for Medicare & Medicaid Services (CMS) are affecting results.

Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for a period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If policyholders utilize more benefits than were projected in the contract, the insurer may experience losses because the income from CMS is set for a full year. Analysts should consider obtaining and reviewing information on the contracted benefits, premium, and cost-sharing with CMS. Analysts should also evaluate a comparison of premiums, reserves, expected utilization, and benefit costs to actual experience on each plan.

Procedures/Data

Consider evaluating the following items to determine whether concerns exist regarding the insurer's Medicare Part D coverage:

- Underwriting loss of either group or individual coverage
- Medical loss ratio of either group or individual coverage
- Expense loss ratio of either group or individual coverage
- Combined ratio of either group or individual coverage

Additional Review Considerations

- Obtain and review information regarding the contracted benefits, premium and cost sharing with the federal Centers for Medicare & Medicaid Services (CMS).
- Review the types of products being written, including any enhanced benefit products.
- Request information on and review the assumptions for reserves, utilization, and benefit costs projected in the development of the contract.
- If concerns exist regarding operating performance, request, review and evaluate information from the insurer regarding its plans to address the issues.

Poor Underwriting Performance on A&H Lines – Life/A&H

Evaluate the underwriting performance of the individual A&H lines of business through a review of the Annual Financial Statement, A&H Policy Experience Exhibit (April 1 filing), including a review of the loss ratio by line and consideration of multiyear trend analysis by line.

Procedures/Data

- Ascertain whether the insurer reported an underwriting loss on any line of business as reported on the Analysis of Operations by Line of Business page of the Annual Financial Statement.

Additional Review Considerations

- If underwriting losses were reported on the Analysis of Operations by Lines of Business page, review the A&H Policy Experience Exhibit to further identify specific health lines that may be experiencing losses.

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- Compare results with prior years to identify any concerns with multiyear trends in premium, benefit, loss ratios or membership.

Poor Underwriting Performance on Long-Term Care Insurance – Life/A&H

Evaluate the underwriting performance of the long-term care insurance (LTCI) line of business through a review of the Annual Financial Statement, Long-Term Care Experience Reporting Forms (April 1 filing), the Actuarial Guideline-51 reporting, actuarial memorandum or any other related actuarial information filed to the department including trends in premiums, claims and loss ratios. Analysts should consider requesting the assistance of the department actuary to review trends in reserving that may affect underwriting results. (See additional guidance in the Reserving Risk Assessment of this Handbook).

Procedures

- Ascertain whether the insurer reported an underwriting loss on the "Other Health" line of business on the Analysis of Operations by Line of Business page of the Annual Financial Statement and determine whether the insurer writes long-term care insurance (LTCI).

  If "yes," further investigate the underwriting loss by reviewing the Annual Financial Statement, LTC Experience Reporting Forms, A&H Policy Experience Exhibit, and the Actuarial Guideline-51 reporting. Request a department actuary to assist in the review, if available.

  - Review the operational results in conjunction with the actuarial review of the LTC Experience Reporting Forms, the Actuarial Guideline-51 reporting, actuarial memorandum, or other related information filed to the department:
    - Identify by policy form or in aggregate trends in premiums, benefits and the LTC loss ratio (benefits divided by premiums).
    - Identify trends in under-reserving that may affect underwriting results. (Refer to the Actuarial Risk Assessment for A&H and Statement of Actuarial Opinion review procedures.)
  - Compare results to prior years to identify any concerns with multi-year trends.

Concerns over Premium Production, Concentration and Writings Leverage – Life/A&H

The following are examples of risks that may be identified related to premium production.

- **Concerns over Changes in Premium Production—**See below.
- **Concentration of Writings**—See below.
- **Lack of Underwriting Expertise**—A lack of underwriting expertise may result in underpricing or faulty risk acceptance if the insurer is not experienced in underwriting a new line of business
- **Lack of Sufficient Underwriting Standards**—A lack of sufficient underwriting policies and procedures may result in underpricing, acceptance of unknown/excessive risks, etc.
- **Negative Variance on Projected Premium/Sales to Actual**—Actual premium volume or new sales results vary materially from projections, leading to an inability to fulfill the strategic plan
- **Rapid Expansion/Growth**—Rapid growth or expansion into new geographic areas or new states may result in a higher-than-expected strain on surplus.
- **Declining Premium Volume** Declines in premium volume may result in insufficient revenue to sustain current operations.

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- **Lack of Clear Underwriting/Marketing Strategy**—Failure to define and update the underwriting/marketing strategy of the insurer may lead to inconsistent results, inappropriate risk acceptance, etc.

Determine whether concerns exist regarding changes in the volume of premiums and deposit-type funds or changes in the insurer's mix of business (lines of business written and/or geographic location of premium written). Significant increases or decreases in premiums written may indicate a lack of stability in the insurer's operations. In addition, a significant increase in premiums written may be an indication of the insurer's entrance into new lines of business or sales territories that might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums might also be an indication that the insurer is engaging in cash flow underwriting to increase cash income in order to cover current benefit payments.

Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums may be an indication of an insurer's entrance into new lines of business or sales territories which might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses, particularly if the insurer primarily writes A&H insurance.

Analysts may also perform qualitative procedures if concerns exist regarding changes in the volume of premiums and deposit-type funds or changes in the insurer's mix of business (lines of business written and/or geographic location of the premiums written) include reviewing the insurer's mix of business to determine: 1) which lines of business are being written; 2) which lines of business have increased or decreased significantly; and 3) whether any new lines of business are being written. Analysts should also consider verifying that the insurer is authorized to write all lines of business being written. If new lines of business are being written or if premiums are being written in new states, analysts should consider determining whether the insurer has expertise in the new lines of business or new sales territories. This would include expertise in distribution, underwriting, claims, and reserving. There is no information in the Annual Financial Statement to assist analysts in making this determination. However, there may be helpful information in the insurer's Management's Discussion and Analysis. Otherwise, information may be requested from the insurer. Analysts should also consider determining if, as a result of changes in the mix of business, the insurer's business is concentrated in specific geographic areas that could result in the insurer being potentially exposed to catastrophic losses.

Procedures/Data

- Ratio of change in net premiums, annuity considerations and deposit-type funds
- Ratio of change in direct and assumed annuities and deposit-type funds for non-health insurers
- Ratio of Change in Product Mix (IRIS Ratio 10).
- Review the Direct Premium Written by State:
  - Identify any significant change in direct premiums written in any one state in which either current or prior year direct premium are material to total direct premium.
  - Identify any premiums being written in any new state where that state's premiums are material to total direct premiums written.

Additional Review Considerations

- Review the Mix of Business in the Annual Financial Profile Reports:
  - Determine which lines of business are being written.

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  - Determine whether there has been a significant increase or decrease or shifts in direct premiums written for any line of business.
  - Determine whether any new lines of business are being written.
- If significant changes in premium volume are identified, consider the following procedures:
  - Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.
  - Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.
- Review Annual Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.
- Review information provided in the Annual Financial Statement and supporting schedules (e.g., Schedule T, the writings section in the Financial Profile Report, etc.) to identify potential risk concentrations in terms of product types, guarantees, geographical exposures, etc. If concerns are identified, request and review information from the insurer regarding mitigation strategies to limit exposure concentrations.
- Request and review the insurer's marketing strategy included in its business plan.
  - If the combined ratio of either group or individual coverage is >100%, evaluate the insurer's marketing and expansion plans in that state.
  - Determine whether the insurer is planning expansion into new states or premium growth in the future.
  - Ascertain whether the insurer has applied for or received new licenses in other states.
  - Identify whether the insurer has reported that it has ceased writing new business, a line of business or writing in certain locations.
  - Determine whether the insurer has closed block operations.
  - Distribution channels/networks, planned growth or cessation of business, expansion into new states or regions, management of closed block operations, etc.
  - Financial projections for expected premium/sales.
  - Determine whether the insurer's marketing strategy and projected premium growth match actual results reported in the current period. If there appears to be a material difference, evaluate the reasons why or ask the insurer for an explanation.
- Determine whether the insurer has expertise (distribution network, underwriting, claims and reserving) in the lines of business written. Consider reviewing the insurer's Management's Discussion and Analysis and/or seeking additional information from the insurer to determine the insurer's expertise in the lines of business written.

High A&H Writings Leverage [or Trend] – Life/A&H

Determine whether the insurer may be excessively leveraged due to its volume of A&H business written. A high writings leverage trend may indicate concentrations, overexposure to certain insurance risks and/or a lack of support from ownership/parent.

Capital and surplus can be considered as underwriting capacity, and the ratios of gross (direct plus assumed reinsurance) A&H premiums to capital and surplus and net (gross less reinsurance ceded) A&H premiums to capital and surplus measure the extent to which that capacity is being utilized and the adequacy of the insurer's capital and surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross A&H premium to capital and surplus ratio greater than 500% may indicate that the insurer is excessively leveraged,

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and special attention should be given to the adequacy of the insurer's reinsurance protection and the quality of the reinsurers. A net A&H premium to capital and surplus ratio greater than 300% may also indicate that the insurer is excessively leveraged and lacks sufficient capital and surplus to finance the A&H business currently being written. In evaluating these leverage ratios, analysts should also consider the nature of the insurer's business. For example, an insurer that has written primarily A&H business for many years and has proven that it can manage the business profitably is probably not as risky as an insurer which has just begun writing A&H business, even if both insurers have the same leverage ratio results.

Analysts may also consider performing qualitative procedures if there are concerns regarding whether the insurer may be excessively leveraged due to its volume of A&H business including comparing the ratios of gross A&H premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to help evaluate the insurer's leverage. Analysts might also want to review Annual Financial Statement, Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written, determine whether the A&H lines of business have historically been profitable for the insurer, and determine whether A&H loss reserve adequacy has been maintained. As noted previously, an insurer that has historically written primarily A&H business might not be considered excessively leveraged, even though it has higher leverage ratio results, because the risk of significant underpricing or adverse underwriting results is less than for an insurer that has just begun writing A&H business.

Procedures/Data

- Ratio of A&H business to net premiums and annuity considerations
- If the ratio of A&H business to net premiums and annuity considerations is material, review
  - Ratio of gross A&H premiums to capital and surplus
  - Ratio of net A&H premiums to capital and surplus

Additional Review Considerations

- Compare the ratios of gross A&H premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to determine any significant deviations from the industry averages.
- In the Annual Financial Statement, review Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written.
- In the Annual Financial Statement, review Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written.
- Review the A&H loss percentage ratio (Annual Financial Profile Reports) for unusual fluctuations or trends between years.

Financial Impact of Affordable Care Act – Life/A&H

Determine whether there are concerns regarding the impact by line of business to the insurer's overall operating results and financial solvency. The strain from writing business subject to ACA requirements may result in significant assessments, high claims experience, rebate obligations or Risk Adjustment Program payments that have the potential to affect the insurer's solvency position. *See Health section of the Pricing/Underwriting chapter for more guidance on ACA solvency challenges.*

Procedures/Data

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- Review the preliminary medical loss ratio (MLR) by line of business (either the national Preliminary MLR or the state-level MLR). If any of the following benchmarks are met, assess the financial solvency of the plan and the impact of the plan on the overall financial solvency of the insurer.
    - Individual comprehensive.
    - Small group employer comprehensive
    - Large group employer comprehensive
    - Individual mini-med
    - Small group employer mini-med
    - Large group employer mini-med
    - Small group expatriate plans
    - Large group expatriate plans
    - Student health plans
- Analyze the underwriting gain/(loss) result by line of business and determine whether any line of business on the Supplemental Health Care Exhibit (SHCE) reported an underwriting loss.
    - Individual comprehensive.
    - Small group employer comprehensive
    - Large group employer comprehensive
    - Individual mini-med
    - Small group employer mini-med
    - Large group employer mini-med
    - Small group expatriate plans
    - Large group expatriate plans
    - Student health plans

Additional Review Considerations

- If any line of business in reported an underwriting loss, determine the reasons for the loss and assess the impact of each line of business to the overall operating results of the insurer.
- Compare the results of your analysis of the Preliminary MLR to your analysis of the existing MLR calculations [refer to Financial Profile Report or Operations Risk Assessment] and assess the impact to the overall solvency of the insurer.
- During the review of the health care business pursuant to the Public Health Service Act and all applicable filings, determine whether the analyst noted any unusual items or areas of concern, not previously noted, that indicate further review is warranted.
- If concerns exist regarding underwriting results for individual plans, consider requesting and reviewing additional information from the insurer on
    - Causes and plans to address poor underwriting performance and negative results (high MLR, rebates, risk sharing payments, line of business [LOB] operating losses, etc.).
    - Planned changes in market focus for federal Affordable Care Act (ACA) business (entering or exiting exchanges, entering or exiting states/regions, etc.).

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- Status of recent and pending rate increases

- Determine if there are concerns regarding recent rate filing requests:
  - Contact internal state insurance department staff responsible for the rate review and request information on any recent rate reviews. Determine whether any concerns were noted by the rate review staff (e.g., were rate adjustment requests disapproved or modified).
  - Review the trend in rate filing requests. Determine whether there are any concerns with the frequency or amount of the requests.
  - Review the Financial Profile Report's PMPM premium data and compare it to rate increases.

ANNUAL PRICING/UNDERWRITING RISK ASSESSMENT – HEALTH

Poor Overall Underwriting Performance – Health

Review the annual statement, summary of operations, and determine whether concerns exist regarding the pricing of the health entity's products. To the extent the health entity's premium PMPM has not increased by an amount that approximates the expected increase in health care costs PMPM, this may be an indication that the health entity's premium rates may not be able to keep pace with the health entity's medical inflation. Although this ratio is a measure of what has occurred since the prior year, it can be used as a gauge in evaluating whether a health entity may be exposed. The ratio is also limited since it can't be applied at the product level using Annual Financial Statement information. However, the purpose of the ratio is to provide analysts some sense of how the entity's premium rate changes compare with medical inflation in general. Analysts should also use the ratio of change in claims PMPM to change in premium PMPM. A result greater than zero indicates that claims increased from the prior year at a faster rate than premiums have increased from the prior year. A result less than zero would indicate that premiums have increased from the prior year at a faster rate than claims have increased from the prior year. The use of PMPM allows the ratio to be broken down to a more meaningful comparison. One other item that analysts should consider is the health entity's use of multiple year provider contracts. Multiple-year provider contracts allow a health entity and a provider to lock in agreed upon rates for an extended period of time. Although not necessarily an indication of underpricing, clearly it is much more difficult to predict the cost of health care three years out than it is one year out. As a result, multiple year contracts by their nature lend themselves to greater pricing risk. Analysts should be aware of the use of these contracts and the extent to which they are used.

If there are concerns, analysts may also consider procedures to assess if one or more of the health entity's products may be underpriced. Although it may be difficult to determine if any specific products are underpriced, one procedure analysts may want to consider is the level of losses on the individual statutory lines of business. To the extent the health entity had a combined ratio of greater than 105% on any line of business; it may be an indication that the product is underpriced. To the extent a health entity has underpriced a product; the financial impact could be significant depending upon the health entity's leverage and the type of product. Analysts should also consider the need to determine if the health entity has established a premium deficiency reserve on a line of business. As discussed in the Health Reserves and Liabilities section, this reserve is established when future premiums and current reserves are not sufficient to pay future claims and expenses. This type of reserve is established because it meets the definition of a loss contingency and should therefore be considered in evaluating the current financial position of the health entity. Analysts should use the information, along with any information from the health entity, to better assess the current financial position of the health entity. Other information could include a monthly assessment from the health entity on the adequacy of the current deficiency reserve based upon updated information. Since the reserve is essentially an estimate of the expected

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losses from one or more contracts, updated information can assist in ensuring that the reserve continues to be adequate and that the health entity's financial position has not materially deteriorated.

Procedures/Data

- Medical loss ratio (does not represent the calculation for the medical loss ratio (MLR) under the Affordable Care Act).
- Change in medical loss ratio
- Underwriting gain/loss
- Determine whether there have been operating losses in two or more of the past three years.
- Premium per member per month compared to prior year
- Determine whether the change in claims per member per month less the change in premium and risk revenue per member per month is greater than zero (See Financial Profile Report) Display the change in claims per member per month, the change in premium per member per month and the variance between the two.
- Direct commissions to direct premium ratio

Additional Review Considerations

- Review the five-year trend with the Annual Financial Profile Report, Annual Statement of Revenue and Expenses, and the Management Discussion and Analysis (MD&A) for the following measures of operating performance, and note any unusual fluctuations, events or trends between years for each:
    - Underwriting gain
    - Medical loss ratio
- Describe any known trends that have had or that the insurer reasonably expects will have a material impact on net revenues or underwriting income, or a material impact on the relationship between benefits, losses and expenses.
- Review the Annual Financial Statement, Analysis of Operations by Line of Business and the Financial Profile Report and:
    - Determine which lines of business were profitable for the insurer and which lines of business generated an underwriting loss.
    - Determine if any lines of business indicate a negative trend in profitability over the past five years.
    - Determine whether commissions on any lines of business appear excessive based on the volume of premiums.
- Review the Annual Financial Statement, General Interrogatories, Part 2, #9.1 and #9.2 and RBC Other Underwriting Risk (XR014-XR016). Ascertain whether the insurer has a significant amount of multi-year contracts with premium rate guarantees.
- Identify if any premium rates are locked for the year. Determine if there are any concerns regarding underpricing of these rates.
- Determine whether a premium deficiency reserve has been established by the insurer on any products in question.
- For lines of business for which a premium deficiency reserve has been established, request information monthly from the insurer that details estimates of how actual claims compare with expected claims and details the estimated impact on the reserve established.

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- If concerns exist regarding underwriting results, consider requesting and review additional information from the insurer:
  - Causes of poor underwriting performance.
  - Plans to address poor underwriting performance (e.g., changes in underwriting, rate changes, etc.).
  - Explanations for unusually high loss and combined ratios.
  - Descriptions of underwriting practices and policies.
  - Descriptions of pricing practices (e.g., frequency of review) and policies.
  - Rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.

Poor Underwriting Performance on A&H – Health

Evaluate the underwriting performance of the individual A&H lines of business through a review of the Annual Financial Statement, A&H Policy Experience Exhibit (April 1 filing), including a review of the loss ratio by line and consideration of multiyear trend analysis by line.

Procedures/Data

- Ascertain whether the insurer reported an underwriting loss on any line of business as reported on the Analysis of Operations by Line of Business page of the Annual Financial Statement.

Additional Review Considerations

- If underwriting losses were reported on the Analysis of Operations by Lines of Business page, review the A&H Policy Experience Exhibit to further identify specific health lines that may be experiencing losses.
- Compare results with prior years to identify any concerns with multiyear trends in premium, benefit, loss ratios or membership.

Concerns over Premium Production, Concentration and Writings Leverage – Health

The following are examples of risks that may be identified related to premium production.

- **Concerns over Changes in Premium Production—**See below.
- **Concentration of Writings**—See below.
- **Rapid Expansion/Growth**—Rapid growth or expansion into new geographic areas or new states may result in a higher-than-expected strain on surplus.
- **High Writings Leverage [or Trend]** —A high writings leverage trend may indicate concentrations, overexposure to certain insurance risks and/or a lack of support from ownership/parent. See below.
- **Lack of Underwriting Expertise** —A lack of underwriting expertise may result in underpricing or faulty risk acceptance if the insurer is not experienced in underwriting a new line of business
- **Lack of Sufficient Underwriting Standards** —A lack of sufficient underwriting policies and procedures may result in underpricing, acceptance of unknown/excessive risks, etc.
- **Negative Variance on Projected Premium/Sales to Actual** —Actual premium volume or new sales results vary materially from projections, leading to an inability to fulfill the strategic plan.
- **Rapid Expansion/Growth** —Rapid growth or expansion into new geographic areas or new states may result in a higher-than-expected strain on surplus.

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- **Declining Premium Volume** —Declines in premium volume may result in insufficient revenue to sustain current operations.
- **Lack of Clear Underwriting/Marketing Strategy** —Failure to define and update the underwriting/marketing strategy of the insurer may lead to inconsistent results, inappropriate risk acceptance, etc.

Determine the business stability of the insurer. Determine whether concerns exist regarding changes in the volume of premium, enrollment levels or changes in the insurer's mix of business (lines of business and/or geographic location). As previously discussed, a significant increase in premiums and enrollment may indicate rapid growth, which can present many different types of problems to a health entity or can also be an indication of the health entity's entrance into new lines of business or sales regions. Significant increases in premiums might also be an indication that the health entity is attempting to increase cash inflow to cover current benefit payments, particularly if the health entity primarily writes longer tail insurance.

If there are concerns analysts may also consider procedures to assess the financial impact of fluctuations in premiums or changes in business mix (line of business written and/or geographic location of premiums written) may have on the insurer's financial position. Analysts should consider comparing any significant changes in premiums to the health entity's most recent projections and business plan. Variances could suggest that consumers have responded to the health entity differently than anticipated. As previously discussed, growth can have a material impact on the operations of a health entity, and analysts should gain more information from the health entity when this has occurred, including how current and future growth is expected to be supported. However, decreases in premium can also place some pressure on the health entity through forced expense reductions. Analysts should attempt to understand how decreases in premiums are expected to impact this issue. If new lines of business are being written or if premiums are being written in new regions, analysts should review the health entity's MD&A for related information. Otherwise, information may be requested from the health entity showing operating results vs. projections for the new lines of business or territories and describing any changes in implementation strategy or revisions in financial projections for future periods. Analysts should also consider determining if, as a result of increases in sales regions, how the health entity prices its products, the contracts used with providers and any future expected changes in the health entity's business. The business of health insurance is very localized, and the health entity must have a reasonable understanding of that market to be successful.

Procedures/Data

- Change in enrollment from the prior year-end. Display the percent change and the enrollment for each of the past five years.
- Change in net premium income from the prior year
- Change in direct premiums written for any line of business
- Does the insurer write long-term care and disability income (long-tailed lines) premium? If "yes," list the percentage of total direct premium.
- If premiums are being written in any new lines, do they account for more than 10% of the total net premium income
- Determine if any direct business is being written in a state in which there were no prior writings [Annual Statement, Schedule T]

Additional Review Considerations

- Review the mix of business in the Annual Financial Profile Reports. If significant changes in premium volume are identified, consider the following procedures:
  - Determine which lines of business and types of are being written.

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- Determine whether there has been a significant increase or decrease or shifts in direct premiums written for any line of business.
- Determine whether any new lines of business are being written.
- Determine if the changes are consistent with the insurer's most recent projections and business plan. Request additional information for variances not discussed in the most recent plan.
- For an overall increase in premium, obtain specific information on when additional funds are expected to be deposited into the insurer to support the growth.
- For an overall decrease, determine the insurer's plans for addressing its expense structure under its new premium base.
- Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.

- If the insurer writes LTC or Disability. (long-tailed lines) is "yes," consider the impact that a reserve shortfall could have on the insurer's overall leverage risk. Request and review additional information from the insurer (if necessary)
  - Source(s) of significant changes in premium volume.
  - Insurer's expertise in the lines of business written.
  - How the insurer shares risk with other entities in order to minimize the overall underwriting risk to the insurer.
  - How the insurer intends to address its operating leverage issue.
  - Explanations for significant shifts in geographic concentrations, lines of business, amounts of premium written, etc.
  - Information regarding contracted benefits, premium and cost sharing with the U.S. Centers for Medicare and Medicaid Services.
- Review the insurer's marketing strategy included in its business plan.
  - If the insurer is writing a material new line of business or writing in a new state, evaluate the insurer's marketing and expansion plans in those states.
  - Is the insurer planning expansion into new states or premium growth in the future?
  - Has the insurer applied for or received new licenses in other states?
  - Has the insurer reported that it has ceased writing new business, a line of business or writing in a certain location?
  - Does the insurer have closed block operations?
  - Does the insurer's marketing strategy and projected premium growth match actual results reported in the current period? If materially different, evaluate the reasons why, or ask the insurer for an explanation. Distribution channels/networks, planned growth or cessation of business, expansion into new states or regions, management of closed block operations, etc.
  - Financial projections for expected premium/sales.
- In new or increasing lines of business, determine whether the insurer has the expertise (distribution networks, systems, underwriting, claims and reserving) needed. Consider reviewing the insurer's Management's Discussion and Analysis and or seeking additional information from the insurer to determine the insurer's expertise in the lines of business written.

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- If the insurer has entered a new region or has significantly increased the business written in an existing region, request information on how the insurer establishes product prices in those regions, the provider contracts used by the insurer in that region and a discussion of the insurer's future expected changes in the region. Compare this information with information available from the insurer's competitors.

High Health Writings Leverage [or Trend] - Health

Determine whether the health entity is excessively leveraged due to its volume of business. Capital and surplus can be considered as underwriting capacity. The ratios of net premiums and risk revenue to capital and surplus measures the extent to which that capacity is being utilized and the adequacy of the health entity's capital and surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A net premium and risk revenue to capital and surplus ratio greater than 10 to 1 (8 to 1 for non-health maintenance organizations (HMOs)) may indicate that the health entity is excessively leveraged. Special attention should be given to the type of coverage provided and the extent to which the health entity is able to transfer some of the risk from the business to another entity. Two health entities both with a 10 to 1 ratio may have different leverage depending on the type of coverage that they write. For example, to the extent the health entity has written primarily comprehensive business for many years in the same region, and is able to capitate some of its business, it may not be as risky as a health entity which has just begun writing Medicare business in a new region and is unable to transfer any of its risk. Even if both of these health entities have the same leverage ratio results, the one starting Medicare Risk coverage will have a riskier financial position. Analysts should also specifically consider if a significant portion of the premium is written on longer tail lines. On these lines, the ultimate experience may not be known for some time, thereby increasing the risk of reserve understatement. Analysts should also determine whether there has been an increase in the writing's ratio or an increase in the amount of long-tail business that is being written, to assist in identifying future trends.

If there are concerns analysts may also consider procedures to assess whether the health entity may be excessively leveraged due to its volume of business. Generally, the threshold for health business on leverage ratios is set at a much higher level than for property/casualty business. This is because property/casualty business tends to carry more catastrophic risk (risk of large loss) than health business, due in part to the long-tailed nature of property/casualty major lines of business. The threshold for HMOs tends to be set at a higher level than other health entities. This is because to some extent, HMOs are able to transfer some of their risk to other entities, thereby reducing their overall risk in comparison to their premium volume. Because of the above, a 10 to 1 threshold is generally used for HMOs (8 to 1 for most other health entities). However, analysts should consider the type of business written by the health entity and the health entity's use of risk transfer in considering the extent to which a health entity may be leveraged. These procedures assist by directing analysts to consider how these items may impact the health entity's overall leverage. Once analysts have a better understanding of these issues for a health entity, analysts may want to consider requesting additional information from the health entity on how it intends to address this issue.

Fluctuations in premium or enrollment may also indicate a reason for concern. Uncontrolled, excessive growth has been found to be one of the major causes of insolvency. If the growth is not accompanied by additional surplus, the capital and surplus may not be able to support the additional exposure. Growth is often times driven by a health entity's desire for greater market share. Many times, the health entity is able to gain that market share by lowering its prices or setting prices below the rest of the market. This desire for greater market share can lead to considerable underpricing. This underpricing can increase the amount of risk to the health entity for every dollar of premium written. Additionally, in many cases, the health entity may establish reserves as a percentage of premiums when it enters a new market, which can lead to additional risk. Therefore, if the product is underpriced, it's possible the reserves may be understated. As a result, growth by a health entity is often associated with underpricing and under reserving, which is a risky combination. In effect, the company may need to establish a greater reserve when unsure about its pricing.

In addition, growth can make administering the operations difficult and can create claims inventory backlogs. A change in premium might also reflect a health entity's entrance into new lines of business or sales regions. This

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could result in financial problems if the health entity does not have expertise in these new lines of business or regions. This is particularly true in the health insurance market where margins are traditionally very thin and critical mass is necessary in establishing new provider contracts. Finally, significant increases in premiums might also be an indication that the health entity is attempting to increase cash inflow in order to cover current benefit payments, particularly if the health entity is writing more longer tail insurance (e.g., long-term care).

In cases where premium or enrollment has not significantly changed, analysts should still assess the level of business written by the health entity by comparing premium and risk revenue to capital and surplus. This comparison should include premium, and risk revenue recorded by the health entity in its income statement since both sources of revenue represent exposure to the health entity. This type of comparison is generally considered a measure of a health entity's operating leverage and is important in determining the potential losses to the health entity. The higher the writings ratio, the more likely the health entity will record a material loss when morbidity spikes. For example, if a health entity is writing at a 5 to 1 ratio and reports a combined ratio of 105% (assuming no investment income and no federal income taxes) the health entity would report a 25% decrease in capital and surplus based upon the net loss alone. Therefore, for every $5 in writings at a loss of 5%, surplus would be impacted 5 times greater and incur a 25% loss. If a health entity is writing at a 10 to 1 ratio and reports a combined ratio of 105% (assuming no investment income and no federal income taxes) the health entity would report a 50% decrease in capital and surplus. Therefore, for every $10 in writings at a loss of 5%, surplus would be impacted 10 times greater and incur a 50% loss.

Procedures/Data

- Premiums and risk revenue to capital and surplus for HMOs
- Premiums and risk revenue to capital and surplus for non-HMOs
- Change in ratio of premiums and risk revenue to capital and surplus

Additional Review Considerations

- Compare ratios of premiums and risk revenue to capital and surplus to industry averages to determine any significant deviations from the industry averages.
- Request and review additional information from the insurer (if necessary), on how the insurer intends to address its operating leverage issue.

Poor Underwriting Performance for Medicare Part D Prescription Drug - Health

Review the annual financial statement, Medicare Part D Coverage Supplement and determine whether concerns exist regarding the insurer's underwriting performance of the Medicare Part D Prescription Drug coverage. The procedures utilize data in the Annual Financial Statement, Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, analysts should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated when the contract was made. If the insurer is reporting unusual results, analysts should consider if any delays in payments from the federal Centers for Medicare & Medicaid Services (CMS) are affecting results.

Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for a period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If policyholders utilize more benefits than were projected in the contract, the insurer may experience losses because the income from CMS is set for a full year. Analysts should consider obtaining and reviewing information on the contracted benefits, premium, and cost-sharing with CMS. Analysts should also evaluate a comparison of premiums, reserves, expected utilization, and benefit costs to actual experience on each plan.

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Procedures/Data

Consider evaluating the following items to determine whether concerns exist regarding the insurer's Medicare Part D coverage:

- Underwriting loss of either group or individual coverage
- Medical loss ratio of either group or individual coverage
- Expense loss ratio of either group or individual coverage
- Combined ratio of either group or individual coverage

Additional Review Considerations

- Obtain and review information regarding the contracted benefits, premium and cost sharing with the federal Centers for Medicare & Medicaid Services (CMS).
- Review the types of products being written, including any enhanced benefit products.
- Request information on and review the assumptions for reserves, utilization, and benefit costs projected in the development of the contract.
- If concerns exist regarding operating performance, request, review and evaluate information from the insurer regarding its plans to address the issues.

Poor Underwriting Performance on Long-Term Care Insurance [Health]

Evaluate the underwriting performance of the long-term care insurance (LTCI) line of business through a review of the Annual Financial Statement, Long-Term Care Experience Reporting Forms (April 1 filing), the Actuarial Guideline-51 reporting, actuarial memorandum or any other related actuarial information filed to the department including trends in premiums, claims and loss ratios. Analysts should consider requesting the assistance of the department actuary to review trends in reserving that may affect underwriting results. (See additional guidance in the Reserving Risk Assessment of this Handbook).

Procedures/Data

- Ascertain whether the insurer reported an underwriting loss on the "Other Health" line of business on the Analysis of Operations by Line of Business page of the Annual Financial Statement, and determine whether the insurer writes long-term care insurance (LTCI).

  If "yes," further investigate the underwriting loss by reviewing the Annual Financial Statement, LTC Experience Reporting Forms, A&H Policy Experience Exhibit, and the Actuarial Guideline-51 reporting. Request a department actuary to assist in the review, if available.

- Review the operational results in conjunction with the actuarial review of the LTC Experience Reporting Forms, the Actuarial Guideline-51 reporting, actuarial memorandum, or other related information filed to the department:
  - Identify by policy form or in aggregate trends in premiums, benefits and the LTC loss ratio (benefits divided by premiums).
  - Identify trends in under-reserving that may affect underwriting results. (Refer to the Actuarial Risk Assessment for A&H and Statement of Actuarial Opinion review procedures.)
- Compare results to prior years to identify any concerns with multi-year trends.

Financial Impact of the Federal Affordable Care Act [Health]

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Determine whether there are concerns regarding the impact of underwriting gains or losses by line of business and assessing the impact of each line to the insurer's total operating results and financial solvency. Note that the preliminary medical loss ratio (MLR) included in this supplemental health care exhibit (for any given state) is not the MLR that is used in calculating the federal mandated rebates.

The MLR used in the rebate calculation (i.e., the ACA MLR) will differ for two reasons. First the ACA MLR will reflect the development of claims and claims reserves between December 31 of the Statement Year and March 31 of the following year. The second and far more important reason is that the ACA MLR includes a credibility adjustment that is based on the number of covered lives and certain benefit provisions of the coverages provided. The adjustment takes the form of an addition of percentage points to the calculated MLR. The ACA MLR is then used to determine if a rebate is due and to calculate the amount of the rebate. If the ACA MLR is greater than the relevant MLR standard, no rebate is due. If the ACA MLR is less than the relevant MLR standard the rebate is calculated by multiplying the difference between the ACA MLR and the standard MLR by earned premium. Except for very large blocks of business (75,000 lives or more), the ACA MLR will always be larger than the Preliminary MLR. Conversely, for very small blocks of business (under 1,000 lives) the ACA MLR is not calculated since no rebate is due.

Despite the differences, the validity and reasonableness of the ACA MLR calculation, and therefore of the rebate calculation can be assessed using the data from the Annual Financial Statement, Supplemental Health Care Exhibit (SHCE). The following elements from the SHCE and the rebate calculation can be used for such an assessment.

For the following items, there should be little or no difference between the amounts in the SHCE and the rebate calculation:

- Earned premium.
- Federal and state taxes and licensing or regulatory fees.
- Expenses to improve health care quality.

For other items, there are expected to be differences between the SHCE and the rebate calculation due to the difference in the time of reporting between the two:

- Paid claims, unpaid claim reserve, and incurred claims.
- Experience rating refunds and reserves for experience rating refunds.
- Change in contract reserves.
- Incurred medical pool incentives and bonuses.
- Net healthcare receivables.

For the Contingent Benefit Reserve, the expected relationship between the SHCE and the rebate calculation is unknown as yet.

Identify any risks or concerns regarding recent rate filings and reviews. The rate review process may be performed by the U.S. Department of Health and Human Services (HHS) or by the state department of insurance (DOI), depending on the states' authority. Analysts should review any recent rate reviews performed (or if a different department, communicate with the rate review staff) and assess if any concerns exist. An analyst should also consider how the increase in the per member per month (PMPM) premiums compares with approved rate increases. Consider that there may have been different rate increases for different plans. Also consider the overall increase in premium PMPM for reasonableness compared to the approved rate increase.

In 2010, the NAIC adopted a form used to meet the requirements of Section 2794 of the federal Patient Protection and Affordable Care Act (PPACA) that specifies insurers must provide justifications for any rate filing request that meets an "unreasonable" threshold. The form is not an endorsement of any definition of "unreasonable" that HHS may develop. The form does not apply to large group business.

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Analysts should have a general understanding of the states' rate regulation laws and practices. Currently, states have a number of ways to regulate rates. In the individual market, the majority of states rely on actuarially justified ratings, while some states rely on community ratings, adjusted community ratings and rating bands. In the small group market, rating bands are more prevalent, while a small number of states utilize community ratings and adjusted community ratings. Rating bands limit the variation in premiums attributable to health status and other characteristics. Community ratings prohibit the use of any case characteristics besides geography to vary premium. Adjusted community ratings prohibit the use of health status or claims experience in setting premiums. Actuarial justification requires the insurer to demonstrate a correlation between the case characteristics and the increased medical claims costs. The NAIC has adopted safe harbors for case characteristics commonly used for setting premiums without providing justification. For further guidance, refer to the applicable state law or regulation.

Risk Related to Enrollment Fluctuations – New Entrants into the ACA Market

Health insurers are exposed to a variety of pricing and underwriting risks that have the potential to impact their insolvency position. This is particularly true for those insurers that participate in the ACA Health Insurance Market Exchange where guaranteed issuance is required, and pricing differential of products between the participating insurers have the potential to result in significant variances in enrollments. In addition, health insurers are sometimes exposed to significant increases or decreases in enrollment which can greatly impact solvency if the insurer is not adequately capitalized or has access to additional capital resources to be prepared to adjust operational support either up or down to accommodate the swings in membership. These considerations increase the importance of closely reviewing pricing adequacy in ongoing solvency monitoring efforts.

The intent of the ACA Risk Adjustment Program is to transfer funds from insurers with a relatively low-risk enrollee population to insurers with a relatively high-risk membership population. Operational and coding issues have the potential to impact the risk adjustment calculation and could result in an insurer owing a material risk adjustment payment even though it experienced higher than expected medical loss ratios. This can be most detrimental to some smaller or new insurers on the ACA Exchange where their projected marketing and growth strategy resulted in higher than projected claims experience. Insurers and regulators should be aware of the need to balance gaining membership growth, e.g., by creating more competitive pricing, with the insurer's sustainability and future solvency, especially for smaller or newer health insurers. It is possible at times, that increased membership at lower prices could result in better overall risk than the market average which results in the insurer paying into the risk assessment program, which in turn puts upward pressure on future premium as the insurer should account for future risk assessment payments.

It is important for regulators to evaluate and assess the insurer's operational and coding expertise in this area, particularly for those insurers that may be thinly capitalized or growing quickly, where the risk adjustment calculation could potentially negatively impact insurer solvency. Further the risk assessment process is complicated and requires expertise and significant resources that may result in unpredictable results and initially disadvantage a smaller or new health insurance carrier.

Procedures/Data

- Review the preliminary medical loss ratio (MLR) by line of business (either the national Preliminary MLR or the state-level MLR). If any of the following benchmarks are met, assess the financial solvency of the plan and the impact of the plan on the overall financial solvency of the insurer.
    - Individual comprehensive.
    - Small group employer comprehensive
    - Large group employer comprehensive
    - Individual mini-med

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- Small group employer mini-med
- Large group employer mini-med
- Small group expatriate plans
- Large group expatriate plans
- Student health plans

- Analyze the underwriting gain/(loss) result by line of business and determine whether any line of business on the SHCE reported an underwriting loss.
  - Individual comprehensive.
  - Small group employer comprehensive
  - Large group employer comprehensive
  - Individual mini-med
  - Small group employer mini-med
  - Large group employer mini-med
  - Small group expatriate plans
  - Large group expatriate plans
  - Student health plans

Additional Review Considerations

- If any line of business in reported an underwriting loss, determine the reasons for the loss and assess the impact of each line of business to the overall operating results of the insurer.
- Compare the results of your analysis of the Preliminary MLR to your analysis of the existing MLR calculations [refer to Financial Profile Report or Operations Risk Assessment] and assess the impact to the overall solvency of the insurer.
- During the review of the health care business pursuant to the Public Health Service Act and all applicable filings, determine whether the analyst noted any unusual items or areas of concern, not previously noted, that indicate further review is warranted.
- If concerns exist regarding underwriting results for individual plans, consider requesting and reviewing additional information from the insurer
  - Causes and plans to address poor underwriting performance.
  - Explanations of negative results (high MLR, rebates, risk sharing payments, line of business [LOB] operating losses, etc.).
  - Planned changes in market focus for ACA business (entering or exiting exchanges, entering or exiting states/regions, etc.).
  - Status of recent and pending rate increases.
- Determine if there are concerns regarding recent rate filing requests:
  - Contact internal state insurance department staff responsible for the rate review and request information on any recent rate reviews. Determine whether any concerns were noted by the rate review staff (e.g., were rate adjustment requests disapproved or modified)?
  - Review the trend in rate filing requests. Determine whether there are any concerns with the frequency or amount of the requests.

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- Review the Financial Profile Report's PMPM premium data and compare it to rate increases.

- For health insurers who offer ACA plans, particularly smaller and/or newer health insurers in the ACA Exchange, consider the following additional procedures:
  - Request and review projections from the insurer, including the volume and the type of membership being attracted during open enrollment periods to compare against future actual membership.
  - Review and compare rates against their peers to identify any indications that they may be underpricing one or more of their products which could assist in determining the impact of the risk adjustment calculation.
  - Gain an understanding and assess the insurer's expertise and resources for pricing ACA business and managing the impact of pricing and health care coding on the risk adjustment process.
  - Inquire of the insurer and assess its prospective strategic plan for preparing for and managing the operational and capital support that would be necessary should the insurer experience potentially large shifts in enrollment.

ADDITIONAL PROCEDURES

Examination Findings

Consider a review of the most recent examination report, Summary Review Memorandum (SRM) and communication with the examination staff to identify if any pricing and underwriting risk issues were discovered during the examination. If outstanding issues are identified, perform follow-up procedures as necessary to address the concerns.

Own Risk and Solvency Assessment (ORSA) Summary Report:

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing risks faced by the insurer.

If the insurer is required to file ORSA or part of a group that is required to filed ORSA:

- Determine whether the ORSA Summary Report analysis conducted by the lead state indicates any pricing and underwriting risks that require further monitoring or follow-up.
- Determine whether the ORSA Summary Report analysis conducted by the lead state indicates any mitigating strategies for existing or prospective pricing and writing risks.
- Determine whether the ORSA Summary Report presents the results of the modeled CAT exposure analysis at various levels, on both a gross and net basis [Property & Casualty]

Holding Company Analysis

Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

- Ascertain whether the Holding Company analysis conducted by the lead state indicates any pricing and underwriting risks impacting the insurer that require further monitoring or follow-up.
- Determine whether the Holding Company analysis conducted by the lead state indicates any mitigating strategies for existing or prospective risks impacting the insurer.

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QUARTERLY PRICING/UNDERWRITING ASSESSMENT – PROPERTY/ CASUALTY

The quarterly pricing and underwriting risk procedures are designed to identify the following. For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Poor Overall Underwriting Performance – P/C

Determine whether concerns exist regarding the insurer's underwriting performance including the impacts of premium revenue, incurred losses, loss adjustment expenses and commissions expenses.

Procedures/Data

- Change in net premiums earned from prior year-to-date
- Change in net incurred losses from prior year-to-date
- Net loss ratio
- Change in pure loss ratio from prior year-to-date
- Change in direct loss incurred for any line of business from prior year-to-date [quarterly financial statement, Part 1]

Additional Procedures

- Review the trend in the Financial Profile Report, for the following measures of operating performance and note any unusual fluctuations, events (e.g., catastrophes) or trends between years for each ratio:
  - Loss ratios
  - Incurred loss and loss adjustment expense (LAE)
- Review the write-ins for underwriting deductions in the Quarterly Financial Statement, Statement of Income and the Financial Profile Report, and note any unusual fluctuations or trends.
- If concerns exist regarding underwriting results, consider the following procedures:
  - Request and review additional information from the insurer on the causes of poor underwriting performance.
  - Request, review, and evaluate information from the insurer regarding its plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
  - Inquire of the rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.

Concerns with Premium Production, Concentration, and Writings Leverage – P/C

Determine whether concerns exist regarding changes in volume of premiums written, changes in the insurer's mix of business (lines of business and/or geographic location) and changes in writing leverage

Procedures/Data

- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis.
- Change in direct premiums written (DPW) for any line of business
- Ratio of DPW for new lines of business to total DPW

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- Change in DPW in any one state when DPW is greater than 10% of DPW in either the current or prior year
- Ratio of DPW in new states to total DPW
- Ratio of net writings leverage (rolling year)

Additional Procedures

- If significant changes in premium volume are identified, consider the following procedures:
  - Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.
  - Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.
- Review, by line of business, premiums written by year in the Financial Profile Report for shifts in the mix of business between years and gain an understanding of lines of business written.
- Review Quarterly Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.
- Review Quarterly Financial Statement, Schedule T and the writings section in the Financial Profile Report to evaluate the top states in terms of direct premiums and the percentage of total DPW in those states. Based on the lines of business written, determine whether large concentrations of premiums are written in areas prone to catastrophic events.
- Determine whether the company is diversified in terms of product lines and geographical exposure. If not, request and review information from the insurer regarding mitigation strategies to limit exposure concentrations.
- Review the insurer's underwriting/marketing strategy included in its business plan.
  - If 2.d is "yes," evaluate the insurer's marketing and expansion plans in that state.
  - Make an inquiry to the insurer whether it is planning expansion into new states or premium growth in the future.
  - Inquire of the insurer whether the insurer has applied for or received new licenses in other states.
  - Determine whether the insurer has reported that it has ceased writing new business, a line of business or writing in a certain geographical location.
  - Determine whether the insurer has closed block operations.
  - Determine whether the insurer's marketing strategy and projected premium growth match actual results reported in the current period. If materially different, evaluate the reasons why, or ask the insurer for an explanation.
- Determine whether the insurer has expertise (e.g., distribution network, underwriting, claims and reserving) in the lines of business written.

QUARTERLY PRICING/UNDERWRITING ASSESSMENT – LIFE, ACCIDENT & HEALTH

The quarterly pricing and underwriting risk procedures are designed to identify the following. For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

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Poor Overall Underwriting Performance – Life, A&H

Review the quarterly financial statement, summary of operations, and determine whether concerns exist regarding the insurer's underwriting performance including the impacts of premium revenue, incurred losses, and commissions expenses.

Procedures/Data

- Ratio of operating income to total income (before realized capital gains and losses).
- Determine where there has been operating losses in two or more of the past three consecutive quarters.
- Accident and health (A&H) loss ratio.
- Total Commissions and Incurred Expenses to Gross Premiums
- Total Commissions and Incurred Expenses to Gross Premiums Total Commissions and Incurred Expenses to Gross Premiums

Additional Procedures

- Review the five-year trend with the Quarterly Financial Statement, Summary of Operations, Quarterly Financial Profile Report, for the following measures of operating performance, and note any unusual fluctuations, events or trends between quarters for each:
  - Operating income, ratios.
  - A&H loss ratio.
- Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on net revenues or net income, or a material impact on the relationship between benefits, losses and expenses.
- If concerns exist regarding underwriting results, consider the following procedures:
  - Request and review additional information from the insurer on the causes of poor underwriting performance.
  - Request, review and evaluate information from the insurer regarding its plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
  - Inquire of the rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.
- Review the components of the Quarterly Financial Statement, Summary of Operations line items Aggregate Write-ins for Miscellaneous Income and Aggregate Write-ins for Deductions for reasonableness.

Concerns Over Change in Premium Volume – Life/A&H

Determine whether concerns exist regarding changes in the volume of premiums and deposit-type contract funds or changes in the insurer's mix.

Procedures/Data

- Ratio of change in net premiums, annuity considerations, from the prior year, same quarter
- Change in direct premiums for any line of business the prior year, same quarter? [Quarterly Financial Statement, Exhibit 1]
- Review the direct premium written by state:

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- Significant change in direct premiums written in any one state in which the current or prior year direct premium exceeds 10% of total direct premium.
- Premiums being written in any new state where that state's premiums exceed total direct premiums written.

Additional Procedures

- Review the mix of business in the Quarterly Financial Profile Reports:
  - Determine which lines of business are being written.
  - Determine whether there has been a significant increase or decrease or shifts in direct premiums written for any line of business.
  - Determine whether any new lines of business are being written.
- If significant changes in premium volume are identified, consider the following procedures:
  - Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.
  - Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.
- Review Quarterly Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.
- Review information provided in the Quarterly Financial Statement and supporting schedules (e.g., Schedule T, the writings section in the Financial Profile Report, etc.) to identify potential risk concentrations in terms of product types, geographical exposures, etc. If concerns are identified, request and review information from the insurer regarding mitigation strategies to limit exposure concentrations
- Review the insurer's marketing strategy included in its business plan.
  - If 2.d above is "yes," evaluate the insurer's marketing and expansion plans in that state.
  - Is the insurer planning expansion into new states or premium growth in the future?
  - Has the insurer applied for or received new licenses in other states?
  - Has the insurer reported that it has ceased writing new business, a line of business or writing in a certain location?
  - Does the insurer have closed block operations?
  - Does the insurer's marketing strategy and projected premium growth match actual results reported in the current period? If materially different, evaluate the reasons why, or ask the insurer for an explanation.
- Determine whether the insurer has expertise (distribution network, underwriting, claims and reserving) in the lines of business written.

High A&H Writings Leverage – Life/A&H

Determine whether the insurer may be excessively leveraged due to its volume of accident and health (A&H) business.

Procedures/Data

- Determine if A&H Business is material. Ratio of A&H business to net premiums and annuity considerations is material. If so, review,

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- Ratio of gross A&H premiums to capital and surplus.
- Ratio of net A&H premiums to capital and surplus.

Additional Procedures

- Compare ratios of gross A&H premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to determine any significant deviations from the industry averages.
- Review the A&H loss percentage ratio (Quarterly Financial Profile Reports) for unusual fluctuations or trends between quarters.

Financial Impact of the Federal Affordable Care Act (ACA) – Life/A&H

Determine whether there are concerns regarding the impact of the federal Affordable Care Act (ACA) to the insurer's overall operating results and financial solvency.

Procedures

- Determine whether the insurer wrote accident and health insurance premium which is subject to the Affordable Care Act risk-sharing provision and if the amount of premium written exceeded projections and ascertain whether the insurer's level of capital can support the impact of underestimation of the qualified premium.
- Review the insurer's current RBC to identify if it is at a deteriorating level due to ACA Risk Adjustment Program or as a result of the ACA fee assessment payable.
- Review the reinsurance and risk-adjustment accruals to identify insurers that:
  - Might not be adequately accruing liabilities for premium adjustments payable and for risk adjustment user fees payable.
  - That might be overestimating premium and adjustments receivables, or;
  - That might have liquidity issues because payments will be delayed until final determination can be made.

QUARTERLY PRICING/UNDERWRITING ASSESSMENT – HEALTH

The quarterly pricing and underwriting risk procedures are designed to identify the following. For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Poor Underwriting Performance – Health

Review the Quarterly Financial Statement, Summary of Operations, and determine whether concerns exist regarding the insurer's underwriting performance.

Procedures/Data

- Medical loss ratio (MLR)
- Change in MLR from prior-year end
- Change in MLR from prior-year-to-date

Additional Procedures

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- Review the five-year trend with the Quarterly Financial Statement, Statement of Revenue and Expenses, Quarterly Financial Profile Report, for the following measures of operating performance, and note any unusual fluctuations, events or trends between years for each:
    - Operating income, ratios
    - MLR
- Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on net revenues or net income, or a material impact on the relationship between benefits, losses and expenses.
- If concerns exist regarding underwriting results, consider the following procedures:
    - Request and review additional information from the insurer on the causes of poor underwriting performance.
    - Request, review and evaluate information from the insurer regarding its plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
    - Inquire of the rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.

Concerns over Change in Premium Volume – Health

Determine whether concerns exist regarding changes in the volume of premium, enrollment levels or changes in the insurer's mix of business (lines of business and/or geographic location) and changes in writings leverage.

Procedures/Data

- Change in premium income from prior year-to-date
- Change in enrollment from the prior year-end
- Change in direct premium written for any line of business
- If premiums are being written in any new lines, do they account for more than 5% of the total earned premiums?
- Determine if any direct business is being written in a state in which there were no prior writings [Quarterly Financial Statement, Schedule T]

Additional Procedures

- Review the mix of business in the Quarterly Financial Profile Reports. If significant changes in premium volume are identified, consider the following procedures:
    - Determine which lines of business are being written.
    - Determine whether there has been a significant increase or decrease or shifts in direct premiums written for any line of business.
    - Determine whether any new lines of business are being written.
    - Determine if the changes are consistent with the insurer's most recent projections and business plan. Request additional information for variances not discussed in the most recent plan.
    - For an overall increase in premium, obtain specific information on when additional funds are expected to be deposited into the insurer to support the growth.

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- For an overall decrease, determine the insurer's plans for addressing its expense structure under its new premium base.
- Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.
- Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.

- Review Quarterly Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.
- Review information provided in the Quarterly Financial Statement and supporting schedules (e.g., Schedule T, the writings section in the Financial Profile Report, etc.) to identify potential risk concentrations in terms of product types, geographical exposures, etc. If concerns are identified, request and review information from the insurer regarding mitigation strategies to limit exposure concentrations.
- Review the insurer's marketing strategy included in its business plan.
  - If 2.f. above is "yes," evaluate the insurer's marketing and expansion plans in that state.
  - Is the insurer planning expansion into new states or premium growth in the future?
  - Has the insurer applied for or received new licenses in other states?
  - Has the insurer reported that it has ceased writing new business, a line of business or writing in a certain location?
  - Does the insurer have closed block operations?
  - Does the insurer's marketing strategy and projected premium growth match actual results reported in the current period? If materially different, evaluate the reasons why, or ask the insurer for an explanation.
- Determine whether the insurer has expertise (e.g., distribution networks, underwriting, claims and reserving) in the lines of business written.

High A&H Writings Leverage – Health

Determine whether the insurer is excessively leveraged due to the volume of premiums written.

Procedures/Data

- Premiums and risk revenue to capital and surplus for HMOs
- Premiums and risk revenue to capital and surplus for non-HMOs
- Change in ratio of premiums and risk revenue to capital and surplus

Additional Procedures

- Compare ratios of gross accident and health (A&H) premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to determine any significant deviations from the industry averages.
- Review the A&H loss percentage ratio (Quarterly Financial Profile Reports) for unusual fluctuations or trends between years.

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Concerns with Product Pricing – Health

Determine whether concerns exist regarding the pricing of the insurer's products.

Procedures

- Increase in premium per member per month compared to prior year-end
- Change in claims per member per month less the change in premium and risk revenue per member per month from the prior year-end [Financial Profile Report]

Financial Impact of the Federal Affordable Care Act (ACA) – Health

Determine whether there are concerns regarding the impact of the federal Affordable Care Act (ACA) to the insurer's overall operating results and financial solvency.

Procedures

- Determine whether the insurer wrote accident and health insurance premium which is subject to the Affordable Care Act risk-sharing provision and if the amount of premium written exceeded projections and ascertain whether the insurer's level of capital can support the impact of underestimation of the qualified premium.
- Review the insurer's current RBC to identify if it is at a deteriorating level due to ACA Risk Adjustment Program or as a result of the ACA fee assessment payable.
- Review the reinsurance and risk-adjustment accruals to identify insurers that:
    - Might not be adequately accruing liabilities for premium adjustments payable and for risk adjustment user fees payable.
    - That might be overestimating premium and adjustments receivables, or;
    - That might have liquidity issues because payments will be delayed until final determination can be made.

For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

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REPUTATIONAL RISK: Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.

The Reputational Risk Assessment is focused primarily on how changes in the way the insurer is perceived can affect its solvency position. As such, risks in this area are often prospective in nature and may require consideration of third-party information to understand and assess their potential impact. For example, analysts may monitor news reports and movements in a company's stock price to identify risks and trends that may be affecting the insurer's reputation.

An analyst's risk-focused assessment of reputational risk should take into consideration the following areas (but not be limited to):

- Reputational impact of legal risks
- Reputational impact of operational risks
- Reputational impact of strategic risks
- Potential impairment of goodwill
- Agency ratings and outlooks
- News reports
- Press releases
- Stock trends
- Volume and trends in company complaints
- Market conduct violations and findings

ANNUAL REPUTATIONAL RISK ASSESSMENT

Reputational Impact of Other Risks

Identify and assess risks associated with other branded risk classifications on the insurer's reputation. While risks that are primarily addressed in any of the eight other branded risk classifications might have the potential to harm the insurer's reputation, the classifications most likely to directly affect reputational risk are legal risk, operational risk and strategic risk. Therefore, these possible considerations reference a number of common risk factors/components associated with each of these classifications for consideration of their impact on the insurer's reputation. For example, reports of fraud, problems in operating performance, and significant turnover in senior management all have the potential to result in reputational risk. Therefore, the procedure encourages the reputational impact of these risks to be considered and assessed, if applicable. In addition, the procedure asks analysts to consider the reputational impact of any other significant risks identified throughout the risk assessment process, including the impact of goodwill impairment on the insurer or insurance group's reputation.

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Procedures

- Identify and evaluate the impact of legal risks on the insurer's reputation, such as:
  - Violations of legal and regulatory requirements
  - Ongoing regulatory investigations
  - Significant ongoing litigation
  - Reports of fraud or fraud investigations
  - Ethical violations
- Identify and evaluate the impact of operational risks on the insurer's reputation, such as:
  - Information technology (IT) security concerns
  - Weak or ineffective corporate governance
  - Problems in operating performance
  - Third-party administrator (TPA) or managing general agent (MGA) relationships
- Identify and evaluate the impact of strategic risks on the insurer's reputation, such as:
  - Significant turnover at the board and senior management level
  - Merger and acquisition activity
  - Changes in business plan or strategic direction
  - Increasing leverage or concerns over capital adequacy
- Identify and evaluate the impact of an impairment of goodwill of any investment in parent, subsidiaries or affiliates (PSA) and the causes for such impairment on the insurer's reputation.
- Identify and evaluate the impact of all other significant risks with the potential to affect the insurer's reputation.

Additional Review Considerations

- Inquire of the Insurer:
  - The financial impact to the insurer and/or group's operations and surplus
  - Disclosures of financial impact to the public and agent distribution force
  - The insurer's efforts to mitigate any impact of the risk. For ORSA filers, this may be identified in the ORSA Summary Report for certain risks.
  - Policies and procedures in place to mitigate adverse publicity
  - Revised business plan

Poor, Downgrade, or Negative Trends in Ratings (Financial Strength or Credit) and Outlooks

Determine if concerns exist regarding the insurer or insurance group's ratings. Ratings received from a rating agency, as well as changes in the ratings and company/industry outlooks, can have a significant impact on the insurer or insurance group's reputation. A rating decline or a poor rating could negatively affect the insurer's ability to write new business, or it may affect other business operations. For example, debt covenants often include requirements to maintain ratings above a certain level. Therefore, analysts are strongly encouraged to monitor agency ratings and outlooks when assessing an insurer's exposure to reputational risk. The primary

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agencies that issue ratings to insurers include A.M. Best, Fitch Ratings, Moody's Investors Service, Standard & Poor's and Weiss Financial Group. For more information on these agencies and their ratings processes, see I. Introduction C. External Information. In reviewing agency ratings, reports and outlooks, analysts should consider and assess the reputational impact of any negative movements or trends with the potential to impact the insurer, as such trends may limit the insurer's ability to write new business or otherwise affect ongoing operations.

Procedures

- Review the most recent report from a credit rating provider (e.g., A.M. Best, Moody's, Standard & Poor's, Fitch, and Weiss) for the current financial strength and credit ratings and outlook, as well as an explanation of any change in the ratings.

Additional Review Procedures

- If concerns exist regarding a poor financial strength or credit rating, a negative outlook, or a rating change for the insurer or the insurance holding company, review the most recent report from the credit rating provider (CRP) to determine if the rating is at a level that may impact the insurer's ability to continue to write new business or that may impact other business functions (e.g., terms of debt covenants, ability to attract financing, ability to place reinsurance, etc.).
- Inquire of the insurer:
  - Strategies for maintaining or improving ratings.
  - Dependency on quality ratings.
  - Information from the insurer on the impact of ratings or changes in ratings to the insurer and/or group's operations.
  - If the insurer is downgraded or has a low rating, request information on any efforts to restore its rating.
  - Outcome of recent meetings with rating agencies.
  - Revised business plan, sales and marketing strategies.
  - If rating downgrades occur at the parent or affiliate, what impact do those changes have on the insurer.

Poor Star Rating (Health Only)

Star Ratings apply to health insurers and the procedures instructs the analyst to obtain and review the most recent information about Centers for Medicare and Medicaid Services (CMS)'s Star Rating of the insurer, as well as an explanation of any change in the rating. Star ratings are calculated by CMS based on the insurer's performance and member satisfaction data for Medicare plans including Medicare Advantage and Medicare Part D prescription drug plans. The ratings measure various factors and assign ratings on a scale from 1 to 5 stars, where 5 is the best. Star ratings help consumers compare the quality of Medicare plans. Performance data including Star ratings are available on the following CMS website:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData

A low or lowering of the Star rating may result in concerns regarding the insurer's reputation leading to loss of membership, decrease in underwriting results, and changes in future strategic plans. Where concerns exist, the analyst should consider gaining an understanding of the reasons for the low or lowering of the Star rating from the insurer, and how it impacts membership and future operations.

Also noteworthy is that insurers with Star ratings of 4 or higher receive annual bonus payments from CMS, which is required to be spent on extra benefits for members, which benefits consumers. Plans that receive at

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least four out of five stars have their benchmark increased. Total Spending on Medicare Advantage plan bonus payments have risen every year. The growth in spending on bonus payments has coincided with the increase in Medicare Advantage enrollment. Annual bonus payments from the federal government to Medicare insurers have reached an all-time high at a time when the Medicare program is facing growing fiscal pressures. The analyst should consider the amount of the bonus payments relative to the overall profit/loss and assess the reliance on those bonus payments and the possible impact should the insurer no longer receive them.

Procedures

- Health Lines of Business Only (filing on either Health or Life/A&H financial statements): Obtain and review the most recent information about Centers for Medicare & Medicaid Services' (CMS) Star Rating of the insurer, as well as an explanation of any change in the rating, to determine if concerns exist regarding the impact to the insurer's reputation, pricing and underwriting, and/or future strategic plans. Also note whether if the insurer has received a Star Rating of 4 or more and in turn received annual bonus payments from CMS to be spent on extra benefits for its members. Assess the reliance on bonus payments and the possible impact should the insurer no longer receive them.

Negative Publicity [or Negative Trends] in News, Press Releases and Industry Reports

Determine if concerns exist regarding news, press release, stock movements or industry reports involving the insurer or insurance group. The focus of this procedure is on reviewing sources of information outside of the regulatory filings to identify and assess relevant issues for their potential impact on the insurer's reputation. Negative publicity for the insurer or its affiliates could affect the insurer's ability to write new business or retain its current business. To obtain information from these sources, analysts should consider performing internet searches, subscribing to news feeds and taking other steps as necessary to accumulate and collect relevant information. In addition, analysts should consider using information accumulated and provided by the NAIC for this purpose, including industry snapshots and industry analysis reports, Capital Markets Bureau reports and solvency monitoring risk alerts. For insurers that are part of publicly traded groups, movements and trends in stock price may be indicative of potential reputational issues and should, therefore, be reviewed and assessed.

Procedures

- Review insurer or insurance group press releases to identify if any negative publicity or other issues have the potential to adversely impact the insurer's reputation.
- Review any insurance, marketplace or economic industry reports, news releases, and emerging issues to identify if any issues have the potential to negatively impact the insurer's reputation.
    - Examples: NAIC "Insurance Industry Snapshots" and "Insurance Industry Analysis Reports," NAIC Capital Markets Bureau reports, rating agency reports, insurance news sources, NAIC Risk Alerts, etc.

Additional Review Procedures

- If concerns exist regarding a recent industry report, news release, stock movement or emerging issue, determine if the news or industry issue has the potential to impact the insurer's reputation, operations or financial solvency.
- Review movements and trends in the insurer's or group's stock price and trading volume to assist in identifying and assessing reputational risk.
- Perform additional non-routine procedures where applicable (e.g., survey or questionnaire, stress testing, etc.).
- Inquire of the insurer:

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- Policies and strategies for mitigating reputational damages or crises sustained by the insurer or insurance group
- Assessment of emerging risks in the industry and economic impacts on ongoing business plans. (If an Own Risk and Solvency Assessment (ORSA) filer, this may be included in the ORSA Summary Report)

Market Conduct Violations/Issues,

OR

Market Conduct Examination Findings [or Corrective Action Plan],

OR

Financial Impact of Remediation of Market Conduct Violations

Determine if reputational concerns exist as a result of market conduct issues, including complaints, market conduct actions, issues raised by market conduct staff, etc. In identifying and assessing reputational risks emerging as a result of market conduct considerations, analysts should review information available through NAIC market analysis tools and databases(e.g., Market Analysis Procedures (MAP), the Market Analysis Review System (MARS), the Market Action Tracking System (MATS), the Regulatory Information Retrieval System (RIRS), the Market Conduct Annual Statement (MCAS), Complaints, etc.). These tools are made available to financial analysts through links on iSITE+ and can be a valuable resource in identifying issues with the potential to harm the insurer's reputation. If any concerns are identified through use of the tools, financial analysts are encouraged to contact market conduct regulators in their state to investigate further, discuss and follow-up on the issues identified. In addition, analysts should routinely reach out to market conduct regulators to inquire regarding any significant issues they are aware of that could affect the insurer's reputation or solvency position.

Material findings or corrective actions, including large fines, settlements or required remediation (e.g., re-reviewing denied claims), may have a current or prospective financial impact on the insurer. (E.g., if corrective actions extend into future years and result in future costs or changes in operating practices)

Procedures

- Review any market conduct information available from the NAIC market analysis tools and databases (MAP, MARS, MATS, RIRS, MCAS, and Complaints). Note any unusual items or negative trends that translate into financial risks or indicate further review is needed.
  - Count of total confirmed complaints
    - Current year
    - Prior year
    - Second prior year
  - Confirmed complaint index (nationwide)
    - Current year
    - Prior year
    - Second prior year

Additional Review Considerations

- Review any market conduct information, including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee). Note any unusual items that translate into financial risks or indicate further review is needed.

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- Review any inter-departmental communication, as well as communication with other state, federal or international insurance regulators and the insurer. Note any unusual items or prospective risks that indicate further analysis or follow-up is necessary.
- If market conduct information is unusual and indicates the potential for reputational damage, perform the following procedures:
    - Describe and document the findings of the most recent market conduct examination and analysis and communication with the insurance department's market conduct staff.
    - Describe any current or future actions of the insurance department, other state insurance departments or other regulatory bodies against the insurer related to market conduct violations.
- Inquire of the insurer:
    - Its assessment of the financial impact to operations and surplus of market conduct examination findings, fines, settlements or remediation.
    - Claims payment policies (including use and oversight of third parties)

ADDITIONAL PROCEDURES

Examination Findings

Review the most recent examination report, Summary Review Memorandum (SRM) and communication with the examination staff to identify if any reputational risk issues were discovered during the examination.

Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding reputational risks. If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

Own Risk and Solvency Assessment (ORSA) Summary Report

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing reputational risks faced by the insurer.

If the insurer is required to file ORSA or part of a group that is required to file ORSA:

- Determine whether the ORSA Summary Report analysis conducted by the lead state indicates any reputational risks that require further monitoring or follow-up.
- Determine whether the ORSA Summary Report analysis conducted by the lead state indicates any mitigating strategies for existing or prospective reputational risks.

Holding Company Analysis

Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing reputational risks that could impact the insurer.

- Determine whether the Holding Company analysis conducted by the lead state indicates any reputational risks impacting the insurer that require further monitoring or follow-up.
- Determine whether the Holding Company analysis conducted by the lead state indicates any mitigating strategies for existing or prospective reputational risks impacting the insurer.

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QUARTERLY REPUTATIONAL RISK ASSESSMENT

The quarterly reputational risk assessment procedues are designed to identify the following.

Reputational Impacts of Other Risks

Evaluate the impact of risks associated with other branded risk classifications may emerge from other branded risks.

Procedures

- Identify and evaluate the impact of legal risks on the insurer's reputation, such as:
  - Violations of legal and regulatory requirements
  - Ongoing regulatory investigations
  - Significant ongoing litigation
  - Reports of fraud or fraud investigations
  - Ethical violations
- Identify and evaluate the impact of operational risks on the insurer's reputation, such as:
  - Information technology (IT) security concerns
  - Weak or ineffective corporate governance
  - Problems in operating performance
  - Third-party administrator (TPA) or managing general agent (MGA) relationships
- Identify and evaluate the impact of strategic risks on the insurer's reputation, such as:
  - Significant turnover at the board and senior management level
  - Merger and acquisition activity
  - Changes in business plan or strategic direction
  - Increasing leverage or concerns over capital adequacy
- Identify and evaluate the impact of an impairment of goodwill of any investment in parent, subsidiaries, or affiliates (PSA) and the causes for such impairment on the insurer's reputation.
- Identify and evaluate the impact of all other significant risks with the potential to affect the insurer's reputation.

Poor, Downgrade, or Negative Trends in Ratings (Financial Strength or Credit) and Outlooks

Determine if concerns exist regarding the insurer's or group's ratings.

Procedures

- Review the most recent report from a credit rating provider (e.g., A.M. Best, Moody's, Standard & Poor's, Fitch, and Weiss) for the current financial strength and credit ratings and outlook, as well as an explanation of any change in the ratings.

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- If concerns exist regarding a poor financial strength or credit rating, a negative outlook, or a rating change for the insurer or the insurance holding company, review the most recent report from the credit rating provider (CRP) to determine if the rating is at a level that may impact the insurer's ability to continue to write new business or that may impact other business functions (e.g., terms of debt covenants, ability to attract financing, ability to place reinsurance, etc.).

Poor Star Rating (Health Only)

Procedures

- Health Lines of Business Only (filing on either Health or Life/A&H financial statements): Obtain and review the most recent information about CMS's Star Rating of the insurer, as well as an explanation of any change in the rating, to determine if concerns exist regarding the impact to the insurer's reputation, pricing and underwriting, and/or future strategic plans. Also note whether the insurer has received a Star Rating of 4 or more and in turn received annual bonus payments from CMS to be spent on extra benefits for its members. Assess the reliance on bonus payments and the possible impact should the insurer no longer receive them.

Negative Publicity [or Negative Trends] in News, Press Releases and Industry Reports

Determine if concerns existregarding news, press release or industry reports involving the insurer or insurance group.

Procedures

- Review insurer or insurance group press releases to identify if any negative publicity or other issues have the potential to adversely impact the insurer's reputation.
- Review any insurance, marketplace or economic industry reports, news releases and emerging issues to identify if any issues have the potential to negatively impact the insurer's reputation.
    - Examples: NAIC "Insurance Industry Snapshots" and "Insurance Industry Analysis Reports," NAIC Capital Markets Bureau reports, rating agency reports, insurance news sources, NAIC risk alerts, etc.
- If concerns exist regarding a recent industry report, news release or emerging issue, determine if the news or industry issue has the potential to impact the insurer's reputation, operations or financial solvency.

Market Conduct Violations/Issues,

OR

Market Conduct Examination Findings [or Corrective Action Plan],

OR

Financial Impact of Remediation of Market Conduct Violations

Determine if concerns exist regarding market conduct issues, including complaints, market conduct actions, issues raised by market conduct staff, etc. If concerns exist, communicate risks/issues to the state insurance department's market conduct unit to conduct further investigation.

Procedures / Data

- Review any market conduct information available from the NAIC market analysis tools and databases (MAP, MARS, MATS, RIRS, and Complaints). Note any unusual items or negative trends that translate into financial risks or indicate further review is needed.
    - Count of total confirmed complaints

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- Current year-to-date
- Prior year-to-date
- Second prior year-to-date

- Confirmed complaint index (Nationwide)
  - Prior Year-End
  - Second Prior year-end
  - Third prior year-end

Additional Review Considerations

- Review any market conduct information, including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee). Note any unusual items that translate into financial risks or indicate further review is needed.
- Review any inter-departmental communication, as well as communication with other state, federal or international insurance regulators and the insurer. Note any unusual items or prospective risks that indicate further analysis or follow-up is necessary.
- If market conduct information is unusual and indicates the potential for reputational damage, perform the following procedures:
  - Describe and document the findings of the most recent market conduct examination and analysis and communication with the insurance department's market conduct staff.
  - Describe any current or future actions of the insurance department, other state insurance departments or other regulatory bodies against the insurer related to market conduct violations.

For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

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Reserving Risk: Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

Analysis Documentation: The Statement of Actuarial Opinion Worksheet is intended to provide procedures for reviewing the Statement of Actuarial Opinion, Actuarial Opinion Summary, and Actuarial Report for compliance and assessment of risks. Results of the reserving risk analysis should be documented in Section III: Risk Assessment of the insurer.

Note that reserving risks also are included in the Reserving Risk Assessment.

Actuarial Opinion - General

1. Determine whether the insurer is exempt from filing the Actuarial Opinion.

	Comments
a. Actuarial Opinion filed	
b. Exemption granted	
i. Exemption attached to Annual Financial Statement	
ii. Reason for exemption: • Small company • Under supervision or conservatorship • Nature of business • Financial hardship • Other	

Actuarial Opinion - Identification

2. Determine whether the Actuarial Opinion was prepared by a qualified actuary who was appointed by the insurer's board of directors prior to Dec. 31 of the calendar year for which the opinion was rendered.

	Comments
a. Appointed Actuary:	
i. Name	
ii. Relationship to insurer: • Office/employee of insurer or group (E) • Consultant (C)	
iii. Qualification (List the same qualification as listed in the Actuarial Opinion): • Fellow of the Casualty Actuarial Society (F) • Associate of the Casualty Actuarial Society (A) • Fellow of the Society of Actuaries through the General Insurance track (S) • Member of the American Academy of Actuaries approved by the Casualty Practice Council (M) • Other (O)	

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iv. Appointed by the board of directors by Dec. 31 of the calendar year for which the opinion was rendered	
v. Same actuary who was appointed for the previous Actuarial Opinion ("yes" or "no")	
If "no": • The insurer notified the domiciliary state insurance regulator within five days of the replacement. • Within 10 days of above notification, the insurer provided an additional letter stating whether there were any disagreements with the former appointed actuary and also in writing requested the former appointed actuary provide a letter of agreement. • The insurer furnished the former appointed actuary's letter of agreement.	

3. Determine whether the appointed actuary made the required disclosures if the insurer is a member of an intercompany pooling arrangement. (P/C only)

	Comments
a. Member of intercompany pooling arrangement ("yes" or "no") (The analyst should refer to Annual Financial Statement, Notes to Financial Statements, Note #26 to verify.)	
i. If "yes," the Actuarial Opinion includes: • Description of pool • Pool lead company identification • List of pool members, states of domicile and pooling percentages	
ii. Exhibits A and B represent company's share of pool and reconcile to company's financial statement	
iii. If company has 0% share: • The Actuarial Opinion reads similar to that provided for the lead company • Responses to Exhibit B, items #5 and #6 are $0 and "not applicable," respectively • Lead company's Exhibits A and B are attached	

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Actuarial Opinion - Scope

4. Determine whether the Appointed Actuary included the appropriate loss reserves, loss adjustment expense (LAE) reserves, and (if appropriate) other loss and premium reserves within the scope of the opinion as required by the Annual Statement Instructions Property/Casualty (P/C) and Annual Statement Instructions Title (Title) and whether the reserve amounts included in Exhibit A and Exhibit B of the Actuarial Opinion agree with the amounts reported in the Annual Statement.

	Comments
a. SCOPE paragraph contains a sentence such as: • "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 Dec. 31, 20xx, and reviewed information provided to me through xxx date." • "I have examined the reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of Dec. 31, 20xx and reviewed information provided to me through xxx date." • Other or none (provide comments).	
b. Exhibit A:	
i. Attached to or made part of the Actuarial Opinion	
ii. Lists items and amounts with respect to which the Appointed Actuary is expressing an opinion, including: • Reserve for net unpaid losses • Reserve for net unpaid LAE • Reserve for direct and assumed unpaid losses • Reserve for direct and assumed unpaid LAE	
iii. Shows amounts that reconcile to corresponding Annual Financial Statement references. If amounts do not reconcile, the analyst should discuss any differences and concerns.	
iv. Lists other items on which the Appointed Actuary is expressing an opinion (P/C only), including: • Reserve for retroactive reinsurance assumed (page 3 write-in item) • Other loss reserve items • Reserve for direct and assumed unearned premiums for P&C long duration contracts • Reserve for net unearned premiums for P&C long duration contracts • Other premium reserve items such as premium deficiency reserves	
v. Cite any concerns with amounts or unusual findings with other items	

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vi. Statement that items in Exhibit A reflect the disclosure items #8 through #14 in Exhibit B	

5. Determine whether the Appointed Actuary relied on an officer of the company for data preparation and whether the data used in forming the Appointed Actuary's opinion were reconciled to Annual Financial Statement, Schedule P – Part 1 (P/C) or Schedule P – Parts 1 and 2 (Title).

	Comments
a. SCOPE paragraph:	
i. Gives the name and title of the individual at the company that the Appointed Actuary relied on for data preparation.	
ii. States that the Appointed Actuary evaluated that data for reasonableness and consistency.	
iii. States that the Appointed Actuary reconciled or reviewed the reconciliation of that data to Annual Financial Statement, Schedule P – Part 1 (P/C) or Schedule P – Parts 1 and 2 (Title).	
iv. If the data was not reconciled, the analyst should document any reasons provided by the Appointed Actuary as to why the reconciliation was not performed. Further, if the reconciliation was performed but the data did not reconcile, the analyst should document any reasons provided by the Appointed Actuary as to why the data did not reconcile.	
v. States that the Appointed Actuary's examination included a review of the actuarial assumptions and methods used and tests of the calculations as considered necessary.	

Actuarial Opinion - Opinion

6. Determine whether the Actuarial Opinion states that reserves meet the requirements of the insurance laws of the state of domicile, are computed in accordance with accepted loss reserving standards and principles, and make a reasonable provision for all unpaid loss and LAE obligations of the insurer under the terms of its policies and agreements, and whether all portions of the insurer's reserves are covered by the Actuarial Opinion.

	Comments
a. OPINION paragraph states that the:	
i. Amounts shown in Exhibit A meet the requirements of the insurance laws of the state of domicile.	
ii. Amounts shown in Exhibit A are computed in accordance with accepted actuarial standards and principles or similar language, such as "consistent with reserves computed in accordance with …".	
iii. Amounts shown in Exhibit A make a reasonable provision (carried reserve is within the Appointed Actuary's range of reasonable reserve estimates) for all unpaid loss and LAE	

obligations of the insurer under the terms of its contracts and agreements.	
• If "no," the type of opinion is: o Deficient or Inadequate. (Carried reserve is less than the minimum amount that the Appointed Actuary believes is reasonable.) o Redundant or Excessive. (Carried reserve is greater than the maximum amount that the Appointed Actuary believes is reasonable.) o Qualified. (Carried reserves for a certain item or items are in question because they cannot be reasonably estimated or the Appointed Actuary is unable to render an opinion on those items.) o No Opinion. (The Appointed Actuary cannot reach a conclusion due to deficiencies or limitations in the data, analysis, assumptions, or related information.)	
b. If the SCOPE includes material unearned premium reserves for P&C long duration contracts, the OPINION paragraph states that the amounts shown in Exhibit A make a reasonable provision for the unearned premium reserves for P&C long duration contracts. (P/C only)	
c. If the SCOPE includes other loss or premium reserve items on which the Appointed Actuary is expressing an opinion, the OPINION paragraph states that the amounts shown in Exhibit A make a reasonable provision for the other loss or premium reserve items.	
d. If the Appointed Actuary made use of the analysis of another actuary not within the Appointed Actuary's control for a material portion of the reserves: i. The other actuary is identified by name, credential and affiliation. ii. The Appointed Actuary discloses whether he or she reviewed the other actuary's underlying analysis. If a review was conducted, the Appointed Actuary should disclose the extent of the review including items such as the methods and assumptions used and the underlying arithmetic calculations.	
e. If the Appointed Actuary made use of the work of a non-actuary not within the Appointed Actuary's control for a material portion of the reserves: i. The individual is identified by name and affiliation. ii. The Appointed Actuary describes the type of analysis the non-actuary performed.	
f. If the Appointed Actuary made use of the work of another not within the Appointed Actuary's control for a material portion of the	

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reserves, what percentage of the total reserves was based on the work of others?	

7. If applicable, identify the reasons why the Actuarial Opinion states the reserves do not make a reasonable provision for unpaid loss and LAE obligations.

	Comments
a. If the Appointed Actuary issues a Qualified Opinion, the Appointed Actuary: i. Discloses the item(s) to which the qualification relates, the reason(s) for the qualification and the amounts of such items. ii. States whether the carried reserves make a reasonable provision for the liabilities, except for the item(s) to which the qualification relates.	
b. If the Appointed Actuary issues a statement of No Opinion, the Appointed Actuary includes a description of the reasons why no opinion could be given.	
c. Review and assess, as applicable: i. If the type of opinion is Deficient or Redundant, the differences between the Appointed Actuary's indicated reserves (or range of reasonable reserves) and those carried by the insurer, and the impact of the differences on the insurer's policyholders' surplus. ii. The reasons why a Qualified Opinion or No Opinion was given. iii. The need to perform additional analysis and procedures on the items or risks affected.	

Actuarial Opinion – Relevant Comments and Exhibit B Disclosures

8. Determine whether the Appointed Actuary commented on various topics and issues in Exhibit B of the Actuarial Opinion as required by the *Annual Statement Instructions Property/Casualty and Title Insurers*.

	Comments
a. Risk of Material Adverse Deviation:	
i. Description of company-specific risk factors	
ii. Identification of materiality standard and the basis for establishing this standard	
iii. Risk of material adverse deviation ("yes" or "no")	
iv. Bright Line Indicator triggered (If "yes," comments from the Appointed Actuary should be pursued if the Appointed Actuary does not believe a risk of material adverse deviation exists.) (P/C only)	
b. Other disclosures in Exhibit B:	

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i. The following amounts in Exhibit B match the corresponding Annual Financial Statement references. The Appointed Actuary may include RELEVANT COMMENT paragraphs describing the significance of the items. <u>P/C</u> • Statutory surplus • Anticipated net salvage and subrogation • Nontabular discount • Tabular discount • Net reserves for the company's share of voluntary and involuntary pools' and associations' reserves • Net asbestos reserves • Net environmental reserves • Extended claims made loss reserves • Extended claims made unearned premium reserves • Other items on which the Appointed Actuary is providing relevant comment <u>Title</u> • Known claims reserve • Statutory premium reserve • Aggregate of other reserves required by law • Supplemental reserve • Anticipated net salvage and subrogation • Discount included as a reduction to reserves If the amounts do not match the Annual Statement references, discuss the differences and any concerns.	
c. Reinsurance:	
i. Discussion of retroactive reinsurance	
ii. Discussion of financial reinsurance	
iii. Discussion of reinsurance collectability: • No discussion • Discussion with little comment • The Appointed Actuary solicited information from management on actual collectability problems • The Appointed Actuary reviewed ratings of reinsurers • The Appointed Actuary reviewed Schedule F of the Annual Financial Statement	
d. Exceptional values for one or more reserve-related IRIS ratios (P/C only): • None • One-year development to PY PHS (#11) • Two-year development to 2nd PY PHS (#12) • Estimated current reserve deficiency to PHS (#13)	

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e. Comment if reserves cause the ratio of one-year or two-year reserve development to the respective prior year's policyholders' surplus to be greater than 20% (Title only)	
f. Significant change in the actuarial assumptions or methods from those previously employed	
g. Comments on any additional topics (e.g., lack of historical data, etc.)	

Actuarial Opinion – Assurance That an Actuarial Report Has Been Prepared, Signature, Requirements for Actuarial Report

9. Determine whether the Appointed Actuary indicates that an Actuarial Report has been prepared that supports the findings expressed in the Actuarial Opinion. Determine whether the Actuarial Opinion has been signed according to the Instructions. If the Actuarial Report is requested, determine if the report contains the required elements.

	Comments
a. The Appointed Actuary indicates that an Actuarial Report and underlying actuarial work papers supporting the Actuarial Opinion will be maintained at the company and available for regulatory examination for seven years.	
b. The Actuarial Opinion concludes with the signature, the printed name, the employer's name, the address, the telephone number and the email address of the Appointed Actuary, as well as the date the Actuarial Opinion was rendered.	
c. Copy of the Actuarial Report requested.	
d. Requirements of the Actuarial Report (to be verified by analyst if report is requested):	
i. The Actuarial Report is signed and dated by the Appointed Actuary.	
ii. The Actuarial Report is consistent with Actuarial Standard of Practice (ASOP) No. 41, *Actuarial Communications* and includes:	
• Narrative component that provides sufficient detail to clearly explain to company management, the board of directors, the regulator, or other authority the findings, recommendations and conclusions, as well as their significance.	
• Technical component that provides sufficient documentation and disclosures for another actuary practicing in the same field to evaluate the work and shows the analysis from the basic data (e.g., loss triangles) to the conclusions.	
iii. Actuarial report includes required elements from the Instructions:	
• Description of the Appointed Actuary's relationship to the company with clear presentation of the Appointed	

Actuary's role in advising the board of directors and/or management regarding the carried reserves. The actuarial report should identify how and when the Appointed Actuary presents the analysis to the board of directors.	
• An exhibit that ties to the Annual Statement and compares the Appointed Actuary's conclusions to the carried amounts consistent with the segmentation of exposure or liability groupings used in the analysis. The Appointed Actuary's conclusions include the Appointed Actuary's point estimate(s), range(s) of reasonable estimates or both.	
• An exhibit that reconciles and maps the data used by the Appointed Actuary, consistent with the segmentation of exposure or liability groupings used in the analysis, to the Annual Financial Statement, Schedule P line of business reporting. An explanation should be provided for any material differences.	
• An exhibit or appendix showing the change in the Appointed Actuary's estimates from the prior Actuarial Report, including extended discussion of factors underlying any material changes. If the Appointed Actuary is newly appointed and does not review the work of the prior Appointed Actuary, the Appointed Actuary should disclose this.	
• Extended comments on trends that indicate the presence or absence of risks and uncertainties that could result in material adverse deviation.	
• Extended comments on factors that led to unusual IRIS ratios for One-Year Reserve Development to Surplus (#11), Two-Year Reserve Development to Surplus (#12) or Estimated Current Reserve Deficiency to Surplus (#13), and how these factors were addressed in current and prior year analyses. (P/C only)	
• Extended comments on factors that led to exceptional reserve development and how these factors were addressed in prior and current analyses. (Title only)	
• Disclosure of all reserve amounts associated with A&H long duration contracts. (P/C only)	

Actuarial Opinion Summary

10. Determine whether the Actuarial Opinion Summary (AOS) was prepared according to regulatory requirements.

	Comments
a. Domiciliary state insurance regulator requires a confidential AOS.	

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i. Required AOS was submitted by March 15 or by a later date specified by the domiciliary state. ii. AOS was signed and dated by the same Appointed Actuary who signed the Actuarial Opinion.	

11. If the insurer is a member of an intercompany pooling arrangement, verify that the AOS discloses pooling information. (P/C only)

	Comments
a. Member of intercompany pooling arrangement:	
i. Percentage of company's share of pool is disclosed.	
ii. Numbers for non-0% companies reflect the company's share of the pool. Numbers for 0% pool participants are those of the lead company.	

12. Determine whether the AOS contains the required comparisons and whether the amounts in the AOS reconcile with those in the Actuarial Opinion, Actuarial Report and Annual Financial Statement.

	Comments
a. The AOS includes:	
i. The Appointed Actuary's range of reasonable estimates for loss and LAE reserves, net and gross of reinsurance, when calculated. ii. The Appointed Actuary's point estimates for loss and LAE reserves, net and gross of reinsurance, when calculated. iii. The company's carried loss and loss adjustment expense reserves, net and gross of reinsurance. iv. The difference between the company's carried reserves and the Appointed Actuary's estimates calculated in i. and ii. above, net and gross of reinsurance.	
b. Net and gross reserve amounts reported by the Appointed Actuary in the AOS reconcile to the corresponding values reported in the insurer's Annual Statement, the Appointed Actuary's Actuarial Opinion and the Actuarial Report. If not, the Appointed Actuary provides an explanation of the difference.	
c. If the company's carried reserves are below the Appointed Actuary's point estimate or below the midpoint of the Appointed Actuary's range, how material is the difference? • As a percent of surplus • As a percent of carried reserves • In relation to the company's risk-based capital (RBC) position (P/C only) • Is the difference greater or less than the materiality standard	

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13. Determine whether the Appointed Actuary's opinion implied by the comparisons in the AOS is consistent with the type of opinion rendered in the Actuarial Opinion.

	Comments
a. The AOS is consistent with the Appointed Actuary's conclusion that the amounts shown in Exhibit A are Reasonable, Deficient, or Redundant; the Opinion is Qualified; or No Opinion can be given. i. Opinion type is "Reasonable": Carried reserves are at or near the Appointed Actuary's point estimate and/or within the Appointed Actuary's range. ii. Opinion type is "Deficient": Carried reserves are materially below the Appointed Actuary's point estimate and/or below the low end of the Appointed Actuary's range. iii. Opinion type is "Redundant": Carried reserves are materially above the Appointed Actuary's point estimate and/or above the high end of the Appointed Actuary's range. iv. Opinion type is Qualified or No Opinion: The Appointed Actuary's choice of presentation in AOS will vary.	

14. Determine whether the AOS is compliant with reporting requirements regarding persistent adverse development. (P/C only)

	Comments
a. The company has experienced one-year adverse development in excess of 5% of prior year's surplus, as measured by the Annual Financial Statement, Schedule P – Part 2 – Summary, in three or more of the past five calendar years.	
i. If "yes," the Appointed Actuary includes an explicit description of the reserve elements or management decisions that were the major contributors.	

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RESERVING RISK: Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

The Reserving Risk Assessment is focused on reserve adequacy. The analysis of reserves relies heavily on the review of the Statement of Actuarial Opinion and other related filings. Analysts' risk-focused assessment of reserving risk should take into consideration the following areas (but be limited to):

- Reasonableness of assumptions and methodologies used by the Appointed Actuary to determine reserves
- Completeness and accuracy of the underlying data used by the Appointed Actuary in reserve calculations
- Accuracy of the Appointed Actuary's reserve calculations
- Relationship between the Appointed Actuary's reserve estimates and the company's carried amounts
- Appropriate reporting of reserves and consistency between amounts recorded in the Statement of Actuarial Opinion, Actuarial Opinion Summary (AOS), Actuarial Report and Annual Financial Statement
- Effect of discounting on the carried reserves
- Lines of business written by the insurer
- Reserve development
- Changes in ceded reinsurance program
- Collectability of ceded reinsurance
- Adequacy of assets to support policyholder benefits

ACTUARIAL OPINION, ACTUARIAL REPORT, & ACTUARIAL OPINION SUMMARY

Actuarial Opinion

The Statement of Actuarial Opinion (Actuarial Opinion) provides a qualified actuary's opinion on the reasonableness of the insurer's reserves and gives insight into company-specific risk factors. The Actuarial Opinion can be valuable in determining whether the insurer requires further regulatory attention. The Actuarial Opinion is not independent from the Annual Financial Statement itself. Everything that follows in describing the Opinion should be expected to be consistent with all other elements of the Annual Financial Statement, including but not limited to the General Interrogatories, Notes to Financial Statements, MD&A, and Independent Auditors' Report. (Note that the Annual Financial Statement is also referred to as the Annual Statement within this reference guide.)

Exhibit A (Scope) and Exhibit B (Disclosures) are crucial elements of the Actuarial Opinion. Exhibit A details the specific areas the actuary examined, such as loss and loss adjustment expense reserves, premium reserves, and

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other relevant reserve items. Exhibit B includes the Appointed Actuary's identification, qualifications, opinion type, materiality standard, risk assessment, reserve discounting, and other disclosures.

The *Annual Statement Instructions* identifies the insurer's responsibilities regarding the appointment of a qualified actuary, notification to regulators, regulatory requirements for a change in actuary, requesting an exemption from filing the Actuarial Opinion, and reporting requirements for insurers that participate in an intercompany pooling arrangement.

Actuarial Report

The Actuarial Report is a confidential document separate from the Actuarial Opinion. It serves as a formal means of communicating the Appointed Actuary's professional conclusions and recommendations to the state regulatory authority and the Board of Directors. Additionally, it documents the methods and procedures used, ensures that all parties involved understand the significance of the Actuary's opinion, and provides a record of the underlying analysis.

Actuarial Opinion Summary

The Actuarial Opinion Summary (AOS) is a confidential document that offers valuable insight into an Appointed Actuary's assessment of the reasonableness of carried reserves. While nearly all Actuarial Opinions conclude that carried reserves are reasonable, the AOS provides quantitative information that helps analysts understand the basis for this conclusion. By examining the additional information in the AOS, analysts can determine whether further regulatory attention is warranted. As with the Actuarial Opinion, the *Annual Statement Instructions* for the AOS are directed to the insurer.

The Actuarial Opinion and AOS may contain broad general caveats. These include generalizations about the unpredictability of future jury awards, coverage expansions, etc. They are not to be confused with disclosures about company-specific sources of uncertainty, such as new lines of business or territories, new claims/underwriting/marketing/systems initiatives, etc. These specific disclosures should be viewed as areas for formal investigation through an examination or informal investigation via correspondence or conversation.

Statement of Actuarial Opinion Worksheet (P/C and Title)

The Statement of Actuarial Opinion Worksheet (SAO Worksheet) is intended to provide procedures for reviewing the Actuarial Opinion, AOS and Actuarial Report for compliance and assessment of risks. In many states, the Actuarial Opinion, AOS and Actuarial Report are reviewed by actuarial staff. Whether the reviews are performed by the analyst or the actuary, the SAO Worksheet provides for the results of the reviews to be documented and communicated to the analyst.

The SAO Worksheet should be supplemented with comments and questions as needed. Both the Actuarial Opinion and the AOS should be reviewed and considered <u>together</u> before any action is taken. At the completion of the SAO Worksheet, analysts should conclude what, if any, further action is needed.

a. <u>Consult with the regulatory P/C actuary, if available</u>

   If the insurance department has a regulatory P/C actuary on staff, analysts may consult with him or her for any questions or concerns.

b. <u>Contact the insurer</u>

   Analysts may need to contact the insurer for additional information, particularly if the materiality standard is large relative to surplus or if the insurer's RBC is likely to fall below the Company Action Level. Some of the items that may need clarification are a concern over reinsurance collectability, a change in discounting procedures, or other items noted in the Relevant Comments section of the Actuarial Opinion as having the potential to result in material adverse deviation. Typically, items of a

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general nature, such as the risk from a change in the legal or regulatory environment, would not require further investigation.

The Relevant Comments section may note a concern with collectability of reinsurance. Contracts with reinsurers that are not financially strong, reinsurance coverage obtained under a program that is no longer offered or reinsurance coverage on unusual risks could increase the uncertainty regarding reinsurance collectability. Also, a change in reinsurance contract language, a change in reinsurers or writing a new program in a new line or class of business may affect the uncertainty concerning reinsurance collectability if the insurer does not have a good understanding of the primary coverage written and the reinsurance coverage obtained.

If an insurer has recently implemented loss reserve discounting or if the discount rate used to determine the reserves has changed, analysts should ascertain the impact on the reserve estimates arising from these changes. Analysts should consider the magnitude of the impact in relation to the materiality standard and the potential effect on RBC levels.

Analysts may need to contact the insurer when the insurer has provided coverage for certain classes of business where liabilities are especially uncertain. Asbestos, environmental, pollution and other mass tort liabilities are particularly difficult to estimate and are often determined by models that examine the risk profile of the company's policyholders, particularly when the insurer's loss history has limited predictive power. The results from these models often have a wide range in estimates for loss and LAE reserves and, therefore, a high degree of uncertainty. Construction defect claims have a 10-year reporting period in some states, making their liabilities particularly difficult to estimate. Analysts should consider submitting a request for additional information from the insurer if an RMAD from these types of claims is identified.

The Appointed Actuary must include comments on the factors that led to any exceptional values for Insurance Regulatory Information System (IRIS) ratios #11, #12 or #13 in the Actuarial Opinion. An explanation that identifies risk elements that are part of the insurer's ongoing operations rather than a one-time occurrence would merit further investigation by analysts. It is generally not sufficient to explain an exceptional value by simply stating the insurer has strengthened reserves. Detail regarding lines of business, accident years, or changes in operations should be requested if the Appointed Actuary has not provided that explanation for the specific IRIS ratio.

c. Obtain a copy of the Actuarial Report

If there are particular items identified as significant in the Relevant Comments section or there is significant risk of the insurer falling below the RBC Company Action Level, a review of the Actuarial Report supporting the Actuarial Opinion can give analysts insight into the nature and severity of the risks identified. If one or more portions of the carried reserves are excluded from the Actuarial Opinion, the Actuarial Report may give analysts information on the relative amount of any excluded items and the reasons why those items were excluded from the Actuarial Opinion.

If the analyst requests the Actuarial Report, the analyst might start by reviewing the narrative component. The narrative, often referred to as the executive summary, should contain the summary exhibits and the Appointed Actuary's point estimate and/or range. The technical component should contain the loss development triangles and factors, support for ultimate loss selections, and required data reconciliations. Normally, the technical component would be requested for a full-scope examination or limited-scope examination that includes a risk-focused review of the carried reserves, since such a review would often include a review of the Appointed Actuary's report.

If the Relevant Comment paragraphs mention the use of retroactive reinsurance or financial reinsurance, analysts need to understand how these agreements may affect the insurer's financial position. The Actuarial Report may include information about these arrangements.

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Any items in the insurer's carried reserves that were identified in the Actuarial Opinion as not quantifiable require further investigation. The particular reasons or circumstances given can provide guidance on how to proceed. Analysts should consult with the Appointed Actuary to find out why there was not an opinion rendered on a portion of the reserves.

d. Consult with the Appointed Actuary

Analysts may contact the Appointed Actuary regarding any issues noted in the Actuarial Opinion or the AOS, regardless of where the Appointed Actuary is employed. However, analysts should consider informing company management before contacting the Appointed Actuary and copying company management on communications with the Appointed Actuary. In particular, companies with an external Appointed Actuary may request that they be notified before the Department of Insurance contacts its Appointed Actuary.

e. Engage an independent actuary to review the insurer's reserves

For items that were not quantified in the Actuarial Opinion or any liability items for which there is significant concern, analysts may recommend engaging an independent actuary to provide a review of the carried reserves in question. This independent review can also be valuable if there is a significant difference between management's view and the Appointed Actuary's view concerning a material item identified in the Actuarial Report.

f. Meet with the insurer's management

Analysts may recommend meeting with the insurer's management when there are items in the Actuarial Report that need clarification or require the insurer to take further action. Further actions could include developing a business plan, setting up interim reporting, developing a corrective action plan, or providing additional information about the underlying factors contributing to the risk in the insurer's Annual Statement. Any concerns with company financial data or reconciling various data sources should be investigated with the insurer's management. Concerns about a company's exposure due to policy coverage terms or lack of available data should be investigated as warranted.

g. Refer the insurer to the examination section for a target examination

Analysts may recommend a target examination if, after obtaining further information, there is still concern about the financial position of the insurer. The target examination should determine if the insurer is taking proper steps to mitigate the potential adverse impact arising from the risks identified in the Actuarial Opinion.

Insurer Exemption from Filing an Actuarial Opinion

Procedure #1. Determine whether the insurer is exempt from filing the Actuarial Opinion. Insurers may be exempt from filing an Actuarial Opinion under the following circumstances:

- *Small Companies*: Insurers with total direct and assumed written premiums and loss reserves below $1,000,000 for the preceding calendar year.
- *Insurers Under Supervision or Conservatorship*: Unless directed by the domiciliary commissioner, insurers under supervision or conservatorship are exempt.
- *Nature of Business*: Insurers may apply for an exemption based on the nature of their business.
- *Financial Hardship*: Insurers may apply for an exemption due to financial hardship. This is presumed to exist if the projected cost of the Actuarial Opinion exceeds the lesser of 1% of capital and surplus or 3% of premiums.

The commissioner has discretion to grant or deny exemptions, even if one or more of these conditions are met.

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Actuary Identification, Qualifications, Relationship to the Company, and Date of Appointment

Procedure #2. Determine whether the Actuarial Opinion was prepared by a Qualified Actuary who was appointed by the insurer's board of directors prior to Dec. 31 of the calendar year for which the opinion was rendered; To be considered a "Qualified Actuary" as defined in the NAIC Statement of Actuarial Opinion, an actuary must satisfy specified qualification standards, retain an Accepted Actuarial Designation, and maintain membership in a professional actuarial association that requires adherence to the same Code of Professional Conduct promulgated by the American Academy of Actuaries and participation in the Actuarial Board for Counseling and Discipline.

Intercompany Pooling Arrangement Disclosures

Procedure #3. Determine whether the Appointed Actuary made the required disclosures if the insurer is a member of an intercompany pooling arrangement (pool). Pool members' financial results may need to be evaluated differently than those of insurers that operate independently. Exhibits A and B for each company in the pool should reflect the company's share of the pool and should reconcile to values filed with the Annual Statement.

For companies whose pool participation is 0%, (i.e., no reported Schedule P data), the Appointed Actuary is directed to write an Actuarial Opinion that reads similar to that of the lead company. Exhibits A and B of the lead company should be filed as an addendum to the Actuarial Opinions of the 0% pool companies. This will allow for proper data submission for each company in the pool while providing additional meaningful data to analysts. The Instructions require specific answers for the Exhibit B questions regarding materiality and the risk of material adverse deviation (RMAD).

Note the distinction between pooling with a 100% lead company with no retrocession and ceding 100% via a quota share agreement. These affiliate agreements must be approved by the regulator as either an intercompany pooling arrangement or a quota share reinsurance agreement. The proper financial reporting is dependent on the approved filings, regardless of how company management regards its operating platform.

Scope

Procedure #4. Determine whether the Appointed Actuary included the appropriate loss reserves, LAE reserves, and (if appropriate) other loss and premium reserves within the scope of the opinion and whether the reserve amounts included in Exhibits A and B of the Actuarial Opinion agree with the amounts reported in the Annual Statement. If the reserve amounts included in the Actuarial Opinion do not agree with the amounts per the Annual Statement, analysts should: 1) comment on the reasons for the differences; 2) consider the impact of the differences on the analyst's conclusions about the Annual Statement; and 3) consider the need to perform additional analysis on the Annual Statement.

Procedure #5. Determine whether the Appointed Actuary relied on an officer of the company for data preparation. The individual(s) relied upon should have both authority and responsibility for relevant data and data systems. A company Appointed Actuary may choose to accept responsibility for the data without identifying reliance on another company person. If someone from the regulated insurance entity is not named here, analysts should request that the insurer provide a clarifying amendment.

The Appointed Actuary is also directed to state whether the data used in forming the Appointed Actuary's opinion was reconciled to Schedule P – Part 1 of the insurer's Annual Statement. (Schedule P – Part 1 is then required to be tested by the independent certified public accountant (CPA) as a part of the audit of the insurer.)

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Opinion

Procedures #6 and #7. Determine whether the Actuarial Opinion states that the reserves meet the requirements of the insurance laws of the state of domicile, are computed in accordance with accepted loss reserving standards and principles and make a reasonable provision for all unpaid loss and LAE obligations of the insurer under the terms of its policies and agreements. The Appointed Actuary must explicitly state his or her opinion using one of five opinion types. Any opinion that is not 'Reasonable' should be flagged for immediate attention by the state insurance regulator to determine the need for follow-up action.

If unearned premium reserves or other reserve items are included within the scope of the Appointed Actuary's opinion, this section of the Actuarial Opinion will also provide the Appointed Actuary's conclusion on the reasonableness of these reserves.

If the Actuarial Opinion deviates from the above statements or if a material portion of the insurer's reserves is excluded from the scope of the Actuarial Opinion, analysts should: 1) comment on the deviations or exclusions; 2) consider the impact on the analyst's conclusions about the Annual Statement; and 3) consider the need to perform additional analysis on the Annual Statement.

Relevant Comments and Exhibit B Disclosures

Procedure #8. Determine whether the actuary commented on various topics and issues in Exhibit B of the Actuarial Opinion as required by the *Annual Statement Instructions Property/Casualty*.

The most important relevant comment relates to the Risk of Material Adverse Deviation (RMAD). The Appointed Actuary should provide explanation of the major risk factors affecting the company. The Appointed Actuary must also identify the materiality standard and the basis for establishing it. The Appointed Actuary must then explicitly state whether or not he or she reasonably believes that there are significant risks and uncertainties that could result in material adverse deviation.

Appointed Actuaries often choose a materiality standard as a percentage of surplus or reserves, but other standards may also be appropriate. The standard chosen quantifies the amount of adverse deviation that the Appointed Actuary judges to be material. The standard may vary based on the solvency position of the insurer. The materiality section of the Preamble to the *Accounting Practices and Procedures Manual* (AP&P Manual) contains excellent guidance regarding the selection of a materiality threshold. Based on this guidance, an Appointed Actuary for two companies with comparable business and comparable reserves could select different materiality standards. For example, an insurer with a risk-based capital (RBC) ratio of 205% could possibly need only a small change in reserves to put it in Company Action Level, so the Appointed Actuary's chosen materiality standard for this insurer may be lower than for a similar insurer with an RBC ratio of 600%.

If the company is subject to RBC reporting requirements, the results of the Bright Line Indicator test should be reviewed in conjunction with the Appointed Actuary's RMAD statement: If the insurer triggers the Bright Line Indicator test, meaning that 10% of the insurer's net loss and loss adjustment expense (LAE) reserves is greater than the difference between the Total Adjusted Capital and Company Action Level Capital, and the Appointed Actuary opines that there is not a RMAD, the Appointed Actuary should be asked to explain this opinion. A special report on the Bright Line Indicator is located on StateNet under the Financial Analysis link.

A similar comparison could be made between 10% of the insurer's net reserves and the size of its underwriting or operating income. It should be noted that the RMAD might increase with more volatile exposures such as asbestos and environmental, excess casualty, or other commercial lines.

Collectively the Relevant Comments should reveal exposures, transactions, historical developments, processes, and uncertainty that contribute to the Appointed Actuary's opinion. Some of the comments call for judgment on the part of the Appointed Actuary. The disclosures in Exhibit B are required to ensure that the Appointed Actuary acknowledges consideration of certain items in reaching his or her opinion.

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The Actuarial Opinion should also indicate if any of the reserving IRIS ratios produce exceptional values and discuss any exceptional values.

Actuarial Report Prepared, Supports Actuarial Opinion, Signed, and Contains Required Elements

Procedure #9. Determine whether the Appointed Actuary indicates that an Actuarial Report has been prepared which supports the findings expressed in the Actuarial Opinion. In some cases, analysts may consider obtaining a copy of the Actuarial Report. The Actuarial Report is a confidential document that describes the sources of data, material assumptions, and methods used, and supports the Appointed Actuary's opinion. The Actuarial Report generally includes relevant loss and LAE data triangles and discusses significant issues that affected the Appointed Actuary's interpretation of the data. Examples of significant issues that may be discussed by the Appointed Actuary include changes in the following: management of the insurer, claims payment philosophy, the claims reporting process, computer systems, mix of business, contract limits or provisions, and reinsurance. While the Actuarial Report should not be filed with the Actuarial Opinion, the Actuarial Report is required to be retained by the insurer for a period of seven years and available for regulatory examination. The Instructions dictate certain elements that must be included in the Actuarial Report. In addition, the Actuarial Report must be signed and dated by the Appointed Actuary and must be consistent with the documentation and disclosure requirements of Actuarial Standard of Practice (ASOP) No. 41 – *Actuarial Communications*.

Actuarial Opinion Summary

Procedure #10. Verify the regulatory requirements for filing the AOS and the company's compliance with the requirement.

Procedure #11. Verify that the AOS discloses required pooling information if the insurer is a member of an intercompany pooling arrangement.

Procedure #12. Verify that the AOS contains the required comparisons and that the amounts in the AOS reconcile with those in the Actuarial Opinion, Actuarial Report and Annual Financial Statement. Inconsistencies in reported values may indicate weak controls within the company.

Procedure #13. Verify that the Appointed Actuary's opinion implied by the comparisons in the AOS is consistent with the type of opinion rendered in the Actuarial Opinion. Analysts should note concerns regarding carried reserves that appear significantly low relative to the Appointed Actuary's estimate(s).

Parts A, B, C and D of Section 5 of the AOS call for a comparison that can be presented in a simple table. Regardless of how the information is presented, the intention is to translate for the regulator the qualitative/subjective opinion regarding "reasonableness" into a quantitative/objective financial comparison.

Parts A and B require the Appointed Actuary to compare his/her point estimate and/or range of estimates (whatever is calculated), to the carried loss and LAE reserves. The Appointed Actuary must compare these estimates on both a net and gross of reinsurance basis. The carried amounts should agree with the amounts presented in Exhibit A of the Actuarial Opinion and the Annual Statement. Analysts should note that the amounts provided in the AOS are commonly presented as combined loss and LAE amounts (Exhibit A of the Actuarial Opinion, lines 1 and 2 for net and lines 3 and 4 for direct and assumed). If the amounts do not agree, this could be an indication of weak controls within the reserving or financial reporting process of the company. Discrepancies that are not adequately explained by the Appointed Actuary require follow up.

If the Appointed Actuary issues a "reasonable" opinion, the comparisons in the AOS will likely be described by one of the following three situations. The tables in these illustrations show both point and range estimates by the Appointed Actuary. The Appointed Actuary is not required to calculate both, but regulators expect Appointed Actuaries to report whatever is calculated. A small percentage of Appointed Actuaries calculate a range only.

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Situation 1: Appointed Actuary's Point Estimate or Range Midpoint = Carried Reserves

	Net Loss + LAE Reserves			Direct & Assumed Loss + LAE Reserves		
	Low	Point	High	Low	Point	High
B. Appointed Actuary's Estimates	17,000	20,000	23,000	21,500	25,000	28,000
C. Company Carried Reserves		20,000			25,000	
D. Difference	3,000	0	(3,000)	3,500	0	(3,000)

The example above is simple and can represent a situation in which the company relies completely on the Appointed Actuary by carrying his or her estimate. In this case, there is no difference between the Appointed Actuary's estimate and the carried amount. Further action is generally not necessary.

There may be small variations from this scenario in which the Appointed Actuary's estimate is "close to" the company's carried reserves. Analysts need to determine "How close is close enough?". Regulatory emphasis is on financial solvency. Therefore, an initial consideration might be the impact on surplus of management's decision to carry an amount different from the Appointed Actuary's estimate. Further action is generally not necessary unless the analyst is concerned that carried reserves are far enough below the Appointed Actuary's estimate as to not obviously be "close enough."

Situation 2: Appointed Actuary's Point Estimate or Range Midpoint < Carried Reserves

	Net Loss + LAE Reserves			Direct & Assumed Loss + LAE Reserves		
	Low	Point	High	Low	Point	High
B. Appointed Actuary's Point Estimates	17,000	20,000	23,000	21,500	25,000	28,000
C. Company Carried Reserves		21,000			26,500	
D. Difference	4,000	1,000	(2,000)	5,000	1,500	(1,500)

In this case, the company is carrying a reserve amount greater than the Appointed Actuary's point estimate and in the higher end of the Appointed Actuary's range. From a solvency perspective, surplus is more conservatively stated. Further action is generally not necessary.

Situation 3: Appointed Actuary's Point Estimate or Range Midpoint > Carried Reserves

	Net Loss + LAE Reserves			Direct & Assumed Loss + LAE Reserves		
	Low	Point	High	Low	Point	High
B. Appointed Actuary's Point Estimates	17,000	20,000	23,000	21,500	25,000	28,000
C. Company Carried Reserves		17,100			22,000	
D. Difference	100	(3,000)	(5,900)	500	(3,000)	(6,000)

When the carried reserves are less than the Appointed Actuary's point estimate or range midpoint, the question of "How close is close enough?" becomes more relevant. This is a more challenging situation for analysts to evaluate. Analysts should focus on the difference between the carried reserves and the point estimate or range midpoint. If the Appointed Actuary has issued a "reasonable" opinion, analysts should consider the following factors:

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- The difference as a percent of surplus
- The difference as a percent of carried loss and LAE reserves
- The company's RBC position

At this point, consider an alternate question: "If the company had carried the Appointed Actuary's higher estimate and surplus was comparably reduced, would my evaluation of the company's financial condition change to a less favorable one?". If the answer to that question is "yes," then consider requesting management's rationale and documentation to support the lower carried reserve amount(s). In addition, analysts might require the company to have its Appointed Actuary provide additional information regarding the range of estimates, if calculated. The Appointed Actuary's description of the range should also be documented in the Actuarial Report supporting the Actuarial Opinion.

As a rule of thumb, it is concerning if carried reserves are more than 5% (of surplus) below the Appointed Actuary's point estimate or range midpoint, even if the reserves still lie within the Appointed Actuary's range. The 5% (of surplus) is a common examiner materiality starting selection for financial examinations.

Next, consider the AOS in the context of RMAD as addressed in the Actuarial Opinion. If a range is provided, is the materiality standard less than the difference between the carried reserves and the high end of the Appointed Actuary's range? This means that reserves would still lie within the Appointed Actuary's range of reasonable reserve estimates if carried reserves developed adversely by an amount the Appointed Actuary considers to be material. In this situation, state insurance regulators generally expect the Appointed Actuary to conclude that there is a significant risk of material adverse deviation. If the Appointed Actuary concludes that there is not a significant RMAD in this situation, analysts should document any comments or concerns and consider following up with the Appointed Actuary.

Most opinions issued are "Reasonable," which means that the carried reserve amounts are within the Appointed Actuary's range of reasonable reserve estimates. Only a handful of opinions fall into the other categories as defined in the Instructions (Deficient or Inadequate, Redundant or Excessive, Qualified, or No Opinion). These types of opinions likely require further action by analysts. The Considerations section identifies several actions that could be taken, particularly with regard to a Qualified Opinion or No Opinion.

A Deficient or Inadequate Opinion, while rare, presents a challenge for analysts. This type of opinion means that the carried reserves are less than the minimum amount the Appointed Actuary considers to be reasonable. As with Situation #3 above, analysts should evaluate the materiality of the deficiency in light of surplus, the company's RBC position, net income, and other factors. Analysts should review all options listed in the Considerations section. In this situation, the regulator may wish to initiate a target examination or engage an independent actuary to evaluate the reasonability of the carried reserves so that the implied deficiency can be evaluated.

Regardless of analysts' concerns, it is important to remember that the carried reserves are the responsibility of management. The Appointed Actuary may or may not be part of management. In nearly all cases, analysts should direct initial questions to company management for rationale and documentation of decisions regarding the carried reserves.

Procedure #14. Verify compliance with the AOS reporting requirement regarding persistent adverse development. Analysts should note concerns regarding the nature of historical adverse development.

Part E of Section 5 addresses what the Casualty Actuarial and Statistical (C) Task Force calls "persistent adverse development." When the company experiences one-year adverse development in excess of 5% of the prior year's surplus as measured by Schedule P – Part 2 Summary in at least three of the past five calendar years, the Appointed Actuary must provide an explicit description of the reserve elements or management decisions that were the major contributors. The one-year adverse development ratio can be found in the Five-Year Historical Data exhibit of the Annual Statement.

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In the discussion of persistent adverse development, the Appointed Actuary is encouraged to address common questions that regulators have, such as:

- Determine if the development is concentrated in one or two exposure segments, or broad across all segments.
- How does the development in the carried reserve compare to the change in the Appointed Actuary's estimates?
- Determine if the development is related to specific and identifiable situations that are unique to the company.
- Determine if the development is judged to be random fluctuation attributable to loss emergence.
- Determine if either the development or the reasons for the development differ depending on the individual calendar or accident years.

Analysts should also consider the following situations:

- *Situation A*: Prior AOSs indicate that the company relies on the Appointed Actuary's estimates. If persistent adverse development occurs, analysts might infer that the Appointed Actuary's methods and assumptions have a bias towards underestimation.
- *Situation B*: Prior AOSs indicate that the company regularly carries amounts lower than the actuarial point estimate or low in the Appointed Actuary's range. If persistent adverse development occurs, analysts might infer that management takes a more optimistic view of its liabilities, regardless of what the Appointed Actuary calculates.

RESERVING RISK ASSESSMENT OVERVIEW

The single largest liability reported by most P/C insurers is the liability for unpaid losses (commonly known as loss reserves). Loss reserves are estimates rather than definitive amounts, as they are based on projections of future claim payments.

The underlying goal of loss reserve estimation is to accurately reflect the outstanding liability, net of reinsurance, for all losses that have occurred and not been paid as of the financial statement date. While most policies recognize losses when they occur, claims-made policies create a unique dynamic. Under these policies, losses are recognized when they are reported to the insurer, not when they occur. This distinction impacts the timing of loss recognition and reserve estimation.

Unpaid losses are categorized as either "reported" or "incurred but not reported" (IBNR). Because the dollar amount of IBNR losses is not known as of the financial statement date, the estimate is highly subjective. Even with respect to those claims that have been reported to the insurer, the actual amount that the insurer will pay will not be known until the claims are settled in full, which could be years after the insurer initially established the reserve. Generally, an insurer is required to estimate the value of what its claims will be when they are ultimately settled. Excluding certain types of losses that an insurer may be allowed to discount, statutory accounting practices require that for every dollar of unpaid losses, an insurer reserve a dollar for the future payment of those losses.

In addition to unpaid losses, insurers must also establish reserves for loss adjustment expenses (LAE). LAE represents the estimated future costs associated with settling unpaid losses, including claims adjustment expenses, legal fees, court costs, investigation fees, claims processing, and payment expenses. LAE is classified as either "defense and cost containment (DCC) expense" or "adjusting and other expense." DCC expenses are correlated with the loss amounts and include defense, litigation, and medical cost containment expenses. Adjusting and other expenses are correlated with the number of claim counts and include all LAE other than DCC

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expenses, such as fees of adjusters and attorney fees incurred in the determination of coverage. The reserve for LAE should be the insurer's best estimate of the LAE that will be paid to settle both reported and IBNR unpaid claims.

Due to the complexity of reserving for unpaid losses and LAE, most insurers rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some insurers may not employ actuaries for reserve estimation, they are nonetheless required to obtain an annual opinion from a qualified actuary regarding the reasonableness of their carried reserves.

As these liabilities necessitate estimation, they are inherently considered a high-risk area for P/C insurers. The reasonableness of an insurer's reserves for unpaid losses and LAE must be closely monitored on an ongoing basis. A deficiency in these liabilities directly impacts surplus, which, in turn, affects the insurer's overall financial solvency. Therefore, the primary focus of analysts reviewing unpaid losses and LAE is to assess whether the insurer's established liabilities are sufficient to cover the future costs of settling all of the insurer's covered losses that have occurred as of the financial statement date. In conducting the analysis, utilize available tools in iSite+, such as financial profile reports, dashboards, loss reserves tool (projection and development triangles).

ANNUAL RESERVING RISK ASSESSMENT

Understated Loss and LAE Reserves

Incorporate any concerns noted in the review of the Actuarial Opinion into the review of the insurer's reserves. Issues noted in the review of the Actuarial Opinion may be relevant to aspects of reserve risk identified in other procedures.

Significance of Potential Understatement of Loss and LAE Reserves

Determine whether an understatement in loss and LAE reserves would be significant to the insurer. The ratio of loss and LAE reserves to surplus is a leverage ratio that indicates the margin of error an insurer has in estimating its reserves. For an insurer with a reserve leverage ratio of 300%, a 33% understatement of its reserves would eliminate its entire surplus. In addition to the reserve leverage ratio, consider the nature of the insurer's business. An insurer that writes primarily short-tail property lines might not be a concern, even if its leverage ratio is greater than 300%. The risk of significant understatement of its reserves is less than that of an insurer that writes primarily long-tail liability lines, such as medical professional liability.

Procedures/Data

- Ratio of loss and LAE reserves to surplus
- Ratio of net premiums written (long-tail) to total net premiums written
- Increase in ratio of net premiums written (long-tail) to total net premiums written from the prior year
- Review the shift in business mix from short-tail property lines to long-tail liability lines within the past five years.

Reserve Development

Determine whether unpaid losses and LAE appear to have been adequately reserved. The ratios of one-year reserve development to prior year-end surplus and two-year reserve development to second prior year-end surplus measure the adequacy of the loss reserves. Positive results for these ratios represent additional or adverse loss reserve development on the reserves originally established (the amount by which the reserves

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originally established have proved to be understated based on subsequent activity). If the insurer's ratio results consistently show adverse development, or the two-year reserve development to second prior year-end surplus result is consistently worse than the one-year reserve development to prior year-end surplus, the insurer has been understating its reserves.

The ratio of estimated reserve deficiency to surplus compares the estimated reserves needed by the insurer (calculated by multiplying the current year's net earned premiums by the average ratio of developed reserves to earned premiums for the last two years and subtracting the actual reserves established by the insurer) to the actual reserves established by the insurer and expresses the resulting difference as a percentage of the insurer's surplus. A positive ratio reflects an estimated reserve deficiency. The results of this ratio can be affected by changes in product mix and significant changes in premium volume.

In addition, the mix of the insurer's business should be reviewed for changes from prior years. For example, a property insurer that begins writing significant liability business, for which it is more difficult to establish an accurate reserve and which the insurer does not have historical experience writing, might cause concern regarding the adequacy of the unpaid loss and LAE.

Also consider performing a review, by line of business, of items including: one-year and two-year development in net incurred losses and DCC expenses per the Annual Financial Statement, Schedule P – Part 2 to determine which lines of business are developing adversely, and incurred loss and LAE ratios per the Annual Financial Statement, Schedule P – Part 1 to determine any unusual fluctuations between years.

Also consider a review of cumulative paid net losses and DCC by line of business in the Annual Financial Statement, Schedule P – Part 3 to determine whether there were any unusual fluctuations or aberrations in payment patterns between accident years or within an accident year. The review of the Annual Financial Statement, Schedule P Interrogatories, #7.1 is used to determine if there are any other factors that the insurer indicated should be considered in the analysis of the adequacy of unpaid losses and LAE. If there are still concerns regarding the adequacy of unpaid losses and LAE as a result of other steps performed, analysts should consider performing a loss reserve analysis on the more volatile long-tail liability lines of business using the Loss Reserves Estimation Tool (or other loss reserve analysis software) to project loss reserves based on incurred and paid claims per the Annual Financial Statement, Schedule P. However, be aware that this loss reserve analysis tool merely projects reserves based on historical experience without considering changes in product design, pricing, claims payment practices, etc. If unusual results are obtained as a result of the loss reserve analysis performed, Consider having an actuary review the analysis performed.

Procedures/Data

- One-year reserve development to PYE surplus ratio [IRIS ratio #11]
- Two-year reserve development to second PYE surplus ratio [IRIS ratio #12]
- Adverse or unusual trend in
    - One-year reserve development
    - Two-year reserve development
- Estimated current reserve deficiency to surplus ratio [IRIS ratio #13]

Additional Review Considerations

- Review, by line of business, the one-year and two-year development in incurred net losses and defense and cost containment expenses by accident year reflected in Annual Financial Statement, Schedule P – Part 2, or review the loss reserve development section in the Financial Profile Report.
    - Note any unusual development. Consider the significance of the lines of business producing unusual development in relation to the insurer's total book of business.

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  - Determine if any internal changes have been initiated that may impact the reserve estimates (e.g., accelerating claim payments).

- Review, by line of business, the cumulative net paid losses and defense and cost containment expenses by accident year in Annual Financial Statement, Schedule P – Part 3 and comment on any unusual fluctuations or aberrations in loss and expense payment patterns between accident years or within an accident year.
- Review the Annual Financial Statement, Schedule P Interrogatories, #7.1 for information on significant events or changes in coverage, retention, or accounting changes.
- Perform loss reserve analysis on the more volatile long-tail liability lines of business using the Loss Reserves Estimation tool or other loss reserve analysis software to project loss reserves based on incurred claims data in Annual Financial Statement, Schedule P – Part 2 less Part 4, and paid claims data in Annual Financial Statement, Schedule P – Part 3. Compare the projected reserves to the reserves established by the insurer.
- If significant concerns regarding reserve development are identified, request the assistance of a department or consulting actuary in reviewing and assessing the adequacy of the reserves carried by the insurer.

Exposure to Asbestos and Environmental Claims

Assess the insurer's exposure to asbestos and environmental (A&E) liabilities.

A&E liabilities pose unique challenges for insurers due to their complex nature and potential long-term consequences. These liabilities often involve a significant lag between exposure, the manifestation of adverse effects, and the reporting of a loss, making accurate estimation difficult. Legal decisions, varying court interpretations, and policy coverage disputes can further complicate matters.

To assess the insurer's exposure to A&E claims, review the Notes to Financial Statements – Note #33. This note provides valuable information into the nature of the liabilities. However, it is important to note that Note #33 does not account for any A&E exposures assumed or ceded under retroactive reinsurance agreements.

Procedures/Data

- Exposure to A&E liabilities
- Ratio of net A&E loss and LAE reserves to surplus
- Increase in net A&E loss and LAE reserves over prior year, where current year change in reserves is material to surplus
- A&E survival ratio

Additional Review Considerations

If significant exposure to A&E reserves is identified, analysts may further assess the exposure by reviewing the following sources of information:

- The Actuarial Opinion:
  - Determine if the Appointed Actuary mentions A&E exposure as a risk factor or potential source of material adverse deviation and if A&E exposure is material.
- Annual Financial Statement, Notes to Financial Statement, Note #33:
  - Determine if there have been material changes in A&E reserves over time. Note #33 provides both qualitative and quantitative information on an insurer's exposure to asbestos and environmental liabilities, including:
    - Whether the insurer has potential exposure to asbestos or environmental claims.

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- The lines of business for which there is potential exposure and the nature of the exposure.
- Loss and LAE payments during the year for the most recent five calendar years.
- Loss and LAE reserves at the end of the year for the most recent five calendar years.
- The amount of bulk and IBNR reserves within the most recent year-end's reserves.
- The amount of LAE reserves within the most recent year-end's reserves.

- A&E survival ratios in the Financial Profile Report.
  - Determine if material changes have occurred over time.
    - A survival ratio is calculated as the carried reserves divided by the average paid losses. The ratios in the Financial Profile Report combine asbestos and environmental exposures and use the most recent three years in the average of paid losses. The ratio gives the number of years the insurer's reserves will last if future average payments equal the current average payments. All else equal, a higher survival ratio indicated greater reserve adequacy. When compared to industry averages, the survival ratio for an insurer serves as one metric of the insurer's reserve adequacy.
    - Survival ratios may be distorted by unusual one-off transactions such as large settlements or loss portfolio transfers. The survival ratio in the Financial Profile Report do not include the effects of any asbestos and environmental exposure assumed or ceded under retroactive reinsurance agreements.
- Actuarial Report, if requested:
  - Determine if the report provides information on the insurer's exposure to A&E losses and the Appointed Actuary's reserving methodology.
- After review of the information above a meeting with company management may be warranted, particularly given the uniqueness of A&E exposures and variation in companies' reporting and reserving practices for A&E losses and LAE.

Exposure to Discounted Loss and LAE Reserves

Determine whether unpaid losses and LAE have been discounted and, if so, whether concerns exist regarding the amount of the discount or the interest rate used.

While present value discounting of P/C loss reserves is generally not accepted under statutory accounting principles, there are exceptions. For example, fixed and determinable payments, such as those resulting from workers' compensation tabular indemnity reserves and long-term disability claims, can be discounted. However, some state insurance departments permit insurers to discount other types of business on a non-tabular basis.

Any discounting, other than tabular discounting as specified in *Statement of Statutory Accounting Principles* (SSAP) *No. 65—Property and Casualty Contracts*, requires approval from the domiciliary state insurance department and must be disclosed in the Schedule P Interrogatories of the Annual Financial Statement. Annual Financial Statement, Schedule P – Part 1 is required to be completed gross of non-tabular discounting, and Schedule P – Part 2 and 4 are required to be completed gross of all discounting.

If loss reserves are discounted, the Annual Financial Statement, Underwriting and Investment Exhibit, Part 2A, is completed net of the discount. Additionally, the Annual Financial Statement, Notes to Financial Statements – Note #32 must disclose the discounting, including the discount rates used and the underlying rationale. In addition, if the rates used to discount prior accident years' reserves have changed from the previous Annual Financial Statement, the insurer is required to disclose the amount of discounted current reserves (excluding the current accident year) at current interest rate assumptions, the amount of discounted current reserves

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(excluding the current accident year) at previous interest rate assumptions, and the change in discounted reserves due to the change in interest rate assumptions.

Analysts should carefully review the information in Note #32 and compare the interest rates used to discount reserves to the insurer's investment yield. Analysts may also consider comparing the maturities of the insurer's investment portfolio and the estimated timing of future payments on unpaid claims.

Procedures/Data

- Determine the ratio of time value of money discount on unpaid losses and LAE to surplus

Additional Review Considerations

- Review the Annual Financial Statement, Notes to Financial Statements, Note #32, consider the following:
    - The lines of business with discounted reserves
    - The interest rates used to discount reserves, including the basis indicated for using those rates
    - The amount of discount in relation to surplus
    - If the interest rates used to discount the prior accident years' reserves have changed from the previous Annual Financial Statement, document the change in discounted reserves due to the change in interest rate assumptions and the effect on surplus
- Determine whether the interest rates used to discount reserves appear to be reasonable considering the insurer's investment yield and the insurer's comments in Note #32 regarding the basis for the interest rates used.
- If the insurer is using discounting procedures that depart from the guidance in *Statement of Statutory Accounting Principles* (SSAP) *No. 65—Property and Casualty Contracts*, ensure that the insurer received a permitted practice to do so. (The insurer may describe permitted practices in the Annual Financial Statement, Notes to Financial Statements, Note #1. The NAIC's iSite+ also has a Permitted Practices for Accounting report for each insurer in the Financial Analysis/Examination report category.)

Exposure to Salvage and Subrogation

Determine whether unpaid losses and LAE are reduced for anticipated salvage and subrogation recoveries and, if so, whether concerns exist regarding the consideration of estimated salvage and subrogation in establishing unpaid losses and LAE.

Salvage refers to the proceeds an insurer receives from the sale of property on which the insurer has paid a total loss to the insured. For example, when an insurer pays the insured the full value of a wrecked automobile, it takes ownership and then sells the damaged automobile, using the proceeds to reduce its ultimate loss on the claim.

Subrogation is the legal right of an insurer to recover from a third party responsible for a loss it has paid. For example, in an auto accident where the insurer pays a not-at-fault insured, it may subrogate against the at-fault part to recoup the amount paid or a portion thereof. Subrogation recoverables are treated as a reduction of ultimate losses paid.

Because of the difficulty in determining an estimate of anticipated salvage and subrogation on unpaid losses, they are generally recognized in the Annual Financial Statement only after they have been reduced to cash or its equivalent. However, if loss and LAE reserves reported in the Annual Financial Statement are net of anticipated salvage and subrogation, the estimated amount must be disclosed in Schedule P.

Analysts should review the Annual Financial Statement, Schedule P – Part 1 to determine which lines of business have anticipated salvage and subrogation recoverables.

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Procedures/Data

- Determine the anticipated salvage and subrogation to surplus ratio

Additional Review Considerations

- Review the Annual Financial Statement, Schedule P – Part 1 to determine which lines of business have unpaid losses and LAE that have been reduced due to consideration of anticipated salvage and subrogation.
- For the more significant lines of business, review Annual Financial Statement, Schedule P – Part 1 and compare the ratio of anticipated salvage and subrogation to unpaid losses and LAE (gross of anticipated salvage and subrogation) to the ratio of salvage and subrogation received to claims paid (gross of salvage and subrogation received) to determine the reasonableness of anticipated salvage and subrogation.

ADDITIONAL PROCEDURES

Examination Findings

Review the recent examination report, summary review memorandum and communication with the examination staff to identify if any reserving risk issues were discovered during the examination.

Inquire of the Insurer

Consider requesting additional information from the insurer if reserving risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of reserving risk for specific topics where concerns have been identified.

- Request a copy of the qualified actuary's actuarial report and review the actuary's comments regarding the analysis performed and conclusions reached.
    - If additional questions or concerns are noted after reviewing the report, contact the appointed actuary to discuss the nature and scope of the reserve valuation procedures performed.
- Request a copy of the insurer's business plan and review the insurer's plans to assess and mitigate reserve risks.
- Request information regarding any significant changes in reserve methodologies and assumptions, underwriting practices, case reserving, or claims handling practices with the potential to affect reserve setting.
- Request information on who ultimately determines the insurer's carried reserves and the Board of Director's role in overseeing the reserving process.
- If filed on an insurance entity basis or if your state is the lead state, review the insurer's Corporate Governance Annual Disclosure (CGAD) filing to understand and assess the board of directors' role in overseeing the reserving process. If your state is not the lead state, rely on the information provided in the Group Profile Summary (GPS) or provided by the lead state, where the CGAD is filed on a group basis.

Own Risk and Solvency Assessment (ORSA)

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing reserving risks faced by the insurer.

- Determine if the ORSA Summary Report analysis conducted by the lead state indicated any reserving risks that require further monitoring or follow-up.

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- Determine if the ORSA Summary Report analysis conducted by the Lead State indicated any mitigating strategies for existing or prospective reserving risks.

Holding Company Analysis

Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

- Determine if the Holding Company analysis conducted by the lead state indicated any reserving risks impacting the insurer that require further monitoring or follow-up?
- Determine if the Holding Company analysis conducted by the lead state indicated any mitigating strategies for existing or prospective reserving risks impacting the insurer?

QUARTERLY RISK ASSESSMENT

The quarterly reserve risk procedures are designed to identify the following. For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Change in Losses and LAE

Determine whether the change in unpaid losses and LAE since the prior year-end or incurred losses and LAE since the prior year-to-date was significant.

Procedures / Data

- Change in loss reserves
- Change in LAE reserves
- Change in net losses incurred
- Change in net LAE incurred

Reserve Development

Evaluate the materiality of adverse development in unpaid losses and LAE established as of the prior year-end.

Procedures / Data

- Ratio of loss and LAE reserves to surplus
- Change in loss and LAE reserves to surplus ratio from prior year-end
- Review the year-to-date reserve development of prior year-end's loss and LAE reserves.
    - Ratio of year-to-date reserve development of prior year-end total loss and LAE reserves to prior year-end surplus

Exposure to Discounted Unpaid Losses and LAE

Evaluate if there have been notable changes in the discounting of loss reserves since the prior year.

Procedure

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- Review Note #32 of the Quarterly Financial Statement's Notes to identify any changes in the discounting of loss reserves. If such changes exist, provide an explanation of the changes and assess the materiality.

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Reserving Risk: Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

Analysis Documentation: The Actuarial Opinion Risk Assessment is intended to provide procedures for reviewing the Statement of Actuarial Opinion (SAO) and other actuarial filings for compliance and assessment of risks. In many states, the Actuarial Opinion and related filings are reviewed by actuarial staff. Whether the SAO review is performed by the analyst or the actuary, the Repository provides for the results of the SAO review to be documented, and if performed by the actuary, communicated to the analyst. Analysts should document overall results of the Actuarial Opinion Analysis and risk identified in Section III: Risk Assessment of the insurer within reserving risk or other relevant risk category.

The analyst should involve an actuary where indicated in the procedures or as needed. To stay within any required deadlines for reviews, the analyst should document any greater in-depth reviews being performed by the actuary (such as those involving the confidential actuarial memorandum) and supplement the documentation when such actuarial review is complete. Questions or requests for assistance regarding asset adequacy analysis in this repository may be made to the NAIC actuarial resources. Please see the NAIC website for the Valuation Analysis (E) Working Group for contact information regarding the use of NAIC actuarial resources and use of the Working Group, if needed.

Note that reserving risks also are included in the Reserving Risk Assessment.

Filing Compliance of the SAO Based on an Asset Adequacy Analysis

1. Determine if the following were included in the SAO or otherwise provided.

	Comments
a. Reserve amounts included in the SAO agree with the amounts per the Annual Financial Statement.	
b. The insurer provided a notification letter to the domiciliary state that includes the name, title (and in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the insurer as an appointed actuary, and the notice states that the person meets the definition of a qualified actuary.	
c. Is this actuary the same actuary who was appointed for the previous Actuarial Opinion? If no: i. Did the insurer notify the domiciliary state insurance regulator within five days of the replacement? ii. Within 10 days of above notification, did the insurer provide an additional letter stating whether in the 24 months preceding such event there were any material disagreements with the former actuary and also in writing request the former actuary for a letter of agreement? iii. Did the insurer furnish the former actuary's responsive letter?	
d. The SAO covers at least the following items and amounts from the Annual Financial Statement: aggregate reserve for life contracts (Exhibit 5); aggregate reserve for accident and health contracts (Exhibit 6); deposit-type contracts (Exhibit 7); and contract claims – liability end of current year (Exhibit 8 – Part 1).	

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e. The SAO includes a table that indicates those reserves that have been analyzed for asset adequacy, including the method of analysis, and provides any additional actuarial reserves that must be established. i. Review Annual Financial Statement, Exhibit 5, 6 and 7. Were the additional actuarial reserves properly included as a result of the asset/liability analysis?	
f. Does the SAO include the table of key indicators described in VM-30 Section 3A.3? i. If so, note the type of opinion (Unqualified, Adverse, Qualified, or Inconclusive) and if it was not Unqualified, note the reasons.	
g. Review the table of key indicators. If it notes that prescribed language was not used, assess the differences. The prescribed language within the opinion section is as follows: i. Are computed in accordance with those presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles. ii. Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method and are in accordance with all other contract provisions. iii. Meet the requirements of the insurance laws and regulations of the state of domicile; and are at least as great as the minimum aggregate amounts required by the state in which the statement is filed. iv. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Financial Statement of the preceding year-end (with any exceptions noted). v. Include provisions for all actuarial reserves and related statement items that ought to be established. vi. The reserves and related actuarial items, when considered in the light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company. *Note: This language is provided unless exempted by the commissioner for a company licensed and doing business only in this state and no other state. This language may be adjusted if additional reserves are set up as indicated in (e) above.*	

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Filing Compliance of the Regulatory Asset Adequacy Issues Summary (RAAIS)

2. Determine if the following were included in the RAAIS.

	Comments
a. Did the RAAIS include the following? i. Whether the opinion clearly states it is unqualified or not. If the opinion is not unqualified, the reason(s) why. ii. Descriptions of scenarios tested and sensitivity testing performed relative to those scenarios. iii. Were any negative surplus results noted? Were additional reserves posted as a result of those tests? iv. A summary of the testing results providing a clear understanding of the basis for the actuarial opinion. v. Extent to which assumptions used are materially different from assumptions in the previous asset adequacy analysis. vi. Amount of reserves and product lines not subject to asset adequacy analysis in the current opinion that were subject to analysis in the prior opinion. vii. Comments on interim results that may be of significant concern to the appointed actuary. viii. Methods used to recognize the impact of reinsurance on cash flows under each scenario tested. ix. Whether the appointed actuary has been satisfied that all options in any asset or liability and equity-like features in any investments have been appropriately considered in the asset adequacy analysis	

Reserve Understatement / Reserve Adequacy Risk Based on Review of the Regulatory Asset Adequacy Issues Summary (RAAIS)

3. Review the information provided in the RAAIS and note any concerns. Based on the review of the RAAIS, if concerns exist, consider assessing the following additional prospective risks:

	Comments
a. Did the company book additional reserves for any scenario or interim result that was identified as a problem?	
b. If not provided, request the following additional information from the insurer: i. Has the company modified its business plan in light of current economic conditions or the stress test that have been placed on its products as a result of economic trends? ii. Is further stress testing needed in order to determine how the company would perform in other economic scenarios? iii. How does the insurer consider the prospective risks involved in the products within the insurer's overall business plan?	

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iv. How does the insurer mitigate any such risks within its business strategy (e.g., specific types of hedges, diversified products with natural corollaries)? v. How does the insurer evaluate the effectiveness of such mitigation strategies and document such within its operations? Obtain a copy of such documentation from the insurer to better understand the results of such programs.	

Reserve Understatement/Reserve Adequacy Risk Based on Review of Actuarial Memorandum

4. Consider the following procedures for reviewing the Actuarial Memorandum.

	Comments
a. Did the qualified actuary conduct an asset adequacy test on the insurer's total reserves?	
b. For any reserve or other liability reported as not analyzed, did the qualified actuary indicate that such reserve or other liability was immaterial?	
c. Based upon the judgment of the analyst and after reviewing the SAO and RAAIS and discussing with the department actuary, determine if the actuarial memorandum should be requested from the insurer. *If "yes", the department actuary should perform the review of the Actuarial Memorandum*. *If no, skip the remaining procedures in this sub-section.*	
d. If the company does not have or provide an Actuarial Memorandum or in the review of the Actuarial Memorandum it is determined that the memorandum fails to meet the standards prescribed by the *Valuation Manual* or is otherwise unacceptable to the insurance commissioner, the insurance commissioner may engage a qualified actuary at the expense of the company to review the opinion and basis for the opinion and prepare the supporting Actuarial Memorandum required by the insurance commissioner. See the state's equivalent authority to the NAIC *Standard Valuation Law* (#820), Section 3B(3)(b).	
e. Does the Actuarial Memorandum include an asset adequacy analysis for the following? *(Note that the items required to be included may vary from state to state.)*	
i. For reserves: • Product descriptions. • Source of liability in-force. • Reserve method and basis. • Investment reserves. • Reinsurance arrangements. • Persistency of in-force business. • Identification of any guarantees made by the separate account in support of benefits provided through a separate account. • Discussion of assumptions to test reserves.	
ii. For assets:	

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• Portfolio descriptions. • Investment and disinvestment assumptions. • Source of asset data. • Asset valuation bases. • Documentation of assumptions made.	
iii. For the analysis basis: • Methodology. • Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed. • Rationale for degree of rigor in analyzing different blocks of business. • Criteria for determining asset adequacy. • Effect of federal income taxes and method of treating reinsurance in the asset adequacy analysis.	
iv. Summary of material changes.	
v. Summary of results.	
vi. Conclusions.	
vii. A statement that the actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Actuarial Standards of Practice as promulgated by the Actuarial Standards Boards, which standards form the basis for the memorandum.	
viii. Method for aggregating reserves and assets.	
ix. Method for selecting and/or allocating assets supporting the Asset Valuation Reserve.	
x. Analysis of the effect of required interest rate scenarios.	
f. If required within the scope of Actuarial Guidelines 53 (AG-53) and as required under VM-30, did the AOMR include a separate section documenting the assumptions and sensitivity testing for reinvested high-yielding complex assets?	
g. If required within the scope of Actuarial Guideline 55 (AG-55) and as required under VM-30, did the company provide (either in the AOMR, a standalone document, or similar memorandum) a report documenting the information on treaties, cash-flow testing assumptions and results, attribution analysis and risk identification reinsurance transactions?	

5. Identify any concerns from the review of the Actuarial Memorandum including, but not limited to, the areas of assets, liabilities, scenario results, actuarial assumptions, sensitivity tests and the general overall adequacy of the asset adequacy analysis.

	Comments
If additional concerns are noted based on the review of the RAAIS and/or Actuarial Memorandum, consider performing the following additional procedures *[Note: Procedures "a" through "d" are applicable to insurers utilizing*	

the New York 7 actuarial interest rate scenario tests. Procedure "e" is applicable to other cash flow scenario testing.]	
a. Request from the company's appointed actuary the year-by-year cash flow testing results from the five worst scenarios tested.	
b. Review the five worst year-by-year scenario test results and determine the largest cash flow deficiency.	
c. Assess the materiality of the largest deficiency(ies).	
d. If the worst scenario were to play out, determine the impact on the current RBC ratio.	
e. In the review of interim year-by-year scenario test results, review appropriateness of assumptions to fund negative cash flow, for example: i. Review explanations provided for how the insurer will fund negative cash flows. ii. Request borrowing agreements from the insurer and assess the insurer's borrowing capacity and ability to execute a borrowing strategy. Compare cash flow requirements to the borrowing capacity. iii. If borrowing capacity is insufficient, what are the alternative options within the cash flow model to fund cash flow shortfalls (e.g., selling assets)? iv. Assess the insurer's asset selling strategy.	
f. Review the AG-53 reporting in the AOMR regarding assumptions and sensitivity testing for high-yielding complex assets within the asset adequacy analysis, if within scope of AG-53. Determine whether concerns exist in meeting asset adequacy requirements, such as: i. the adequacy of assumptions utilized ii. the sensitivity testing and attributions analysis performed and its results iii. the determination of fair value of high-yielding assets originated by the company	
g. Review the AG-55 reporting in the AOMR regarding asset intensive reinsurance transactions, if within scope of AG-55. Determine whether concerns exist in meeting asset adequacy requirements, such as: i. the adequacy of assumptions utilized ii. the cash flow testing results iii. attribution analysis performed and its results iv. explanations provided within risk identification or other analysis performed v. the collectability risk associated with the assuming company	

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Filing Requirement of the Non-Guaranteed Elements Opinion (if applicable)

6. Consider the following procedures for reviewing and assessing risk for the non-guaranteed elements (NGE) opinion, if applicable.

	Comments
a. Determine if the NGE actuary has satisfied the continuing education requirement for the Society of Actuaries and/or the American Academy of Actuaries. (The actuaries' profile in the SOA membership directory has a compliance indicator. Please see the website: SOA.org.)	
b. Determine if the NGE opinion includes the following sections. i. Determination procedure section that defines the insurer's policy in determining non-guaranteed elements, particularly the degree of discretion allowed by the insurer ii. Actuarial Interrogatories section iii. Actuarial Opinion section that includes the following: "I, (name, title), am (relationship to Company) and a Member of the American Academy of Actuaries. I have examined the actuarial assumptions and methods used in determining nonguaranteed elements for the individual life insurance and annuity contracts of the reporting entity used for delivery in the United States. The non-guaranteed elements for individual life and annuities policies have been determined in accordance with generally accepted actuarial principles and practices."	

Reserve Understatement/Reserve Adequacy Risk based on Review of the Non-Guaranteed Elements Opinion (if applicable)

	Comments
7. Are any risks identified within the comments of the qualified actuary?	

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RESERVING RISK: Actual losses and other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

The Reserving Risk Assessment is focused primarily on two key aspects of reserving: 1) reserve valuation; and 2) reserve adequacy. Analysis of reserves relies heavily on the review of the Statement of Actuarial Opinion (SAO) and other related filings. In analyzing reserving risk, the analyst may analyze specific types of reserves established by life insurers, reserving methodologies and various aspects of life insurance that affect reserving. For example, an analyst's risk-focused assessment of reserving risk may consider the following areas (but not limited to):

- Reserve valuation in accordance with the appropriate valuation requirements.
- Reasonableness of valuation bases utilized, testing, assumptions, and methodologies to determine reserves.
- Adequacy of assets to support policyholder benefits.
- Appropriate reporting of reserves.
- Lines of business written by the insurer.
- Types of reserves for life, accident, and health (A&H) and annuity lines of business.
- Reserve development.
- Reinsurance.
- Reserving for guarantees on separate accounts.

The analyst may need to review other risks in conjunction with reserves. For example:

- Reserves are also addressed in the Actuarial Opinion Worksheet.
- Separate Accounts are also addressed in the Operations and Liquidity Risks.
- Surrender activity is also addressed in the Liquidity Risk.

GENERAL GUIDANCE

The Annual Reserve Risk Assessment Procedures are designed to identify potential areas of concern to the analyst. While the underlying actuarial techniques relating to life reserves are quite complicated, the analyst should remember that there are two basic objectives regarding life reserves. The first objective is that the insurer's life reserves are calculated using the appropriate valuation methodology (formula or principle-based), and the second objective is that the insurer's assets are adequate to support the future policy obligations. To meet the first objective, reserves for policies and contracts subject to the formula-based valuation methodology, including the formula reserves required by VM-20, should be calculated in accordance with the minimum formula statutory valuation standards, using the appropriate valuation assumptions and valuation methods. For policies and contracts subject to a principle-based valuation methodology, in addition to the formula reserves, reserves should be calculated in accordance with the principle-based valuation requirements of VM-20.

Involvement of an Actuary: The analyst should involve an actuary where indicated in the procedures or as needed. To stay within any required deadlines for reviews, the analyst should document any greater in-depth reviews being performed by the actuary (such as involving the confidential actuarial memorandum or the confidential

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principle-based reserving (PBR) report for life reserves) and supplement the documentation when such actuarial review is complete. Questions or requests for assistance regarding PBR and for asset adequacy analysis may be made to the NAIC actuarial resources. Please see the NAIC website for the Valuation Analysis (E) Working Group for contact information regarding the use of NAIC actuarial resources and use of the Working Group if needed.

Depth of Review: Life, annuity, PBR and accident and health (A&H) involve many products and complex requirements. A complete determination of compliance with all of these requirements during the course of an annual financial analysis review is typically not practical for many companies. Judgment in a risk-focused approach will need to be exercised regarding greater focus and use of actuarial expertise in any procedure provided below.

ANNUAL ASSESSMENT OF ACTUARIAL FILINGS

Statement of Actuarial Opinion Based on an Asset Adequacy Analysis

To assess reserving risk, consider procedures for reviewing the Actuarial Opinion and other actuarial filings for compliance and assessment of risks. In many states, the Actuarial Opinion and related filings are reviewed by actuarial staff. Whether the SAO review is performed by the analyst or the actuary, the risk assessment provides for the results of the SAO review to be documented and communicated to the analyst.

Refer to the Overview sections at the end of this chapter for more guidance on the SAO and Asset Adequacy Analysis.

PROCEDURES #1A AND #1B. Determine that the SAO was prepared by a qualified actuary and that the reserve amounts agree with the Annual Financial Statement.

PROCEDURES #1C–#1F. Determine that the insurer's policy reserves were calculated properly in accordance with the minimum standards required by the NAIC Model Standard Valuation Law, and that the insurer's assets will adequately support the insurer's future policy obligations. The qualified actuary's opinion that the insurer's assets are adequate with regard to policy reserves provides significant comfort to the analyst that policy obligations will be met in the future.

RAAIS and Actuarial Memorandum Worksheet

PROCEDURES #2 AND #3. Review the RAAIS and document any concerns noted. For example, the analyst should further review any comments made by the appointed actuary on any interim results that may be of significant concern.

Additional prospective risk procedures the analyst may consider performing are provided if concerns exist based on the review of the RAAIS. The analyst should take into consideration the current economic environment (i.e., interest rate trends) when performing the analysis.

PROCEDURE #4. Review the actuarial memorandum that supports the SAO. The actuarial memorandum is a comprehensive document that provides an understanding of the insurer's reserves, the assets available to support the reserves, and the projected impact on the insurer's financial condition of varying economic and interest rate projection scenarios. It is not automatically filed with the Annual Financial Statement but is provided to the regulator only upon request. The decision as to whether to request the actuarial memorandum is an important one. The actuarial memorandum should be requested for insurers with known financial problems, significant changes in product mix or investment strategy, or significant growth in a particular product line.

The RAAIS is filed with the Annual Financial Statement and is designed to assist the regulatory actuary in determining whether to request the actuarial memorandum. The RAAIS includes the eight data requests shown below. Note that some items, such as 1), 2) and 5) specifically refer to cash flow testing results.

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1) The number of additional interest rate scenarios that were tested identifying separately the number of deterministic scenarios and stochastic scenarios. Also identify the number of such scenarios which produced ending negative surplus values on market value basis.
2) If sensitivity testing was performed, identify the assumptions tested and describe the variation in ending surplus values on a market value basis from the base case values.
3) If negative ending surplus results under certain tests in the aggregate, the amount of additional reserve which, if held, would eliminate the aggregate negative ending surplus values.
4) The extent to which the appointed actuary uses assumptions in the asset adequacy analysis which are materially different than the assumptions used in the previous asset adequacy analysis.
5) The amount of reserves and the identity of the product lines, which have been subject to asset adequacy analysis in the prior opinion but were not subject to such analysis for the current opinion.
6) Comments should be provided on any interim results that may be of significant concern to the appointed actuary.
7) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested.
8) Whether the actuary has verified that all options embedded in fixed income securities and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

While most states do not require the New York 7 actuarial interest rate scenario tests, states do require other stochastic scenario tests for life insurers and many life insurers, even though not required, still run the New York 7 interest rate scenario tests. The New York 7 interest rate scenario test which is an immediate decrease of 3% and then level would highlight the impact of prolonged low interest rates given the current interest rate environment. Also, the stochastically generated interest rate scenarios will also likely contain an interest rate scenario that represents a prolonged low-interest rate environment.

The Department actuary and analyst should understand each scenario in the insurer's scenario testing and its limitations and assess the likelihood of each scenario in the current economic environment. For example, the New York 7 interest rate scenarios consist of the following scenarios:

- Level with no deviation.
- Uniformity increasing over 10 years at 0.5% per year and then level.
- Uniformity increasing at 1% per year over five years and then uniformly decreasing at 1% per year to the original level at the end of the 10 years and then level.
- An immediate increase of 3% and then level.
- Uniformly decreasing over 10 years at 0.5% per year and then level.
- Uniformly decreasing at 1% per year over five years and then uniformly increasing at 1% per year to the original level at the end of 10 years and then level. An immediate decrease of 3% and then level.

Procedures 4.f. asks the analyst if an insurer that is within the scope of AG-53 has filed the required reporting within the AOMR. Further guidance on that reporting is provided below in procedure #5.

PROCEDURE #5. Document any concerns based on the review of the actuarial memorandum. Additional procedures the analyst may consider performing are provided if additional concerns exist based on the review of the RAAIS, the actuarial memorandum and the asset adequacy testing performed. The procedures should be used to help identify how the insurer will fund a negative cash flow. Procedures 5.a. through 5.d. are applicable to insurers utilizing the New York 7 actuarial interest rate scenario tests. Procedure 5.e. is applicable to other cash flow scenario testing. Explanations of negative cash flow provided by the appointed actuary should explain how the insurer will: 1) sell marketable assets and which type; or 2) borrow, with an explanation of any existing

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agreements to include security, duration and notice period required. If the appointed actuary wrote in his/her report that the insurer expects to sell assets, the modeling should be consistent for the sale of assets. Likewise, if the appointed actuary wrote that the insurer expects to borrow, then the modeling should be consistent with borrowing. If the insurer expects to borrow, the analyst should consider asking the insurer if a formal Lending Agreement is in place.

Procedure 5.f. is applicable to AG-53 reporting on high-yield complex assets. Refer to the guidance above regarding the scope of which insurers are included in this reporting requirement. In line with the goals of AG-53 to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for asset adequacy analysis performed by life insurers, the analyst or reviewing state actuary, should consider if the reporting identifies any concerns, including the following examples that may warrant further investigation or follow-up with the insurer.

1. Reserve adequacy and claims-paying ability in moderately adverse conditions, including conditions negatively impacting cash flows from complex assets.
2. Rationale supporting changes in assumptions, year-over-year.
3. Expected gross returns and related risks (including default rates).
4. Factors supporting margins on asset-related assumptions.
5. That assumptions fit reasonably within the risk-return spectrum.
6. The extent to which high-yielding assets are supporting major product categories.
7. Sensitivity testing results regarding reinvested complex assets supporting life insurer business.
8. Identifies expectations in practice regarding the valuation of complex assets within asset adequacy analysis.
9. Investment fee income relationships with affiliated entities or entities close to the company.

Non-Guaranteed Elements Opinion (if applicable)

PROCEDURE #6. Determine that a qualified actuary prepared the non-guaranteed elements opinion.

PROCEDURES #6B AND #6C. Review the non-guaranteed elements opinion in order to determine that the insurer's reserves were determined in a manner that considered the non-guaranteed elements for individual life and annuities policies.

ANNUAL RESERVING RISK ASSESSMENT

Refer to the Overview sections at the end of this chapter for more guidance on Life, Annuity, A&H and Long-Term Care reserves.

Inappropriate or Inaccurate Valuation of Life Reserves,

OR

Reasonableness of Actuarial Methodologies and Assumptions

- High Expenses affecting Cash Flow Assumptions
- Potential for Understated Life Reserves due to Spread Analysis

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Determine whether the insurer's life reserves for policies and contracts subject to a formula-based valuation methodology are valued in accordance with the minimum formula statutory valuation standards. Risks include that reserves may be understated due to reserve computations that are not performed correctly; assumptions that are unreasonable or not compliant with minimum requirements; high expenses leading to cash flow deficiencies; or, spread analysis that indicates either the need to record additional asset adequacy reserves (asset liability matching (ALM)), changes to policy design to limit guaranteed returns, or potential for investment portfolio changes to improve returns. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary, the information provided in the actuarial memorandum documenting all of the asset and liability assumptions, and the methods used, and scenarios run to determine the reserve adequacy.

Qualitative and Additional Review Considerations

- Review the results of the Statement of Actuarial Opinion worksheet. Identify any concerns regarding the valuation of the insurer's reserves in accordance with minimum statutory valuation standards.
- Review the Notes to Financial Statements, Note #31 – Reserves for Life Contracts and Annuity Contracts and note any unusual items regarding the valuation of life reserves.
- Review the trends of reserve amounts for the various basis groupings in Exhibit 5 over recent annual statements. Contact the state insurance department's actuary or other actuarial resource for assistance with this analysis.
- If questions or concerns are noted, contact the state insurance department's actuary or other actuarial resource to discuss the nature and scope of the life reserve valuation procedures performed.
- Assess the lines of business written by the insurer and gain an understanding of the impact that the difference in types of plans may have on reserving assumptions and methodologies.
    - Through the analyst's interdepartmental communication with the policy forms department, inquire as to whether the insurer had any new and unusual policy forms approved during the past 12 months by either the department or Interstate Insurance Product Regulation Commission (IIPRC). Unusual filings could be product lines the company has not written before or contain new or innovative products or benefit designs.
    - If concerns are noted about the types of life policies written, review the insurer's life insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits.
    - If questions or concerns are noted, contact the state insurance department's actuary for assistance in completing the analysis.
    - If concerns are noted, consider a target examination of reserves in which the field examination staff request a valuation listing by plan and issue year, and test a sample of individual policy reserves from each of the major life insurance plans for accuracy.
    - In considering any limited scope examination or any analysis needed, the analyst may consider use of the state's equivalent authority to the NAIC Standard Valuation Law (#820), Section 11F, which provides the commissioner may engage a qualified actuary at the expense of the company to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in Model #820.

Determine whether any changes in life reserve valuation bases during the year were proper for policies and contracts. From time to time, an insurer may decide to change the valuation basis for a particular segment of the business. The insurer may change the valuation mortality table used, the valuation rate of interest or the valuation method. Reserve strengthening occurs when the insurer substitutes a more conservative basis of valuation for any given block of business. Reserve weakening may also occur but normally requires approval of the domiciliary

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state and reserves cannot be reduced below the minimum reserve standard as defined in the Standard Valuation Law.

The analyst may also consider performing procedures that involve testing the actual reserve calculations for a sampling of individual life insurance policies to ensure that the minimum statutory valuation standards have been met.

Procedures / Data

- Has there been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in the current year capital and surplus. [Annual Financial Statement, Exhibit 5A]

Qualitative and Additional Review Considerations

- Review the specific changes in valuation bases applied to life products noted in Annual Financial Statement, Exhibit 5A, and determine that individual changes in specific mortality tables, interest rates, or valuation methods meet the minimum statutory valuation standards.
- Identify if any changes in life reserve valuation bases did not receive appropriate regulatory approval, if required.
- Request from the insurer information regarding the reason for the change in valuation basis.

Inappropriate or Inaccurate Valuation of PBR Life Reserves,

OR

Accuracy of PBR Reserve (or Exemption) Computations,

OR

Reasonableness of PBR Methodologies and Assumptions

Determine whether the insurer's life reserves for policies and contracts subject to a principle-based valuation methodology appear to be valued in accordance with the requirements of VM-20. Risks include that reserves may be understated due to reserve computations that are not performed correctly or due to assumptions that are unreasonable or not compliant with minimum requirements; or, that exemption test are not computed correctly, resulting in inaccurate exemptions. In this regard, the analyst will need to review and rely on the VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Reserve Valuation, actuarial report that documents the deterministic and stochastic exemption tests, all company experience assumptions and margins, and all the procedures and processes used to calculate the reserves under a principle-based valuation methodology. In addition, the analyst will need to review the VM-20 supplement, which is part of the annual statement filing and contains the various components of the PBR. The analyst may seek the assistance of actuarial staff at the NAIC related to any verification of exclusion test calculations, as well as validation of PBR for a small random sample of policies and contracts subject to a principle-based valuation methodology. Please see the NAIC website for the Valuation Analysis (E) Working Group for contact information regarding the use of NAIC actuarial resources and use of the Working Group if needed.

Qualitative and Additional Review Considerations

- Review Section 1 of the VM-20 Supplement to the annual statement for the business PBR and the resulting reported PBR reserves. Consider the business PBR was applied with respect to the applicability of PBR provided in the *Valuation Manual* (VM), Section II for products within the scope of VM-20 requirements.
- Review Section 2 of the VM-20 Supplement to determine if the company has chosen to delay implementation of VM-20 requirements per Section II(c) of the VM.

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- Review Section 3 of the VM-20 Supplement to the annual statement to determine if the company qualifies for the companywide exemption.
- Based on the judgment of the analyst and after discussing with the department actuary or the NAIC actuarial resources, determine if the VM-31, PBR Report Requirements, report should be requested from the company for review. The state insurance department actuary should perform the following procedures for any VM-31 Actuarial Report to be reviewed. The NAIC actuarial resources may be contacted for any questions or help in this review.
- Review the VM-31 Actuarial Report to identify the insurer's life insurance plan descriptions to understand the types of plans offered and the specific policy features and benefits.
- Review the VM-31 Actuarial Report to identify valuation assumptions based on company experience and valuation assumptions based on industry experience tables.
- For valuation assumptions based on company experience, contact the company valuation actuary to request to see the latest experience studies for those assumptions and evaluate the process used to establish the assumptions and the margins for those assumptions and the credibility factors used for each experience assumption.
- For mortality based on company experience, review the determination of the credibility percentage, the sufficient data period, the mortality segments, and the industry mortality tables to which company experience mortality is graded. Review whether the level of company mortality experience is appropriate in determining the credibility percentage and the sufficient data period. This is significant as the larger the body of experience used the smaller the resulting mortality margins and the lower the PBR reserves. Review to assure the use of any larger body of aggregate mortality experience is appropriate. As mentioned above, the NAIC actuarial resources may be consulted for any questions or support in this review.
- Review the VM-31 Actuarial Report to determine the contracts or plans that passed the stochastic and deterministic exclusion tests. Consider requesting the assistance of the NAIC actuarial resources to independently verify that such contracts and plans do pass the deterministic and stochastic exclusion tests.
- Consider whether to request that a limited-scope examination (or interim examination procedures) be performed to address concerns by reproducing net premium reserve (NPR) calculations on a sample basis. Reproducing calculations may be conducted by asking the company to calculate NPR reserves for a sample of contracts and plans or requesting the NAIC actuarial resources to recalculate the NPR reserves for the same sample of contracts and plans and compare results. Also consider whether to request the NAIC actuarial resources for help in any testing of the deterministic (DR) and stochastic reserve (SR) if there are unusual relationships between the NPR, DR, and SR.
- In considering any limited scope examination or any analysis needed, the analyst may consider use of the state's equivalent authority to Model #820, Section 11F, which provides the insurance commissioner may engage a qualified actuary at the expense of the company to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this model.

Understatement of Reserves,

OR

Insufficient Asset Adequacy

Determine whether the insurer's underlying assets are adequate to support the future obligations of its life insurance policies. Risks may include the potential for understated reserves if unusual or specific policy features and benefits are not valued and reserved for correctly; or, if asset adequacy testing results reflect the assets held and may not be sufficient to support future policy obligations. If the insurer filed an SAO based on an asset

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adequacy analysis, then the SAO itself, and the supporting actuarial memorandum, if requested, can provide the analyst with comfort in this regard. If a SAO that does not include an asset adequacy analysis is filed, the analyst can review net interest spread ratios for insights regarding the relationship of investment income with tabular interest. Insurance Regulatory Information System (IRIS) ratio #11 is included in the procedures as a test of reserve consistency between the current year and the prior year.

The analyst may also consider performing a review of the actuarial memorandum, if available. This will provide the analyst with substantial analyses with regard to asset adequacy. If an actuarial memorandum is not available, the analyst should consider the need to have an independent asset adequacy analysis conducted. Additional procedures regarding the SAO are found in Section III.B.8.d. Additional guidance for new reporting requirements for AG-53 regarding high-yielding complex assets is found above.

Procedures / Data

- Net interest spread on life reserves (net investment income, less tabular interest, divided by average life reserves)
- Change in Asset Mix (IRIS ratio #11)

Qualitative and Additional Review Considerations

- If the insurer filed a Statement of Actuarial Opinion based on an asset adequacy analysis, review the results of the Actuarial Opinion Assessment, and note any concerns regarding the adequacy of the insurer's underlying assets to support future life insurance policy obligations.
- Pursuant to the review of the Regulatory Asset Adequacy Issues Summary (RAAIS) in the Actuarial Opinion Assessment, note whether the responses to the questions were satisfactory.
- If concerns still exist upon review of the asset adequacy analysis, discuss with the appointed actuary and the company, and request any additional information or work to be performed to address these concerns. If the insurance commissioner determines that the supporting actuarial memorandum fails to meet the standards prescribed by the Valuation Manual or is otherwise unacceptable to the insurance commissioner, the insurance commissioner may engage a qualified actuary at the expense of the company to review the opinion and basis for the opinion and prepare the supporting actuarial memorandum required by the insurance commissioner. See the state's equivalent authority to NAIC Model #820, Section 3B(3)(b). This also is noted in the Actuarial Opinion Worksheet.
- Review the Actuarial Guideline 53 reporting relating to assumptions and sensitivity testing for reinvested high-yielding complex assets within the asset adequacy analysis, if applicable. Determine whether concerns exist in meeting asset adequacy requirements. See further guidance in the AOMR procedures and reference guide.
- Review the Actuarial Guideline 55 reporting related to assumptions and cash flow testing for assets that support long-duration reinsurance transactions within asset adequacy analysis, if applicable. Determine whether concerns exist in meeting asset adequacy requirements. See further guidance in the AOMR procedures and reference guide.

Understated Reserves Associated with Separate Account Products & Guarantees

Review and identify situations where separate accounts products may be creating contingent liabilities to the general account that may not be sufficiently reserved for on the general account. This is largely a function of the types of separate accounts products offered by the insurer, and the analyst should rely on general knowledge of the insurer's products at this stage of the analysis.

The analyst should review disclosures in Separate Accounts General Interrogatories, Analysis of Operations by Line of Business (Page 6), Analysis of Increase in Reserves During the Year (Page 7) and the Notes to the Financial Statements of the general account to gain an understanding of the types of products included in the separate

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account and the general account guarantees on separate account products, as well as identify any concerns with reserving or asset adequacy that may require additional analysis of actuarial filings. The analyst should gain an understanding of any products in the separate account that contain guarantees that are held in the separate account instead of the general account and the types of guarantees (guaranteed minimum death benefit [GMDB], guaranteed minimum income benefit [GMIB], etc.). Where the general account provides an inherent/ultimate guarantee, the analyst should review the Separate Account General Interrogatories #2.7 to identify the materiality of the BACV of the separate account assets attributed to those products (i.e. pension risk transfer group annuities, registered index linked annuities, other group and individual annuities and life insurance), the related risk charges to the general account and if the asset were included in asset adequacy testing.

Exposure to Separate Account Products & Guarantee Liabilities and Accuracy of Separate Account Reserve Liabilities

Procedures / Data

- Identify the materiality of Separate Account assets with General Account guarantees [Separate Account General Interrogatories #2.71].
- Identify if any of the separate accounts have guarantees that are designed to mirror an established index (Annual Financial Statement, Note #35B).
- Identify if any of the separate accounts have material non-indexed guarantees. [Annual Financial Statement, Note #35B]

Qualitative and Additional Review Considerations

- If material guarantees exist, or if non-insulated products exist, determine whether the assets associated with these products are being invested in accordance with statutory guidelines.
- If material guarantees exist, gain an understanding of the types of Separate Account products for which the guarantees are provided [Separate Account General Interrogatories #2.71].
- If material guarantees exist, determine whether the assets associated with these products were included in asset-adequacy testing [Separate Account General Interrogatories #2.71].
- Review Separate Account General Interrogatories #5 to identify if the insurer reported a material amount of assets in the separate account at amortized cost rather than fair value. If yes, consider additional analysis of actuarial and asset adequacy reporting.
- Review Separate Account Analysis of Operations by Line of Business (Page 5) and Analysis of Increase in Reserves During the Year (Page 6) to identify if any concerns exist regarding the types of products included in the Separate Account and reserving for those products. If yes, consider additional analysis of actuarial and asset adequacy reporting.
- Based upon an overall understanding of the insurer's separate accounts products, assess if there is evidence that such products may be creating contingent liabilities to the general account with product features such as minimum guaranteed death benefits, minimum guaranteed interest rates, etc.
- If concerns or questions are noted, contact the state insurance department's actuary or other actuarial resource to discuss the nature and scope of the valuation procedures performed relating to guarantees included with separate accounts products. If determined to be necessary, contact the company's qualified actuary.
- Determine whether growth in separate accounts appears to be financed through borrowings of the general account and, if so, whether any concerns exist regarding the terms of repayment or collateralization.

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- Determine whether the insurer writes any modified guaranteed annuities and, if so, the overall materiality and potential negative impact on the insurer's general account.
- Through the analyst's quarterly interdepartmental communication with the policy forms department, inquire as to whether the insurer filed any new and unusual separate account policy forms during the past 12 months.
- If concerns are noted about the types of policies included in separate accounts, review the insurer's separate accounts plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits, particularly minimum guarantees.
- If concerns are noted about reserving for separate accounts, consider a target examination of reserves, request that the field examination staff request a valuation listing by plan and issue year, and test a sample of the individual policy reserves for accuracy.
- Assess if there is any indication of contingent liabilities created by the separate accounts for the general account.
- Assess if separate account assets and liabilities were subject to asset adequacy analysis. If "no," review the actuarial opinion for an explanation.
- Request from the insurer separate accounts plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits, particularly minimum guarantees.
- Request information from the insurer regarding any significant changes in reserve methodologies and assumptions, underwriting practices, case reserving, or claims handling practices with the potential to affect reserve setting.

Exposure to Maximum Guarantees to the Separate Account

Qualitative and Additional Review Considerations

- Identify the variable annuity account value - general account. Document the variable annuity account value, percentage of capital and surplus, and percentage of total admitted assets.
- Assess if any separate accounts have collected amounts from the general account within the past five years related to separate account guarantees. [Annual Financial Statement, Separate Account General Interrogatories, #2.2]
    - If "yes," identify any concerns regarding the amounts or trend of guarantees paid.
    - If "yes," determine if guarantees were appropriately reserved for in the general account.
- Perform an industry peer comparison of the total maximum guarantee and the guaranteed amounts paid by the general account on a company-by-company basis to determine if the amounts appear reasonable.

Risk of Providing Guarantees While Not Receiving Risk Fees

Identify if the insurer reports a maximum guarantee exposure amount in Separate Accounts Annual Financial Statement, General Interrogatory #2.2 and guarantees paid in Separate Accounts General Interrogatory #2.3 but does not report risk charges paid in Separate Accounts General Interrogatory #2.6, which indicates the insurer is providing guarantees and may not be receiving a risk fee in return for that guarantee. Note that, while group products require risk charges, there may be no requirements for risk charges on individual products. Also note that in some instances, risk fees may be imbedded in the management fees paid to the general account. The analyst should gain an understanding of how risk fees are reported by the insurer and if concerns exist regarding the risk fees, the analyst should consider requesting additional details from the insurer. Additional procedures assist the analyst in determining that contingent liabilities to the general account of the insurer created by

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separate accounts assets are properly recorded. Guarantees included with separate accounts products must be recorded as a liability of the general account.

Qualitative and Additional Review Considerations

- Determine if there have been any risk charges paid to the general account related to separate account guarantees. [Annual Financial Statement, Separate Account General Interrogatories, #2.6, and #2.71]
- Determine if the insurer reported maximum guarantees that the general account would provide or pay amounts on guarantees in the current year and report no risk charges to the general account.

Inappropriate or Inaccurate Valuation of Annuity Reserves

Determine whether the insurer's annuity reserves are valued in accordance with the minimum formula statutory valuation standards. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary. The analyst can also gain comfort in this regard by evaluating the change in reserves in relation to increases or decreases in premiums during the year.

Procedures / Data

- Determine if anything has occurred since the last reporting period to raise concern that the insurer's annuity contracts are not valued in accordance with the minimum formula statutory valuation standards.
- Change in individual annuity reserves for the year as a percentage of individual annuity premiums (plus annuity investment income less annuity benefits and other fund withdrawals).
- Change in group annuity reserves as a percentage of group annuity premiums (plus annuity investment income less annuity benefits and other fund withdrawals).

Qualitative and Additional Review Considerations

- Review the results of the Actuarial Opinion assessment. Identify any concerns regarding whether the valuation of the insurer's reserves is in accordance with minimum statutory valuation standards.
- Review the Annual Financial Statement, Notes to Financial Statements, Note #31 – Reserves for Life Contracts and Annuity Contracts and note any unusual items regarding the valuation of annuity reserves (surrender values promised in excess of the reserve, significant changes in components of reserves, etc.).
- Review the trends of reserve amounts for the various basis groupings in Exhibit 5 over recent Annual Statements. Contact the state insurance department's actuary or other actuarial resource for assistance with this analysis.
- If questions or concerns are noted, contact the state insurance department's actuary or other actuarial resource to discuss the nature and scope of the annuity reserve valuation procedures performed. If determined to be necessary, contact the company's qualified actuary.

Assess information on annuity contract benefits offered that may indicate the impact of type of business, reserving assumptions and methodologies.

- Through the analyst's quarterly interdepartmental communication with the policy forms department, inquire as to whether the insurer filed new and unusual policy forms during the past 12 months.
- If concerns are noted about the types of policies, review the insurer's annuity plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits.
- If concerns are noted about reserving for annuity products, consider a target examination of reserves, request that the field examination staff request a valuation listing by plan and issue year, and test a sample of individual policy reserves from each of the major annuity plans for accuracy.

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- In considering any limited scope examination or any analysis needed, the analyst may consider use of the state's equivalent authority to Model #820, Section 11F, which provides the insurance commissioner may engage a qualified actuary at the expense of the company to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this model.
- Request a spread analysis where the current spread earned is compared to the original pricing spread on the annuity block in question. Products with higher guaranteed minimum interest rates relative to the current interest environment. The state insurance department actuary can assist in this review.

Concerns with Changes in Reserves Basis

Determine whether any changes in annuity reserve valuation basis during the year were appropriate. From time to time, an insurer may decide to change the valuation basis for a particular segment of the business. The insurer may change the mortality table used, the rate of interest or the valuation method. Reserve strengthening occurs when the insurer substitutes a more conservative basis of valuation for any given block of business. Reserve weakening may also occur but normally requires approval of the domiciliary state.

The analyst may also consider testing the actual reserve calculations for a sampling of individual annuity policies to ensure that the minimum statutory valuation standards have been met.

Procedures / Data

- Note whether there has been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in capital and surplus. [Annual Financial Statement, Exhibit 5A – Changes in Bases of Valuation During the Year]

Qualitative and Additional Review Considerations

- Review the specific changes in valuation basis applied to annuity products noted in Annual Financial Statement, Exhibit 5A – Changes in Bases of Valuation During the Year and determine that individual changes in specific mortality tables, interest rates, or valuation methods meet the minimum statutory valuation standards.
- Determine if changes in annuity reserve valuation bases received appropriate regulatory approval, if required.
- Test check the calculations involved in applying a change in valuation basis. Contact the state insurance department's actuary or other actuarial resource for assistance with this assessment.
- Request from the insurer information regarding the reason for the change in valuation basis.
- Request information from the insurer regarding any significant changes in reserve methodologies and assumptions, underwriting practices, case reserving, or claims handling practices with the potential to affect reserve setting.

Adequacy of Annuity Reserves (Risk of Understatement of Reserves)

Determine whether the insurer's underlying assets are adequate to support the future obligations of its annuity policies. If the insurer filed an SAO based on an asset adequacy analysis, then the actuarial opinion itself, and the supporting actuarial memorandum, if requested, can provide the analyst with comfort in this regard. If an SAO that does not include an asset adequacy analysis is filed, the analyst can review net interest spread ratios for insights regarding the relationship of investment income with tabular interest.

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The analyst may also consider a review of the actuarial memorandum, if available, as this will provide the analyst with substantial analyses with regard to asset adequacy. If an actuarial memorandum is not available, the analyst should consider the need to have an independent asset adequacy analysis conducted.

Procedures / Data

- Net interest spread (net investment income, less tabular interest, divided by average annuity reserves) on individual annuity reserves.
- Net interest spread (net investment income, less tabular interest, divided by average annuity reserves) on group annuity reserves.
- Change in Asset Mix (IRIS ratio #11)

Qualitative and Additional Review Considerations

- If the insurer filed a statement of actuarial opinion based on an asset adequacy analysis, review the results of the Actuarial Opinion Assessment, and note any concerns regarding the adequacy of the insurer's underlying assets to support future annuity policy obligations. Review the actuary's comments regarding the analysis performed and conclusions reached.
- If available, or if concerns or questions are noted, request and review the RAAIS, and note whether the responses to the questions were satisfactory.
- If concerns exist upon review of the asset adequacy analysis, conduct an independent asset adequacy analysis.

Concerns with Withdrawal and Surrenders Impact on Reserves

Identifying other areas of concern with withdrawal and surrenders that may affect annuity reserves. For example, annuities can have a significant impact on the insurer's liquidity position, particularly significant levels of GICs or amounts subject to withdrawal with minimal or no surrender charge.

Procedures / Data

- Guaranteed interest contracts as a percent of capital and surplus
- Annuity benefits, surrenders and other fund withdrawals for individual and group annuities as a percent of capital and surplus.
- Change in annuity benefits, surrenders, and other fund withdrawals for individual and group annuities and deposits, as a percentage of premiums
- Note significant amounts subject to withdrawal without any surrender charge or market value adjustment (i.e., as a percentage of total annuity reserves and deposit liability). [Annual Financial Statement, Notes to Financial Statements, Note #32]

Qualitative and Additional Review Considerations

- Request from the insurer and review the insurer's annuity plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy withdrawal features and surrender charges.

Adequacy of A&H Reserves (Risk of Understatement of Reserves / A&H Reserve Deficiency)

Determine whether an understatement of A&H reserves would be significant to the insurer. The ratios of gross and net A&H reserves to capital and surplus are leverage ratios which are calculated gross and net of reinsurance ceded. The net A&H reserves to capital and surplus ratio indicates the margin of error an insurer has in estimating

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its A&H reserves. For an insurer with a net A&H reserve to capital and surplus ratio of 300%, a 33% understatement of its A&H reserves would eliminate its entire surplus. In evaluating these leverage ratios, the analyst should also consider the nature of the insurer's business. For example, an insurer which has written primarily A&H business for many years and has proven that it can manage the business profitably is probably not as risky as an insurer which has just begun writing A&H business, even if both insurers have the same leverage ratio results.

Procedures / Data

- For non-life insurers, the gross A&H reserves to capital and surplus ratio.
- Net A&H reserves to capital and surplus ratio.

Determine whether A&H policies appear to have been adequately reserved and valued in accordance with the minimum formula statutory valuation standards. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary. Therefore, the analyst should review the results of the SAO Procedures to determine whether any concerns were noted regarding the valuation of the insurer's A&H reserves in accordance with Appendix A-010, *Minimum Reserve Standards for Individual and Group Health Insurance Contracts*, of the AP&P Manual.

The analyst might want to contact the qualified actuary who signed the insurer's SAO to discuss the nature and scope of A&H valuation procedures performed and/or request a copy of the qualified actuary's actuarial memorandum to review for comments regarding the analysis of A&H reserves performed and the conclusions reached.

Qualitative and Additional Review Considerations

- Review the results of the Actuarial Opinion Assessment. Note any concerns regarding the valuation of the insurer's reserves and if in accordance with minimum statutory valuation standards.
- Request and review the insurer's description of the valuation standards used in calculating the additional contract reserves (which is required to be attached to and filed with the Annual Financial Statement) and consider whether the reserve basis, interest rates and methods appear reasonable.
- If questions or concerns are noted, contact the qualified actuary who signed the insurer's Statement of Actuarial Opinion to discuss the nature and scope of the A&H reserve valuation procedures performed.
- Request from the insurer A&H insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific features and benefits.

The ratio of A&H reserve deficiency measures the adequacy of A&H reserves established in the prior year. A positive result for this ratio represents additional or "adverse" development on the reserves originally established by the insurer (the amount by which the A&H reserves originally established have proved to be understated based on subsequent activity). Current or prospective reserve deficiency could represent a material impact on the insurer's capital and surplus. If the insurer's ratio results consistently show additional development, this could be an indication that the insurer is intentionally understating its A&H reserves. The A&H loss ratio is also reviewed as a part of this procedure. Significant increases in this ratio might be indicative of additional A&H reserves being established due to prior understatements while significant decreases might be indicative of current A&H reserve understatements. Other steps included in this procedure include the review of Exhibit 5A – Changes in Bases of Valuation During the Year, of the Annual Financial Statement to determine whether there has been a change in the valuation basis of the A&H policies during the year which resulted in a decrease in A&H reserves in an amount greater than 5% of capital and surplus.

The analyst may also consider reviewing Annual Financial Statement, Schedule H – Accident and Health Exhibit to determine which A&H lines of business are being written and which A&H lines of business had positive development in reserves during the year.

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Procedures / Data

- A&H reserve deficiency ratio.
- Review the Schedule H claims test and note/explain any adverse trend or unusual fluctuation of one-year A&H loss development during the past five years.
- Assess loss ratios as indicators of reserve adequacy.
    - A&H Loss Ratio
    - Change in A&H loss ratio from the prior year.

Qualitative and Additional Review Considerations

- Review Annual Financial Statement, Schedule H – Accident and Health Exhibit, and perform the following:
    - Determine which A&H lines of business are being written by the insurer.
    - Review Schedule H – Part 3, to determine which A&H lines of business had positive development during the year.
- Review the A&H loss percentage ratio for unusual fluctuations or trends over a multi-year period.
- Compare the A&H loss percentage ratio to the industry average to determine any significant deviations from the industry average.
- Request an explanation from the insurer for any adverse loss development results or adverse trends indicated in the analyst's review of the Schedule H claims test.
- Request information from the insurer regarding A&H claims paid after year-end that were incurred prior to year-end and test the reasonableness of the year-end claim liabilities established by the insurer.

Consider: 1) reviewing the insurer's A&H insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits; and 2) contacting the policy forms section of the insurance department and inquiring as to whether the insurer has filed any new and unusual A&H policy forms during the past year.

The analyst might also consider requesting that the field examination staff request a valuation listing of A&H reserves by policy and testing a sample of policies to determine that the reserve factors were appropriate and that the reserves were correctly computed. If the adequacy of claim liabilities is a concern, the analyst might want to request information from the insurer regarding claims paid after year-end that were incurred prior to year-end, in order to test the reasonableness of the year-end claim liabilities established by the insurer.

Qualitative and Additional Review Considerations

- Assess information on policy benefits offered that may indicate the impact of type of A&H business on reserving assumptions and methodologies.
    - Review the Notes to Financial Statements, MD&A, or other correspondence with the insurer and note whether the insurer initiated any internal changes that could impact the reserve estimates.
    - Through the analyst's quarterly interdepartmental communication with the policy forms department, inquire as to whether the insurer has filed any new and unusual A&H policy forms during the past year.
    - If concerns are noted about the types of policies, review the insurer's A&H insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific features and benefits.
    - If concerns are noted about reserving for A&H, consider a target examination of reserves, request that the field examination staff request a valuation listing of A&H policy reserves by policy and test a sample

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of policies to determine that the reserve factors used were appropriate and that the reserves were correctly computed.

Adequacy of Long-Term Care LTC Reserves (Risk of Understatement of Reserves)

Review the LTC Experience Reporting Form of the Annual Financial Statement and the AG 51 reporting filed to the department if the insurer writes LTCI to gain an understanding of the reserve adequacy of the LTCI line of business. If concerns exist, consider requesting additional information as necessary to assess actual vs. projected results, legacy vs. newer blocks of business separately, any recent rate increases and capital support. If the insurer has recently filed for rate increases on LTCI blocks, consider intra-departmental discussion with the rate increase analysis and outcome with the rate review staff (if a different person than the analyst/actuary performing the valuation reserve analysis).

Qualitative and Additional Review Considerations

Review and assess long-term care (LTC) insurance reserves.

- Review the information reported in the LTC Experience Reporting Form of the Annual Financial Statement the Actuarial Guideline-LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) reporting, actuarial memorandum or any other related actuarial information filed to the department and identify any concerns with reserve adequacy of LTC insurance business. Request a department actuary to assist in the review, if available.
    - Gain an understanding of the asset adequacy and cash-flow testing for LTCI on a stand-alone basis.
    - Consider any negative development in total LTCI reserve, asset adequacy reserves (if available), active life reserves, disabled lives reserves and premium deficiency reserves over the last five years.
    - Evaluate the appropriateness of investment return assumptions factoring in the status of the current economic and interest rate environment.
- If concerns exist:
    - Evaluate actual results vs. original or revised assumptions and financial projections to identify trends and concerns.
    - Consider evaluating legacy blocks of business separately from newer blocks of business.
    - Rate Increases: Obtain and review the following information related to the status of rate increases and reduced benefit options. Consider that some information may be available from rate review staff for recent rate increase filings.
        - Track the progress of rate increases across states where a material amount of business is written.
        - Review projections illustrating the impact of proposed rate increases or reduced benefit options on the company's future profitability.
        - Determine the extent that future rate increases are included in the amount ($) of reserve offsets, asset adequacy/cash-flow testing and the reasonableness of the assumptions.
        - Consider the impact of historical approvals on the company's ability to obtain the rate increases presented in the projections. If concerns are identified in this area, obtain and review information on the company's plans to address these issues.
        - Compare the average percent of rate increases requested to the average approved.
        - Identify the amount of written premium change due to approved rate increases.
    - Regarding the adequacy of internal capital to support the LTCI business, compare the current total LTC reserves (active life and other), net of reinsurance, to the amount of internal capital the company has set

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aside for LTCI (e.g., internal capital per Own Risk and Solvency Assessment [ORSA] if applicable, or rating agency if higher than internal). If necessary, request information to gain an understanding of the degree of conservatism in such capital assumptions.

Impact of Changes in Valuation Bases of Reserves

Review the insurer's description of the valuation standards used in calculating the additional contract reserves and consider whether the reserve bases, interest rates, and methods used appear reasonable. The insurer's description of the valuation standards used is required to be attached to the filed Annual Financial Statement.

If there was a change in the valuation basis of A&H policies during the year, the analyst should consider the following: 1) obtaining information regarding the reason for the change in the valuation basis; 2) determining whether the amount of the change in the actuarial reserve as a result of the change in the valuation basis is reasonable; and 3) determining whether the change in the valuation basis was approved by the domiciliary state insurance department, if required.

Assess the impact of changes in valuation bases on reserves.

Procedures / Data

- Note whether there has been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in capital and surplus. [Annual Financial Statement, Exhibit 5A]

Qualitative and Additional Review Considerations

- If there was a change in the valuation basis of the A&H policies during the year, consider performing the following:
  - Obtain information regarding the reason for the change in valuation basis and assess the change in the actuarial reserve.
  - Determine if changes in A&H reserve valuation bases received appropriate regulatory approval, if required.

Adequacy of Reserves on Captive (Non-Traditional) Reinsurance

Review reserve valuation of captive reinsurance transactions. Refer to the guidance in Chapter III.B.9. Strategic Risk Assessment for an explanation of potential risks. Also, for affiliated transactions, refer to the guidance for Form D captive reinsurance transactions in Chapter V.C. Domestic and/or Non-Lead State Analysis for procedures that may have been conducted at the time the transaction was approved.

Qualitative and Additional Review Considerations

If business is ceded to a captive (non-traditional) reinsurer, consider the following procedures.

- Determine the percentage of gross premium written that is ceded to affiliated captive reinsurers (Schedule S, Part 3, Sections 1 and 2) (Utilize Reinsurance Dashboard).
- Review the information provided in the Form D application for compliance with reserve valuation standards for fixed annuities.
- Consider Handbook procedures similar to the procedures required for XXX/AXXX captive reinsurance (III.C. Special Analysis Procedures).
- Within the Actuarial Opinion Memorandum, require the insurer provide the results of cash flow testing and true-up of the statutory sufficiency of the reserve credit taken on gross reserves ceded to the affiliated

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reinsurer, including appropriate sensitivity tests (e.g., lapse, utilization, combined surrender and utilization, and credit defaults, etc.).

- Consider including confidential disclosure in the Insurer Profile Summary to other state insurance departments if the commissioner approved assets not meeting criteria A–C defined within the *Credit for Reinsurance Model Regulation* (#785) for Funds Withheld.

ADDITIONAL PROCEDURES

Examination Findings

Consider a review of the recent examination report, summary review memorandum and communication with the examination staff to identify if any reserving risk issues were discovered during the examination.

- If outstanding issues are identified perform follow-up procedures as necessary to address concerns.
- Request that the field examination staff request a valuation listing by plan and issue year and test a sample of the individual policy reserves for accuracy.

Inquire of the Insurer

Consider requesting additional information from the insurer if reserving risk concerns exist.

If concerns exist, consider requesting information form the insurer regarding:

- If questions or concerns are noted, contact the insurer to request if the insurer initiated any internal changes that could impact the reserve estimates.
- Request a copy of the insurer's business plan and review the insurer's plans to assess and mitigate reserve risks.
- Request information on who ultimately determines the level of reserves to be booked by the insurer and the board of directors' role in overseeing the reserving process.
- If filed on an insurance entity basis or if your state is the lead state, review the insurer's Corporate Governance Annual Disclosure (CGAD) filing to understand and assess the board of director's' role in overseeing the reserving process. If your state is not the lead state, rely on the information provided in the Group Profile Summary (GPS) or provided by the lead state, where the CGAD is filed on a group basis.

Own Risk and Solvency Assessment (ORSA)

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing reserving risks faced by the insurer.

If the insurer is required to file an ORSA or is part of a group that is required to file an ORSA,

- Review the ORSA Summary Report analysis conducted by the lead state for any reserving risks that require further monitoring or follow-up.
- Review the ORSA Summary Report analysis conducted by the lead state for any mitigating strategies for existing or prospective reserving risks.

Holding Company Analysis

Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing reserving risks that could affect the insurer.

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- Review the Holding Company analysis conducted by the lead state for any reserving risks impacting the insurer that require further monitoring or follow-up.
- Review the Holding Company Analysis conducted by the lead state for any mitigating strategies for existing or prospective reserving risks impacting the insurer.

QUARTERLY RESERVING RISK ASSESSMENT

The quarterly reserving risk assessment is intended to identify significant changes in reserves that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.

Changes in Life Reserves and Reserve Adequacy

Procedures / Data

Determine changes in life reserves to assess any change in the adequacy of reserves.

- Change in reserve from the prior year-end where the aggregate reserve for life contracts exceeds 10% of capital and surplus.
- Change in any asset categories from the prior year-end. [Quarterly Financial Profile – "Mix of Cash & Invested Assets" section]
- Review, by line of business, the year-to-date direct premiums for the current and prior year quarter and note significant changes in direct premiums for any line of business from the prior year, same quarter. [Quarterly Financial Statement, Exhibit 1]

Changes in Accident and Health (A&H) Reserves and Reserve Adequacy

Procedures / Data

Determine changes in accident and health reserves to assess any change in the adequacy of reserves.

- Change in reserve from the prior year-end where the aggregate reserve for A&H contracts exceeds 10% of capital and surplus.
- Change in policy and contract claims from the prior year-end, where the A&H policy and contract claims exceed 10% of capital and surplus.
- Change in benefits from the prior year, same quarter where the disability benefits and benefits under A&H contracts exceed 10% of capital and surplus.
- Aggregate reserve for A&H contracts to capital and surplus ratio.
- Review, by line of business, the year-to-date direct premiums for the current and prior year quarter and note significant changes in direct premiums for any line of business from the prior year, same quarter. [Quarterly Financial Statement, Exhibit 1]

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Changes in Annuity Reserves and Reserve Adequacy

Procedures / Data

Determine changes in annuity reserves to assess any change in the adequacy of reserves.

- Change in liability from the prior year-end where the liability for deposit-type contracts exceeds 3.5% of capital and surplus.
- Change in surrender benefits and other fund withdrawals change from the prior year, same quarter. [Quarterly Financial Statement, Summary of Operations]
- Change in any asset categories from the prior year-end. [Quarterly Financial Profile – "Mix of Cash & Invested Assets" section]
- Review, by line of business, the year-to-date direct premiums and deposit-type contract funds for the current and prior year and note whether direct premiums for any line of business or deposit-type contract funds have changed significantly from the prior year, same quarter. [Quarterly Financial Statement, Exhibit 1]

For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

ACTUARIAL OPINION AND REGULATORY ASSET ADEQUACY ISSUES SUMMARY ASSESSMENT (RAAIS) OVERVIEW

Life insurers required to file an Annual Financial Statement and are also required to file an SAO as a supplement to the Annual Financial Statement. The specific requirements for the SAO are described in the NAIC *Valuation Manual*, VM-30, Actuarial Opinion and Memorandum Requirements (AOMR). The SAO must be issued by an Appointed Actuary. The Appointed Actuary must be a qualified actuary appointed either directly by, or by the authority of, the board of directors through an executive officer of the company other than the qualified actuary. "Qualified actuary" as used herein means a member in good standing of the American Academy of Actuaries, or an individual who has otherwise demonstrated his or her actuarial competence to the satisfaction of the domiciliary state insurance department. Requirements regarding the Appointed Actuary and Qualified Actuary must conform to those prescribed by the *Valuation Manual* authorized by Section 3B of the Standard Valuation Law as amended by the NAIC in December 2009. The Actuarial Opinion should include the general account and the separate accounts.

Life insurers are required to file a comprehensive SAO based on an asset adequacy analysis. The actuarial opinion is supported by an actuarial memorandum. The actuarial memorandum includes the results of the qualified actuary's asset adequacy analysis. While the SAO must be filed with the Annual Financial Statement, the actuarial memorandum is only provided to the regulator upon request. There is also a confidential executive summary, the RAAIS, filed with the insurance departments. In addition to an actuarial opinion, the insurer must also file a non-guaranteed elements opinion if policies containing non-guaranteed elements are currently being issued or are in-force. The specific requirements for the non-guaranteed elements opinion are described in the NAIC *Annual Financial Statement Instructions for Life, Accident and Health Insurance Companies*.

The SAO must follow the guidelines and standards for statements of actuarial opinion prescribed by the *Valuation Manual* authorized by Section 3B of the Standard Valuation Law as amended by the NAIC in December 2009. The SAO should consist of a paragraph identifying the qualified actuary, a scope section identifying the subjects on which an opinion is to be expressed and describing the scope of the qualified actuary's work, and an opinion paragraph expressing the qualified actuary's opinion with respect to such subjects. If there has been a material

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change in the actuarial assumptions from those previously employed, that change should be described in either the Annual Financial Statement or in a paragraph of the SAO. In addition, the scope paragraph should list those items and amounts to which the qualified actuary is expressing an opinion, including the following from the Annual Financial Statement: 1) aggregate reserves for life contracts (Exhibit 5); 2) aggregate reserves for A&H contracts (Exhibit 6); 3) deposit-type contracts (Exhibit 7); and 4) contract claims – liability end of current year (Exhibit 8, Part 1). If the actuary has not examined the underlying records but has relied upon listings and summaries of policies in force prepared by the company, the scope paragraph should include a sentence to this effect.

The Appointed Actuary must report to the board of directors or the Audit Committee each year on the items within the scope of the SAO. The minutes of the board of directors shall indicate that the Appointed Actuary has presented such information to the board of directors or the Audit Committee. A separate SAO is required for each company filing an Annual Statement. If the qualified actuary is unable to form an opinion, the actuary should issue a statement specifically stating the reason(s) why an opinion cannot be formed. If the qualified actuary's opinion is adverse or qualified, the actuary should issue an adverse or qualified actuarial opinion specifically stating the reason(s) for such an opinion. An adverse opinion is an actuarial opinion which the Appointed Actuary determines that the reserves and liabilities are not adequate.

DISCUSSION OF ACTUARIAL OPINION ASSESSMENT PROCEDURES

In most instances, proper review and analysis of the SAO will require a greater in-depth knowledge of actuarial science. In order to achieve this as a part of the financial review process, most opinions will be reviewed in detail by the Department's actuarial staff members. The review should encompass procedures discussed in the next section covering the Actuarial Opinion Assessment for the SAO. Although the analysis of the SAO, Actuarial Memorandum and RAAIS are often performed by the actuarial staff, analysts should have a basic understanding of interest rate risk and should consider reviewing the RAAIS and the New York 7, if available (see below for further discussion), or other stochastic testing results and discussing such results with the Department's actuary. When risks are identified in the RAAIS or actuarial memorandum, the analysts, examiners, and regulatory actuaries should communicate with each other the risk identified so that an overall understanding of the current and prospective risks of the insurer are documented and considered in the overall prioritization and profile of the insurer.

However, if the Annual Financial Statement is received, a cursory review of the opinion should be performed to identify if any extraordinary item is detailed in the opinion. The primary goal of the Actuarial Opinion Assessment Procedures for the SAO is to determine if a SAO was to be filed and, if so, was it received and available for later review.

All life insurers must file an SAO including an asset adequacy analysis unless granted an exemption of such analysis based on doing business only in one state.

An actuarial memorandum, which supports the findings expressed in the SAO, is available upon request by the regulator. The insurer will also file with the commissioner by March 15 a confidential RAAIS.

If the insurer presently issues or has in-force policies that contain non-guaranteed elements, then a Non-guaranteed Elements Actuarial Opinion must also be filed. Other opinions may be required. For example, for business subject to an actuarial guideline—such as *Actuarial Guideline XXXV—The Application of the Commissioners Annuity Reserve Method to Equity Indexed Annuities* (AG 35) or XXXVI, which includes an opinion requirement, a compliant actuarial opinion must also be filed. The domestic insurance regulator should be familiar with all of the opinions each life insurer is required to submit. Reviewing the previous year's checklist is useful, but the state insurance regulator should be aware of new policy forms issued during the year that may add additional opinion requirements.

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Asset Adequacy Analysis

Asset adequacy analysis is a process the appointed actuary uses to ascertain that the assets supporting a block of liabilities, along with future premium payments and investment income, are adequate under moderately adverse conditions to pay future expenses and policy obligations. This analysis may include cash flow testing, gross premium valuations, demonstrations of extreme conservatism, risk theory techniques, or loss ratio methods. Prior to 2001, requirements similar to the AOMR specified seven scenarios for cash flow testing (commonly referred to as the New York 7). Amendments adopted in 2001 removed those required scenarios and allowed the appointed actuary to determine the scenarios to use for cash flow testing.

The asset adequacy analysis is testing the adequacy of the reserves on a block of business as of a valuation date, not the solvency of the company. Typically, cash flow testing includes assets approximately equal to the reserves and therefore does not include assets equal to the surplus. In addition, future new business is not included in the cash flow testing.

The asset adequacy analysis typically includes approximately 95% of the total of life insurance reserves, annuity reserves and reserves for deposit-type contracts. This 95% threshold is included in *procedure #4,* but it is a recommendation, and the standard of materiality may vary among actuaries and among state regulators.

Actuarial Guideline 53

Beginning with annual 2022, certain insurers will be required to document support for asset adequacy analysis for high-yielding complex assets pursuant to *Actuarial Guideline 53 – Application of the Valuation Manual for Testing of Adequacy of Life Insurer Reserves (AG-53)*.

As noted in AG-53, "regulators have observed a lack of uniform practice in the implementation of asset adequacy analysis. The variety of practice in incorporating the risk of complex assets into testing does not provide regulators comfort as to reserve adequacy. Examples of complex assets are structured securities, including asset-backed securities and collateralized loan obligations, as well as assets originated by the company or an affiliated or contracted entity. An initial increase in this activity has been noted in support of general account annuity blocks; however, recent activity was noted in other life insurer blocks. AG-53 is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for asset adequacy analysis performed by life insurers."

This Guideline applies to a limited scope of life insurers, specifically those with:

A. Over $5 billion of general account actuarial reserves (from Exhibits 5, 6, 7, and 8 of the Annual Statement) and non-unitized separate account assets; or,

B. Over $100 million of general account actuarial reserves (from Exhibits 5, 6, 7, and 8 of the Annual Statement) and non-unitized separate account assets and over 5% of supporting assets (selected for asset adequacy analysis) in the category of Projected High Net Yield Assets, as defined in Section 3.F. of the AG-53.

The NAIC Life Actuarial (A) Task Force has developed a template for reporting of AG-53 documentation. The templates include reporting by asset classes, affiliated vs. non-affiliated, and initial assets vs. reinvestment assets. The template along with a narrative are submitted for the filing.

The NAIC Valuation Analysis Working Group (VAWG) anticipates conducting reviews of AG-53 filings and can serve as a resource for state insurance departments for their own AG-53 reviews.

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Actuarial Guideline 55

Beginning with annual 2025, certain insurers will be required to document support for asset adequacy analysis for the assets that support reinsurance transactions pursuant to *Actuarial Guideline LV—Application of the Valuation Manual for Testing the Adequacy of Reserves Related to Certain Life Reinsurance Treaties (AG 55)*.

As stated in AG55, the reporting provides information for the analyst "to better understand the amount of reserves and type of assets supporting long duration insurance business that relies substantially on asset returns. In particular, there is risk that domestic life insurers may enter into reinsurance transactions that materially lower the amount of reserves and thereby facilitate releases of reserves that prejudice the interests of their policyholders. The goal of this Guideline is to enhance reserve adequacy requirements for life insurance companies by requiring that asset adequacy analysis use a cash flow testing methodology that evaluates ceded reinsurance as an integral component of asset-intensive business."

This Guideline applies to all life insurers with asset intensive reinsurance transactions exceeding certain amount of reserve credit plus modified coinsurance reserves (see AG 55 for specific scope limits).

The AG 55 documentation, sensitivity test results, and attribution analysis referenced within AG 55 are to be incorporated as a separate, easily identifiable section of the actuarial memorandum required by VM-30 or as a standalone document, with a due date of April 1 following the applicable valuation date. Similar memorandum may also be allowed under certain circumstances.

The NAIC Valuation Analysis Working Group (VAWG) anticipates conducting reviews of AG-55 asset adequacy analysis filings, on a targeted basis, and coordinating with states as appropriate. VAWG will serve as a resource for state insurance departments for their own AG-55 reviews as well as providing periodic reports identifying outliers and concerns regarding the analysis to help inform regulators about the effectiveness of this Guideline in meeting the objectives.

LIFE RESERVING RISK ASSESSMENT (INCLUDING PRINCIPLE-BASED RESERVING) OVERVIEW

Life insurance reserves represent the liability established by the insurance company to pay future policy benefits such as death benefits upon the death of the insured, endowment benefits upon the maturity of a life insurance policy and cash surrender benefits upon the surrender of the life insurance policy. Historically, the company's liability to pay future policy benefits has been determined by calculating a reserve based on a formula valuation methodology as described below. Life insurance products have evolved over time. Today, such products may be quite complex, offering multiple benefits and/or options to the policyowner or the insured or both the policyowner and the insured within a single contract such as death benefits, accelerated death benefits, secondary guarantees such as no lapse guarantees, policy loans, retirement income benefits such as guaranteed lifetime income benefits, and long-term care (LTC) benefits. The value of some of these complex benefits depends upon the current and future market value of the underlying assets. State insurance regulators have found it increasingly difficult to define or modify a formula-based valuation methodology to value all the options and/or benefits in a single contract. This complexity of current insurance products, along with the fact that the value of certain benefits depends upon the current and future market value of underlying assets, has led to the development of a principle-based valuation methodology that incorporates the value of both asset and liability cash flows. The principle-based valuation methodology is described below.

To implement the principle-based valuation methodology, amendments to the Standard Valuation Law were adopted in 2009, and a *Valuation Manual* was developed. The *Valuation Manual*, which is referred to in the amended Standard Valuation Law, provides reserve requirements for life, health and annuity products issued on and after the manual's operative date. Requirements include all of the details of the methodology for determining

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a principle-based reserve (PBR), as well as any changes to the formula-based valuation methodology that occurs on and after the operative date of the *Valuation Manual*.

Unless a change in the *Valuation Manual* specifies a later effective date, changes to the *Valuation Manual* shall be effective Jan. 1 following the date when the change to the *Valuation Manual* has been adopted by the NAIC by an affirmative vote of at least three-fourths of the members of the NAIC voting but not less than a majority of the total membership and such members voting in the affirmative represent jurisdictions totaling greater than 75% of the direct premiums written as reported in the most recent life, A&H annual statements; health annual statements; or fraternal annual statements. No state legislative adoption is needed to effect changes to the valuation manual.

The *Valuation Manual* defines the insurance contracts that are subject to a principle-based valuation (Section II). Unless otherwise specified in Section II, the principle-based valuation methodology will apply to life insurance contracts issued on and after the operative date of the *Valuation Manual*. However, a company may elect to defer the implementation of the principle-based valuation methodology to life insurance contracts issued during the first three years following the operative date of the *Valuation Manual*.

The Valuation Analysis (E) Working Group consisting of state insurance regulators with expertise in actuarial, financial analysis and examination experience reports to the Financial Condition (E) Committee and supports the states in the review of PBR to ensure consistent implementation and application of the methodology. The Working Group will also suggest necessary changes to the *Valuation Manual* to enhance clarification and interpretation of application of the principle-based valuation methodology.

The NAIC will acquire modeling software and develop actuarial staff expertise in modeling insurance cash flows to assist the Valuation Analysis (E) Working Group and the individual states in conducting analysis and examinations to verify the PBR and exclusion test calculations performed by the company.

As mentioned in the procedures, any questions or requests for assistance regarding PBR and for asset adequacy analysis may be made to the NAIC actuarial resources. Please see the NAIC website for the Valuation Analysis (E) Working Group for contact information regarding the use of NAIC actuarial resources and use of the Working Group if needed.

FORMULA-BASED VALUATION METHODOLOGY

Theoretically, the formula-based reserves represent the present value of future guaranteed benefits reduced by the present value of expected future net premiums. The insurance policy is a unilateral contract whereby the insured can cancel the agreement to pay premiums at any time. However, the insurer is “locked in” regardless of future experience and cannot forfeit on its guarantees as long as the premiums are paid. Life reserves are required in order to ensure that commitments made to policyholders and their beneficiaries will be met, even though the obligations may not be due for many years. Since the primary purpose of life reserves is to pay claims when they become due, life reserves must be adequate, and the funds must be safely invested.

The *Valuation Manual* prescribes the minimum standards to be used in determining the formula-based reserves as applicable in addition to PBR as discussed elsewhere in this document. Currently for most formula-based reserves, the manual refers to requirements in the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual). Insurers may establish life reserves, which equal or exceed these minimum standards. These minimum life reserve standards specify a: 1) valuation mortality table; 2) maximum valuation rate of interest; and 3) valuation method. The valuation method used to define minimum life reserves for statutory accounting purposes is referred to as the Commissioners Reserve Valuation Method (CRVM). The mortality rate assumptions are substantially higher than what the insurer can expect to realize from medically underwritten insurance policies. The interest rate assumptions are intended to be significantly lower than current money and capital market yields. Thus, the life reserves developed are generally conservative.

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There are three general valuation methods under a formula-based valuation methodology used to value life reserves. The net level premium method does not provide for a first-year acquisition cost allowance in determining life reserves. Therefore, this method results in the most conservative, or highest, life reserve valuation of the three methods. The full preliminary term method does provide a first-year expense allowance and then assumes that the remaining premium stream is used to cover policy benefits. The CRVM is a form of the full preliminary method. This method allows for a lower life reserve valuation than the net level premium method in the earlier years of the policy term. The modified preliminary term method is a variation of the two methods described above and results in a reserve valuation between the net level premium and preliminary term methods.

As described below, the type of life insurance policy dictates the amount of the life reserve that must be established and the duration for maintaining the reserve. In addition, special situations arise which require unique reserving techniques. The following summarizes the major types of life insurance policies, and the related reserving implications under a formula-based valuation methodology:

1. **Ordinary Life Reserves**

   Under a whole life plan of insurance, the insurer is obligated to maintain a reserve until the death of the insured. Term life insurance provides coverage only for the period that is specified in the policy. Under a term insurance plan, the insurer must maintain a reserve, which reduces to zero upon expiration of the term period. Similar to term insurance, endowment life insurance provides coverage for a period specified in the policies. Unlike term insurance, the proceeds of endowment insurance are payable if the insured lives to the end of the period. Policies which permit flexible premium payments, are referred to as “universal life” policies and those with fixed premiums are referred to as “interest sensitive” policies. Universal life policies are accumulation type policies where the current account value is determined based upon the accumulation of premiums, less mortality charges and expense charges, plus a current interest rate credit. The account value less surrender charges is the cash value. Because of the unique features of universal life and interest sensitive types of policies, unique reserving requirements are specified for them in Appendix A-585, *Universal Life Insurance*, of the AP&P Manual. The minimum standard for universal life reserves considers guarantees within the policy at the time of issue, present value of future guaranteed benefits, account value and cash value.

2. **Group Life Reserves**

   Most group life insurance is monthly renewable term insurance. For these policies, gross premiums are typically recalculated periodically, most often annually, using the age and sex census of the group along with experience adjustments. Therefore, the reserve is usually calculated as the unearned premiums or a percentage thereof to estimate the claim exposure. However, some group life insurance policies provide permanent or longer-term benefits analogous to individual coverages. In these cases, the reserving methods are similar to those employed for individual insurance, using appropriate mortality tables. Appendix A-820 does not specify a mortality table for group life insurance but leaves that to the discretion and approval of the domiciliary state.

3. **Industrial Life Reserves**

   Industrial life insurance is unique in that it involves higher unit premiums, smaller face amount policies and higher mortality expectations. The minimum standards for reserves are the same as the traditional life insurance except that a unique mortality table is used.

4. **Life Reserves Relating to Riders**

   Life insurance policies frequently include riders for additional benefits such as accidental death and disability and waiver of premium upon disability. The minimum valuation standards for reserves are the same as for the base life insurance except that specialized mortality and disability tables are used, and the net level premium valuation method is required.

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5. **Miscellaneous Life Reserves**

   There are various other special situations involving life reserves. First, a deficiency reserve may be required in situations where the actual policy gross premium is less than the valuation net level premium. This situation occurs when pricing assumptions are used that are different from the minimum reserve valuation standards. This does not necessarily indicate that the policy is being sold at a loss by the insurer but rather is a reflection of the highly conservative nature of the minimum reserve valuation standards. Second, there may be unusual situations where the cash surrender value of a life insurance policy is greater than the minimum reserve standard. In these situations, life reserves must be increased by the amount of this excess.

6. **Minimum Aggregate Reserves**

   In the aggregate, policy reserves for all life insurance policies valued under a formula-based valuation methodology that are reported in the statutory financial statements must equal or exceed reserves calculated by using the assumption and methods that produce the minimum formula standard valuation.

PRINCIPLE-BASED VALUATION METHODOLOGY

In general, under a principle-based valuation methodology, all of the liability cash flows emanating from the contract benefits provided in the product are determined for each period and compared with all of the asset cash flows for each period determined from the assets the insurance company has purchased or plans to purchase or sell to fund the liability cash flows. The resulting differences between the asset and liability cash flows for each period are valued under a range of likely or plausible economic scenarios. Economic scenarios may consist of interest rates or market returns or both depending on the nature of the asset and liability cash flows. A single economic scenario represents multiple consecutive periods (such as 30 or 40 years) of movements in the underlying interest rate or market rate returns. The length of the scenario period is determined by the length of the liabilities being valued. The economic scenarios are stochastically (randomly) generated using a prescribed economic scenario generator (ESG). The prescribed ESG can be found on the Society of Actuaries (SOA) website.

The reserve liability under a principle-based valuation methodology is determined as a function of the discounted value of the differences between the asset and liability cash flows for each period over the range of economic scenarios. The objective is to determine if there is a reasonable likelihood that assets are insufficient to cover the obligations of the company, and by what amount they may be insufficient. Under economic scenarios where assets are insufficient, the principle-based methodology determines all the amounts of the insufficiencies and discounts them back to the valuation date. The largest discounted value is known as the Greatest Present Value of Accumulated Deficiencies (GPVAD) for that scenario. The stochastic reserves may be set at a CTE (70) level (conditional tail expectation at the 70% level). The function CTE (70) means the average of the 30% (100% - 70%) worst (largest) GPVADs. So, for example, if a company randomly generates 1,000 economic scenarios, it would then determine the largest accumulated amount of deficiency for each of the 1,000 scenarios. The CTE (70) stochastic reserve (SR) level would be determined by taking the average of the 300 [1,000 x (100% - 70%)] worst GPVADs out of the 1,000 scenarios.

The principle-based valuation methodology developed for life insurance contracts defines three components of a PBR: 1) a net premium reserve (NPR); 2) a deterministic reserve (DR); and 3) an SR. The level of risk embedded in a life insurance contract will determine whether the PBR will consist of all three reserve components (NPR, DR, SR), only two reserve components (NPR, DR), or only one reserve component (NPR). The principle-based valuation methodology defines a stochastic exclusion test and a deterministic exclusion test, each of which are designed to measure the level of risk embedded in a life insurance contract. Life insurance contracts that pass an exclusion test are then exempt from the calculation of the associated PBR component. For example, all life insurance contracts that pass the stochastic exclusion test but fail the deterministic exclusion test must calculate the NPR and DR components. Life insurance contracts that pass both the stochastic and deterministic exclusion tests must only calculate the NPR component. For groups of policies other than variable life or universal life with a secondary

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guarantee (ULSG), a company may provide a certification by a qualified actuary that the group of policies is not subject to material interest rate risk or asset return volatility risk in lieu of performing the stochastic exclusion test. In addition, a company is not required to compute SR and DR on any of its ordinary life policies if it meets the requirements for a "Companywide Exemption" provided in Section II of the *Valuation Manual*. If the domestic commissioner does not reject a company's application for the companywide exemption pursuant to the *Valuation Manual*, Section II, then the company will compute reserves for its ordinary life policies per the requirements provided in VM-A and VM-C of the *Valuation Manual*.

Note that some states incorporated a "companywide exemption" in the Standard Valuation Law that may override Section II of the VM-20, Requirements for Principle-Based Reserves for Life Products. In such cases, the state's Standard Valuation Law will determine whether a company is not subject to computing the stochastic and deterministic reserves. Note also, the insurance commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in a single state as defined in Section 15 of the amended Standard Valuation Law.

As part of the calculation process, the principle-based valuation methodology allows companies to aggregate or group policies with similar risk characteristics. For example, all term policies that provide only a death benefit and do not provide any cash surrender values may be grouped together by underwriting class. The exclusion tests are then applied on a group or aggregated basis and not a contract-by-contract basis. Also, the DR and the SR are calculated on an aggregated or group basis. The NPR component is a fully prescribed formula-based reserve and can be applied on a contract-by-contract basis.

The annual statement blank contains a VM-20 Supplement. This supplement breaks out the PBR into its various components of NPR, DR and SR. State insurance regulators may request the assistance of NAIC modeling staff and or the Valuation Analysis (E) Working Group in verifying exclusion testing, as well as various components of the PBR on a smaller sample set of company contracts.

ACTUARIAL OPINION AND ASSET ADEQUACY ANALYSIS

Due to the complexity in determining life reserves, insurers must rely on actuaries to assist with valuation of these reserves. Insurers are required to annually obtain an opinion regarding the reasonableness of the reserves by a qualified actuary who is appointed by the company. The actuarial opinion requirements are provided in VM-30 of the *Valuation Manual*. These requirements also include requirements for asset adequacy analysis. As a result of the asset adequacy analysis conducted by the appointed actuary, the actuary may conclude that the insurer's assets are not adequate to cover future liabilities as valued by the calculated reserves. When this occurs, reserves must be increased by the estimated deficiency resulting from asset adequacy testing. Additional procedures regarding the SAO are found in Section III.B.8.d.

ACCIDENT AND HEALTH RESERVING RISK ASSESSMENT OVERVIEW

The purpose of A&H insurance is to protect the insured against economic losses resulting from accident and/or sickness. There are many different types of A&H policies issued by insurers. The economic losses covered, and the types of benefits provided, vary with the different types of A&H policies. For example, a medical insurance policy may provide reimbursement for hospital, surgical, medical and drug expenses and a dental insurance policy may cover dental expenses. Another type of A&H insurance policy issued is disability insurance which provides monthly benefits for loss of income due to disability on either a short-term or long-term basis. A&H insurance is provided through individual policies, group policies and certain special types of policies such as credit disability insurance.

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A&H reserves are complex and difficult to analyze because of the wide variety of types of coverage included in the A&H lines of business and the diversity of benefits which must be reserved for. A&H reserves are comprised of two separate liability line items in the Annual Financial Statement: 1) the aggregate reserve for A&H policies; and 2) the A&H policy and contract claims liability. These liabilities are discussed in more detail below.

1. **Aggregate Reserve for A&H Policies**

   The aggregate reserve for A&H policies consists of two different components: 1) policy reserves; and 2) claim reserves.

   a. **Policy Reserves**

      Policy reserves are required in recognition of the fact that premiums cover future liabilities as well as current claims and expenses. Policy reserves include unearned premium reserves, additional contract and actuarial reserves, reserves for future contingent benefits, and reserves for rate credits. The various types of policy reserves are discussed in more detail below.

      Unearned premium reserves represent the amount of the premium applicable to coverage which extends beyond the valuation date (date of the statement). The unearned portion of the premium is generally computed on a pro rata basis.

      Additional contract reserves are required for those policies with level premiums where the risk of loss increases with the age of the insured. For these policies, the insurer is required to set aside a portion of the current premium to pay claims that experience indicates will be incurred as the policy continues in force. These reserves are actuarially determined and are similar in concept to life reserves with the added requirement to consider morbidity assumptions as well as mortality and interest assumptions. The NAIC AP&P Manual prescribes the minimum standards used in determining the A&H policy reserves. Insurers may establish A&H policy reserves which equal or exceed these minimum standards. These minimum A&H policy reserve standards for most types of A&H insurance include: 1) a given morbidity table; 2) a maximum rate of interest; and 3) a valuation method. In no event, however, may the aggregate reserve for all policies be less than the unearned gross premiums under such policies. For financial statement purposes, the additional contract reserves represent the excess of the required A&H policy reserves over the unearned gross premiums on A&H policies. The insurer is required to attach to the Annual Financial Statement a description of the valuation standards used in calculating the additional contract reserves, specifying the reserve bases, interest rates, and methods.

      Determine if additional actuarial reserves are required as a result of actuarial cash flow testing and asset adequacy analysis.

      If the A&H policy provides for future contingent benefits, a portion of the current premium must also be reserved for such coverage. For example, some A&H policies provide for deferred maternity benefits (which cover medical expenses incurred in childbirth for approximately nine months after the cessation of premium payments, even though the policy has been canceled, so long as conception occurred prior to the policy being canceled). An actuarially determined estimate of the costs associated with this future contingent benefit must be reserved for out of the current premium.

      Some A&H policies provide for rate refunds based on policy year experience. For these policies, a reserve is required to be established for the rate credits based on the amount of the expected credit as of the valuation date. The reserve for rate credits is a difficult liability to establish because many policy years do not end on the valuation date (date of the statement), and subsequent experience may cause the rate credit to be greater or less than the liability established. However, the liability established must be reasonable under the circumstances and consistently calculated.

   b. **Claim Reserves**

      Claim reserves (sometimes referred to as disabled life reserves) are required for claims which involve continuing loss. The claim reserves represent the actuarially determined present value of future benefits

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or future covered benefits not yet due as of the valuation date (date of the statement) which are expected to arise under claims which have been incurred as of the statement date. However, although the liability for future covered benefits which are expected to arise under claims which have been incurred as of the statement date on medical insurance policies should be included in claim reserves according to *Statement of Statutory Accounting Principles* (*SSAP) No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*, some insurers include this liability in the A&H policy and contract claims liability which is discussed below.

2. **A&H Policy and Contract Claims Liability**

The A&H policy and contract claims liability includes: 1) due and unpaid claims; 2) claims in the course of settlement; and 3) incurred but not reported (IBNR) claims.

a. **Due and Unpaid Claims**

Due and unpaid claims are those which are complete except for the payment of the amount due. The amount of an insurer's due and unpaid claims is generally very small, and this liability is generally determined on an exact inventory basis of claims ready to be paid.

b. **Claims in the Course of Settlement**

Claims in the course of settlement include claims which have not been paid because all of the required information has not yet been received as of the statement date, resisted claims and the accrued portion (amount that is payable as of the statement date) of the next periodic payment on disability claims. The unaccrued portion of the next periodic payment on disability claims would be included in claim reserves discussed above. The liability for claims in the course of settlement, other than disability claims, may be determined based on estimates for each outstanding claim or the development of average claim factors or formulas based on historical experience.

c. **IBNR Claims**

IBNR claims are those claims which have occurred but have not yet been reported to the insurer. Since neither the number nor dollar amount of IBNR claims are known as of the statement date, the liability for IBNR claims is difficult to estimate. The liability for IBNR claims is generally estimated based on an actuarial analysis of past experience or on the development of lag studies using historical experience.

Due to the variety of types of A&H policies issued and the complexity of determining the aggregate reserve for A&H policies and the A&H policy and contract claims liability, most insurers rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some insurers do not use actuaries to actually set the A&H reserves, insurers are required to annually obtain an opinion regarding the reasonableness of the established A&H reserves by a qualified actuary. Therefore, qualified actuaries are involved in setting and/or reviewing the A&H reserve liabilities established for virtually all insurers.

ANNUITY RESERVING ASSESSMENT OVERVIEW

Annuity reserves represent the liability established by the insurer to pay future policy benefits. While life insurance provides protection from the loss arising from dying too soon, an annuity protects against the loss from living too long. Theoretically, annuity reserves represent the present value of future guaranteed benefits reduced by the present value of expected future net premiums. An annuity can be in either an accumulation mode or a payout mode. Annuity policies take three forms: 1) annual premium deferred annuity; 2) single premium deferred annuity; and 3) single premium immediate annuity. Under an annual premium deferred annuity, annual premiums are paid during an accumulation period until such time as the policyholder (i.e., annuitant) receives income, surrenders the policy, or it terminates upon death. These annual premiums may be a specified amount or subject to the discretion of the owner under "flexible premium" annuities. Even if premiums are discontinued, the cash value of the policy will continue to accumulate until income is elected or the policy is otherwise terminated for its

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value. At income commencement, the annuitant receives the monthly income based upon cash value of the policy at that time and the annuity factor guaranteed in the policy or currently being applied, if more favorable, for the annuitant's attained age. The single premium deferred annuity also accumulates until such time as the annuitant desires to take income or the policy is otherwise terminated. However, only a single premium is paid at the time the annuity is purchased.

The AP&P Manual prescribes the minimum standards to be used in determining reserves. Appendix A-820*, Minimum Life & Annuity Reserve Standards* of the AP&P Manual defines the minimum standards for all types of policy reserves, including life & annuity policies. Insurers may establish annuity reserves, which equal or exceed these minimum standards. These minimum annuity reserve standards specify a: 1) given mortality table (if applicable); 2) maximum rate of interest; and 3) valuation method. The valuation method used to define minimum annuity reserves for statutory accounting purposes is referred to as the Commissioners Annuity Reserve Valuation Method (CARVM). The mortality rate assumptions, if applicable, are substantially lower than what the insurer can expect to realize from medically underwritten insurance policies. The interest rate assumptions are intended to be significantly lower than current money and capital market yields. Thus, the annuity reserves developed are generally conservative.

As described below, the type of annuity dictates the amount of the annuity reserve that must be established and the duration for maintaining the reserve. In addition, special situations arise that require unique reserving techniques. The following summarizes the major types of annuities and the related reserving implications:

1. **Deferred Annuities (Annual Premium and Single Premium)**

   All deferred annuities are reserved using the CARVM method. The reserve on any specific valuation date requires a calculation of the present value of future guaranteed benefits less the present value of future required net premiums for the current duration of the policy and for each future duration. For purposes of calculating this series of "excesses," premiums are only considered to be payable for the specific duration for which the excess is being calculated. The reserve is the greatest of these excesses. Reserves for guaranteed benefits must consider all contractual guarantees including cash values, death benefits, annuity income, etc. Cash values are actually guaranteed under the policy provisions.

2. **Immediate Annuities**

   Immediate annuities are those that are in payout mode. Reserves are determined using the CARVM method, except that, in the case of supplemental contracts without life contingencies, mortality tables are not used.

3. **Guaranteed Interest Contracts**

   Guaranteed interest contracts (GICs) represent a type of funding vehicle used where group deferred annuities are involved. Under a basic GIC, the insurer accepts a single deposit from the plan sponsor (i.e., the employer) for a specified period of time, such as five years. Interest earned during the period may accumulate until the period expires, or the earned interest may be paid out annually. At the end of the period, the account balance, including any accumulated interest, is returned to the plan sponsor. Numerous variations of this basic guaranteed interest contract have been developed that: 1) allow the plan sponsor to make monthly contributions rather than the single deposit; and 2) provide that the principal and interest can be paid out in installments to make benefit payments to plan participants.

4. **Structured Settlements**

   Structured settlements are a form of immediate annuity generally established in connection with the settlement of a property/casualty claim wherein a predetermined future benefit stream is desired. Reserves are determined using the CARVM method with special actuarial guidelines that prescribe specialized mortality tables and govern the use of lump sum balloon payments.

5. **Variable Annuities**

   Variable annuities are annuities where the amount of each benefit payment is not specified in the annuity contract but rather fluctuates according to the earnings of a separate account fund. The primary concern

relating to variable annuities reserves relates to the treatment of the CARVM expense allowance in the general account. The CARVM method is generally used, but the current thinking is that CARVM may not be appropriate for certain types of variable annuities that do not include guaranteed benefits.

Due to the complexity in determining annuity reserves, insurers must rely on actuaries to assist with valuation of these reserves. Insurers are required to annually obtain an opinion regarding the reasonableness of the reserves by a qualified actuary. In the aggregate, policy reserves for all annuity policies that are reported in the statutory financial statements must equal or exceed reserves calculated by using the assumptions and methods that produce the minimum standard valuation.

LONG-TERM CARE INSURANCE (LTCI) OVERVIEW

"Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital[1]. Historically, insurers that wrote LTCI encountered difficulties accurately projecting claims costs, lapse rates, investment returns, and other factors associated with LTCI, and subsequently many writers have experienced unprofitability in older (legacy) blocks of LTCI business. This has led many companies to request significant rate increases, modify product benefits or exit the product line altogether. Therefore, many insurers continue to experience significant solvency challenges related to this line of business, and state insurance regulators should continue to carefully evaluate and monitor the solvency position of all insurers with a material amount of LTCI business.

These same risks also affect reinsurers because the reinsurance contract may not arbitrarily allow for ceded premium increases. Additionally, in order to effectuate a true transfer of risk, the reinsurer may not have the ability to require the direct writer to request rate increases. As some insurers look for avenues to minimize or eliminate its risk from the LTCI block, they may look to new reinsurance opportunities or nontraditional buyers.

In addition, periods of economic downturn and low interest rates increase the risk that LTCI writers will be challenged to generate sufficient returns to support this line. In addition, declines in projected investment returns could have a significant impact on LTCI reserve assumptions.

Actuarial Guideline 51

Effective for reserves reported with the Dec. 31, 2017, financial statement, Actuarial Guideline 51—*The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) now applies. The *Health Insurance Reserves Model Regulation* (#10) and the *Valuation Manual* VM-25, Health Insurance Reserves Minimum Reserve Requirements, contain requirements for the calculation of LTCI reserves. AG 51 requires companies with more than 10,000 LTCI enrollees to submit stand-alone LTCI asset adequacy analyses to the state. AG 51 is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to a company's LTCI block of contracts. AG 51 requires reporting to the department within the appointed actuary's actuarial memorandum required by VM-30 or in a special actuarial memorandum containing LTCI-specific information on the results of the analysis, assumptions on mortality, voluntary lapse, morbidity, investment returns and rate increase assumptions.

[1] Definition per *Long-term Care Insurance Model Act* (#640) Section 4.A.

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Factors Affecting LTCI Reserves and Rates

This following guidance provides additional information that may assist state insurance department staff in understanding the differences in premium rate review and approval, and valuation review of reserve adequacy assumptions in order to maintain or improve state insurance departments' current intra-departmental coordination/communication practices between the states' rate reviewers, valuation actuaries and analysts/ examiners.

Reserve Increase Factors

1. **Background**

   Ever since asset adequacy testing became a requirement for life insurers in the 1980s, actuaries have been required to analyze reserve adequacy assumptions on an annual basis and make the assumptions more conservative when experience or expectations become more adverse. If the result of the more conservative assumptions was inadequate reserves, companies have been required to establish higher reserves to ensure future claims could be paid in a more adverse environment.

   In some cases, the chain of events is straightforward. For instance, for life insurance, if more people die at earlier ages than expected and the experience is highly credible, then the actuary increases mortality rates in the upcoming year-end filing, leading to higher reserves being established.

   In other cases, the chain of events is less straightforward. For instance, it is expected that cash surrenders on deferred annuity products will increase if interest rates rise. However, most deferred annuities have been sold during a period of decreasing interest rates. Actuarial and regulatory practice require reserves to be adequate in moderately adverse conditions, even if those conditions have not been recently experienced. There is typically judgment by the company actuary and another layer of judgment by regulators in play in this type of complex situation. The *Standard Valuation Law* (#820), the *Valuation Manual* and the Actuarial Standards Board's (ASB's) Actuarial Standards of Practice (ASOPs) describe how these complex situations should be handled.

2. **Long-Term Care Insurance**

   For LTCI blocks of business that experience higher morbidity than expected, this experience will likely lead to changes in expectations on future morbidity for both the observed block and other blocks.

   With LTCI, some factors are likely to play out in a straightforward manner. A combination of higher life expectancy and lower lapses will lead to more people than expected reaching prime LTCI claims ages of 80 and above, which leads to companies holding higher reserves than originally anticipated. Similarly, all companies have experienced the decreasing interest rate environment, which has led to lower-than-expected investment returns and the need to hold higher reserves because investment income is relied upon to help pay claims.

   Mortality, lapse, and interest rate factors become observable and can develop credibility during the premium-paying years prior to policy years when significant claims tend to occur.

3. **Morbidity Assumptions**

   Morbidity, however, has tended to fall into the category of a complex factor. The three main aspects of LTCI morbidity are: 1) incidence, the percentage of people at a given age who start a claim; 2) average length of claim; and 3) utilization, which is less than 100% if, e.g., the daily nursing home cost is lower than the maximum daily benefit in the insurance policy.

   There has not been uniform experience development in morbidity, except that length of claim has tended to increase, likely because cognitive (e.g., dementia and Alzheimer's disease) claims tend to be longer than average and incidence has been higher than expected, likely due to more people reaching the age when cognitive claims tend to occur.

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Because of divergent experience among companies and because morbidity becomes observable and credible during the later claim-paying years, establishing and regulating LTCI morbidity assumptions has not been straightforward. However, as with other factors and other products, the handling of these situations is addressed in Model #820, *Valuation Manual* and ASOPs. Examples of these standards include:

- Model #820 Section 12A(3)(a): "Assumptions shall, to the extent that company data is not available, relevant or statistically credible, be established using other relevant, statistically credible experience."
- Model #820 Section 12A(4): "Provide margins for uncertainty … such that the greater uncertainty, the larger the margin and resulting reserve."
- AG 51 (providing guidance on VM-30) Section 4.B.: "The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks. Material assumptions associated with the LTCI business shall be determined testing moderately adverse deviations in actuarial assumptions."
- *Acounting Practices and Procedures Manual* (AP&P Manual), Appendix A-010 paragraph 48.e (referenced in VM-30): "The total contract reserve established shall incorporate provisions for moderately adverse deviations."
- AP&P Manual, Appendix A-010 paragraph 51 (referenced in VM-30): "Annually, an appropriate review shall be made of the insurer's prospective contract liabilities … and appropriate increments … if such tests indicate that the basis of such reserves is no longer adequate."

The result is that whether credible experience exists or not, the company actuary needs to set assumptions underlying reserves, and the factors underlying the assumptions are often complex and frequently changing. Company and regulatory actuaries are experienced in working in this complex, changing environment with many life insurer products, such as variable annuities, indexed products and LTCI having product features and factors underlying reserves that are complex and changing.

4. **Rate Increases**

A unique aspect of LTCI products is being a long-term product with rate increases that require review by states. Besides states with the largest insurance departments, the actuaries reviewing LTCI reserves are often the same staff reviewing LTCI rate increases. For larger states, there is typically coordination or training to ensure the reserve and rate teams are on the same page regarding developments in, for example, life expectancy and morbidity. State insurance regulator experience in reviews of LTCI reserves and rate increase filings show that reserve increases and requests for rate increases are due to similar factors, including higher life expectancy, lower lapses, lower investment returns and worsened morbidity.

There has been additional regulatory attention on ensuring the companies asking for rate increases based on adversity of certain factors are holding reserves based on at least the same level of adversity in those factors. The questions used in many states' rate increase reviews require the company to explain the consistency between the rate increase filing assumptions and reserve adequacy assumptions.

To date, the most common complex, non-straightforward case is the applicability of a company's adverse morbidity experience of an older LTCI block to morbidity assumptions on a newer block. This complex dynamic comes into play when establishing reserve and rate increase assumptions.

The reserve assumption changes can occur with initiation by the company, through formal or informal agreement between regulators or companies, or by relying on Model #820 Section 11.6., which allows a commissioner to require a company to change reserve assumptions and adjust reserves.

Example:

A typical example of a chain of events would first involve a block issued in 1995 to 1998 to policyholders with issue ages ranging from 52 to 62. By 2019, enough policyholders have reached prime LTC claim ages of 80+. This experience is what drives reserve assumption changes. As policyholders enter ages in the

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upper 80s and 90s, additional experience will be attained that will predict future LTCI costs and result in further changes in reserve assumptions. The development of older-age morbidity experience is expected to generate volatility in LTCI reserves. For some companies, the older-age morbidity experience will likely be unfavorable, with increased reserves needed. For most other companies, the older-age morbidity experience will likely be as expected, leading to no significant, unforeseen reserve increases.

Companies will be expected to apply lessons learned from older blocks of business to their newer blocks. Those lessons will likely differ by situation. For example, to the extent underwriting is different, the newer and older blocks may experience different morbidity trends.

5. **Rate Increase Factors**

Factors affecting LTC reserves, including higher life expectancy, lower lapses, lower investment returns and changes in morbidity also potentially affect LTC rate increases.

If a company's reserve adequacy testing is dependent upon assumption of future LTC rate increases, the state insurance department staff performing reserve valuation should evaluate that assumption for reasonableness. The company's rate increase assumptions and documentation should be consistent with the requirements specified in AG 51 related to rate increase plans. The state insurance department staff performing reserve valuation may wish to coordinate and communicate with the state's rate review staff to help evaluate the appropriateness and reasonableness of the company's future rate increase assumption.

6. **Intra-Department Communication and Coordination of Actuarial Review Work**

While every state insurance department may be structured differently, many state insurance departments have the same staff members perform work on both LTCI reserve valuation analysis and rate increase reviews, while others have separate staff perform these functions. In the latter instance, department staff should be aware of or coordinate the intra-department review work related to each function.

The following are suggested steps a state may consider ensuring that actuarial assumptions associated with the rate increase request are consistent with the assumptions embedded in the asset adequacy testing.

- Inquire of the company's actuary or senior management regarding:
  - The relationship of the actuarial assumptions embedded in the rate filing versus those made for annual statement reporting.
  - Explanation if there is inconsistency between assumptions reported.
  - How AG 51 affects the company's rates and reserves.
  - Affirmation that the assumptions underlying the projections are consistent with the assumptions used in asset adequacy analysis.
  - A copy of the company's rate increase plan when rate increase filings disclose that future rate increase filings, beyond what is currently being requested, are planned.
- Consider reviews of different filings for consistency. For example:
  - Compare reserving assumptions to rate increase assumptions,
    - e.g., review the RAAIS and the Actuarial Opinion and Memorandum (AOM) to ensure that assumptions used for pricing and reserving are similar in nature.
  - Identify assumptions underlying the asset adequacy testing memorandum that appear to be an outlier and then compare against a subsequent rate increase filing.

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Reserving Risk: Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

Analysis Documentation: The Statement of Actuarial Opinion Worksheet is intended to provide procedures for reviewing the Actuarial Opinion and other actuarial filings for compliance and assessment of risks. In many states, the Actuarial Opinion and related filings are reviewed by actuarial staff. Whether the Statement of Actuarial Opinion (SAO) review is performed by the analyst or the actuary, the Worksheet provides for the results of the SAO review to be documented and communicated to the analyst. Analysts should document overall results of the actuarial opinion analysis and risk identified in Section III: Risk Assessment of the insurer within reserving risk or other relevant risk category.

Note that reserving risks also are included in the Reserving Risk Assessment.

Statement of Actuarial Opinion

1. Determine if the following were included in the SAO or otherwise provided.

	Comments
a. Does the SAO include a completed Table of Key Indicators?	
b. Does the SAO state the actuary's qualifications and affiliation?	
c. Was the actuary 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 SAO was rendered?	
d. Is this the same actuary who was appointed for the previous SAO? i. If "no", did the health entity notify the domiciliary state insurance regulator within 5 business days of the replacement? (When reviewing compliance with Section 1, note that the publication of the changes to the Health SAO Annual Statement Instructions in September 2009 may impact the timeliness of notification and compliance.) ii. Within 10 business days of the above notification, did the health entity also provide an additional letter stating whether or not there were any disagreements with the former actuary during the preceding 24 months and also in writing requested the former actuary provide a letter of agreement? iii. Did the company provide the responsive letter from the replaced actuary?	
e. Do the reserve amounts included in the SAO agree with the amounts per the Annual Financial Statement?	
f. If the Appointed Actuary has not examined the underlying records and has relied upon the data prepared by the health entity or a third party, is there a certification letter attached to the SAO signed by the individual or firm who prepared such underlying data?	

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2. Determine if the following were included in the SAO regarding source data and prescribed items.

	Comments
a. The Health Annual Statement Instructions list A through I as prescribed items. If the following items are included in the Annual Financial Statement and required by the Annual Statement Instructions, does the SAO cover the following in the scope and opinion of amounts. Per Annual Statement Instruction: A. Claims unpaid (Page 3, Line 1); B. Accrued medical incentive pool and bonus payments (Page 3, Line 2); C. Unpaid claims adjustment expenses (Page 3, Line 3); D. Aggregate health policy reserves (Page 3, Line 4) including unearned premium reserves, premium deficiency reserves, and additional policy reserves from the Underwriting and Investment Exhibit – Part 2D; E. Aggregate life policy reserves (Page 3, Line 5); F. Property/casualty unearned premium reserves (Page 3, Line 6); G. Aggregate health claim reserves (Page 3, Line 7); H. Any other loss reserves, actuarial liabilities, or related items presented as liabilities in the annual statement; and I. Specified actuarial items presented as assets in the annual statement.	
b. Any examples of an item included in H above include the retrospective premium asset (Page 2, line 15.3). If any of the above are "no," identify item(s) that are missing.	

3. Does the SAO state the following:

	Comments
a. Does the SAO state: "In my opinion, the amounts carried in the balance sheet on account of the items identified above": i. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles? ii. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared? iii. Meet the requirements of the insurance laws and regulations of the state of domicile and are at least as great as the minimum aggregate amounts required by any state in which this statement is filed or are at least as great as the minimum aggregate amounts required by any state with the exception of the following states.	

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For each listed state a separate SAO was submitted to that state that complies with the requirements of that state? iv. Make good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements. v. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Statement of the preceding year-end? vi. Include appropriate provisions for all actuarial items that ought to be established.	
b. The Annual Financial Statement, Underwriting and Investment Exhibit – Part 2B was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice.	
c. Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this SAO.	

Asset Adequacy Analysis

4. Assess the Asset Adequacy Analysis. *[If an asset adequacy analysis was not required, do not proceed with the following procedures for asset adequacy analysis.]*

	Comments
a. If the SAO was based on an asset adequacy analysis: i. Did the actuary determine that the reserves were sufficient in light of the assets held to meet future policy obligations? ii. Based upon the judgment of the analyst and after reviewing the SAO and Regulatory Asset Adequacy Issues Summary, if available, should the actuarial memorandum or other supporting documentation be requested from the health entity? If "no," skip to the summary and conclusion.	

5. Assess the Actuarial Memorandum or other supporting documentation.

	Comments
Based on an asset adequacy analysis, does the actuarial memorandum or other supporting documentation include the following: a. For reserves: i. Product descriptions ii. Source of liability in-force iii. Reserve method and basis iv. Investment reserves v. Reinsurance arrangements	

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vi. Persistency of in-force business	
b. For assets (if the SAO is based on an asset adequacy analysis that involved the direct analysis of investments): i. Portfolio descriptions ii. Investment and disinvestment assumptions iii. Source of asset data iv. Asset valuation bases	
c. For analysis basis: i. Methodology ii. Rationale for inclusion/exclusion of different blocks of business and how pertinent risks were analyzed iii. Rationale for degree of rigor in analyzing different blocks of business iv. Criteria for determining asset adequacy v. Effect of federal income taxes, reinsurance and other relevant factors such as dividends, commissions, etc.	
d. Summary of results.	
e. Conclusions.	
f. A statement that the actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Actuarial Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for the memorandum.	
g. Method for aggregating reserves and assets.	

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RESERVING RISK: Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

The Reserving Risk Assessment is focused primarily on two key aspects of reserving: 1) reserve valuation and 2) reserve adequacy. Analysis of reserves relies heavily on the review of the Statement of Actuarial Opinion (SAO) and other related filings. In analyzing reserving risk, analysts may analyze specific types of reserves established by health entities, reserving methodologies and various aspects of health insurance that affect reserving. For example, an analyst's risk-focused assessment of reserving risk may consider the following areas (but not limited to):

- Reserve valuation in accordance with the appropriate valuation requirements
- Reasonableness of valuation bases utilized, testing, assumptions, and methodologies to determine reserves
- Adequacy of assets to support policyholder benefits
- Appropriate reporting of reserves
- Lines of business written by the insurer
- Types of reserves for health lines of business
- Reserve development
- Reinsurance
- Loss adjustment expenses (LAE)
- Claims adjudication

STATEMENT OF ACTUARIAL OPINION ASSESSMENT WORKSHEET

The Statement of Actuarial Opinion Worksheet is intended to provide procedures for reviewing the Actuarial Opinion and other actuarial filings for compliance and assessment of risks. In many states, actuarial staff review the Actuarial Opinion and related filings. Whether the analyst or the actuary performs the SAO review, the Worksheet provides for the results of the SAO review to be documented and communicated to the analyst.

Refer to the Overview section at the end of this chapter for more guidance on the SAO.

The SAO must be issued by the Appointed Actuary who is a qualified health actuary appointed by the board of directors. For purposes of the health SAO, the Health Annual Statement Instructions define a qualified health actuary as a member in good standing of the Academy or a person recognized by the Academy as qualified for such health actuarial valuation.

PROCEDURE #1A. Determine that the Table of Key Indicators has been completed. Note that within each section of the Table, only one box should be checked. Identify those sections of the SAO for which it may be appropriate to perform additional analysis, specifically when "Prescribed Wording with Additional Wording" or "Revised Wording" has been checked.

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PROCEDURES #1B–#1E. Determine that the SAO was prepared by a qualified actuary and that the reserve amounts agree with the Annual Financial Statement.

PROCEDURE #1F. Determine if the health entity's actuary, the health entity's accounting firm, or an officer of the health entity has verified the accuracy and completeness of source data.

PROCEDURES #2A AND #2B. Determine if the health entity's actuary has covered the required reserves.

PROCEDURE #3A. Determine that the health entity's actuary's SAO on reserves is in accordance with the criteria found in the *Health Annual Financial Statement Instructions* Section 7 and in particular that the SAO states that the reserves meet the requirements of the state of domicile. The *Annual Financial Statement Instructions* list certain items to include in the SAO paragraph, A through H. Certain other items have been included as separate lines in the past. For 2009, these items should be included within item H. Determine the actuary's conclusion concerning reserve adequacy in total. It is important for the actuary to document the reasons for his or her conclusion, which should be available upon request by analysts.

PROCEDURES #3B AND #3C. Determine that the health entity's actuarial methods, considerations and analyses used in forming the actuary's opinion conform to the relevant Standards of Practice as promulgated by the Actuarial Standards Board.

PROCEDURES #4 AND #5. Perform only in the situation where an asset adequacy test has been performed by the actuary. Review the actuary's asset adequacy testing and actuarial memorandum that supports the SAO. The *Annual Financial Statement Instructions* and *Health Insurance Reserves Model Regulation* (#10) do not specifically require asset adequacy testing for health entities but may be required by actuarial standards of practices in some specific situations. A small number of health entities hold life insurance licenses and may, therefore, be subject to the asset adequacy and memorandum regulations. Analysts should become familiar with his or her state requirements and special situations that may exist.

For the small number of health entities that are subject to actuarial memorandum requirements, the actuarial memorandum is a comprehensive document that provides an understanding of the health entity's reserves, the assets available to support the reserves, and the projected impact on the health entity's financial condition of varying economic and interest rate projection scenarios. It is not automatically filed with the Annual Financial Statement but is provided to the regulator only upon request. The decision as to whether to request the actuarial memorandum is an important one. The actuarial memorandum should be requested for health entities with known financial problems, significant changes in product mix or investment strategy, or significant growth in a particular product line. The Regulatory Asset Adequacy Issues Summary (RAAIS), which is filed with the Annual Financial Statement, assists the regulatory actuary in determining whether to request the actuarial memorandum. The RAAIS would include the following eight data requests, many of which may not apply to health asset adequacy analysis. (Refer to the NAIC *Actuarial Opinion and Memorandum Regulation* (#822), Section 7.):

1. For interest sensitive products, the amount of any negative ending surplus values on a market value basis under each of the Required Interest Scenarios.
2. The extent to which the Appointed Actuary uses assumptions in the asset adequacy analysis which are materially different than the assumptions used in the previous asset adequacy analysis.
3. The amount of reserves and the identity of the product lines which have been subject to asset adequacy analysis in the prior SAO but were not subject to such analysis for the current SAO.
4. The number of additional interest rate scenarios that were tested identifying separately the number of deterministic scenarios and stochastic scenarios. Also, identify the number of such scenarios which produced ending negative surplus values on market value basis.
5. If sensitivity testing was performed, identify the assumptions tested and describe the variation in ending surplus values on a market value basis from the base case values.

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6. Comments should be provided on any interim results that may be of significant concern to the Appointed Actuary.
7. The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested.
8. Whether the actuary has verified that all options embedded in fixed income securities and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

ANNUAL RESERVING RISK ASSESSMENT

Refer to the Overview section below at the end of this chapter for more guidance on health reserves.

Adverse Findings from Statement of Actuarial Opinion Assessment

Risks may include:

- **Minimum Statutory Standards Not Met**
  - Analyst identifies that certain minimum statutory reserving standards have not been met as required by state law/regulation.
- **Management Changes - Change in Opining Actuary**
  - If there is a change in actuary, consider if the management change results in any changes in reserving assumptions, methodologies, etc.

Review and incorporate any concerns or issues noted in the review of the Actuarial Opinion into the review of the valuation of the health entity's health reserves. The valuation of these reserves should be in accordance with Appendix A-010 of the AP&P Manual. Issues noted in the review of the Actuarial Opinion may be relevant to aspects of reserve risk identified in other procedures, and risks should be assessed concurrently with those procedures.

Issues or concerns identified through a review of the actuarial opinion assessment may indicate prospective risks. Examples include concerns regarding the qualifications of the appointed actuary, limitations in the scope of the opinion, an inability to reconcile to the Annual Statement, problems with the nature of the opinion, etc.

Procedure

- Review the results of the Statement of Actuarial Opinion Worksheet. Were any concerns noted regarding the valuation of the insurer's reserves in accordance with minimum statutory valuation standards?

Additional Review Considerations

- If questions or concerns are noted, contact the qualified actuary who signed the insurer's actuarial opinion to discuss the nature and scope of the health reserve valuation procedures performed.
- If questions or concerns are noted, request a copy of the qualified actuary's actuarial memorandum and review the actuary's comments regarding the analysis performed and conclusions reached regarding health reserves.
- Request information from the insurer on who ultimately determines the level of reserves to be booked by the insurer and the board of director's role in overseeing the reserving process.
- If filed on an insurance entity basis or if your state is the lead state, review the insurer's Corporate Governance Annual Disclosure (CGAD) filing to understand and assess the board of director's' role in

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overseeing the reserving process. If your state is not the lead state, rely on the information provided in the Group Profile Summary (GPS) or provided by the lead state, where the CGAD is filed on a group basis.

Adequacy of Health Reserves (High Reserve Leverages / Large Reserve Adjustments)

Determine whether an understatement of health reserves would be significant to the health entity.

High reserve leverage is represented by a high ratio of net claim unpaid and net aggregate health reserves to capital and surplus. If claims unpaid, claims reserve, policy reserve and premium deficiency reserve computations are not performed correctly or the selected estimates are unreasonable, capital and surplus could be negatively affected.

In evaluating these leverage ratios, also consider the nature of the health entity's business. For example, a health entity that has written primarily health business for many years and has proven that it can manage the business profitably is probably less risky than a health entity that has just begun writing health business, even if both entities have the same leverage ratio results.

Reserve adjustments made or anticipated to correct assumptions, or other estimates result in a reduction to surplus.

Procedures/Data

- Ratio of gross claims unpaid and gross aggregate health reserves to capital and surplus.
- Ratio of net claim unpaid and net aggregate health reserves to capital and surplus.
- Determine if a reduction in capital and surplus of 10% of the net claim reserve on risk-based capital (RBC) would result in a potential solvency problem if reserves were understated by 10%.

  A 200% RBC ratio is the Company Action Level of concern according to the NAIC *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315). A ratio below 200% indicates a health entity must file an RBC plan with the domiciliary state.

Additional Review Considerations

- If questions or concerns are noted, obtain information from the insurer regarding health claims paid after year-end, which were incurred prior to year-end, and test the reasonableness of the year-end claim liabilities established, by the insurer.

Part 2B – Analysis of Claims Unpaid - Prior Year-Net of Reinsurance of the Underwriting and Investment Exhibit provides information that allows analysts to determine if the health entity has had adverse reserve development in the past year. Using this exhibit, a ratio of the paid claims plus reserves for prior periods to the reserves established in the prior year can be calculated. A positive result (ratio > 1) for this ratio represents additional or "adverse" development on the reserves originally established by the health entity (the estimated amount of the original reserves has proven to be understated based on subsequent activity). The amount of reserve deficiency is compared to the reserve to determine if the deficiency was > 10%.

Part 2C – Development of Paid and Incurred Health Claims of the Underwriting and Investment Exhibit shows a history of reserve development. If the health entity's ratio results consistently show additional development, this could be an indication that the health entity is understating its health reserves. Analysts should review this exhibit to determine if there have been any adverse trends or fluctuations and if reserves have been adequate to pay actual claims.

Inappropriate or Inaccurate Valuation of Health Reserves,

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OR

Adverse Reserve Development, or Negative Reserve Development Trend

- Review reserve development as an indicator in determining whether health policies appear to have been adequately reserved. Reserve development can be used as a measure to assess the insurer's ability to accurately estimate reserves. Analysts also should consider the reserve development trend.

Procedures/Data

- Compare the one-year reserve development to capital and surplus and review and explain any adverse loss development results. [Annual Financial Statement, Underwriting and Investment Exhibit – Part 2B]
    - Determine if the insurer reported a reserve deficiency that was material to capital and surplus.
    - Determine if there has been an increase or decrease in the claim reserve and claim liability as a percentage of incurred claims since prior year-end.
- Review the Annual Financial Statement, Underwriting and Investment Exhibit – Part 2C. Determine if there has been an adverse trend or unusual fluctuation over the last five years.
- Review the Annual Financial Statement, Underwriting and Investment Exhibit – Part 2B and Part 2C. Determine if the reserve has been adequate to pay actual claims.
- Review the Annual Financial Statement, Underwriting and Investment Exhibit to determine which lines of business may have been under reserved at the prior year-end.
- If significant concerns regarding reserve development are identified, request the assistance of a department or consulting actuary in reviewing and assessing the adequacy of the reserves carried by the insurer.

Reserve Adequacy – Loss Ratio Assessment

Assess loss ratio and underwriting gain/loss indicators to determine if health policies appear to be adequately reserved. Significant increases in the loss ratio might be indicative of additional health reserves being established due to prior understatements while significant decreases might be indicative of current health reserve understatements.

Typically, significant increases in membership will result in lower loss ratios since first year claims experience is typically lower in the first year. Dropping membership accompanied with increasing loss ratios may indicate that healthier individuals and groups are leaving. This is often the first sign of a potential adverse selection rate spiral where rates force healthier individuals to leave resulting in inadequate rates. Reviewing the per-member per-month medical expense in the prior year or quarter may be further indication of problems, especially if membership is dropping.

By comparing the health entities medical claims expense per member per month (PMPM) and claims unpaid ratio to similarly situated industry peers, if significant variances from industry peers are noted, the analyst may need to gain a better understanding of the health entity's claim experience.

A deficiency reserve is required when future premiums are not sufficient to pay future claims and expenses. If a line of business is showing an underwriting loss there may be a need for a deficiency reserve. It is possible that premium increases have been implemented to correct the deficiency, but the situation should be considered.

A significant decrease in health reserves to incurred claims may indicate that reserves have been weakened. Note, there are other possible explanations for this type of change such as a shift in provider contracting or product design, however analysts should investigate if material changes occur.

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Analysts should review the percentage of claims paid on a capitated basis. If this percentage is decreasing, indicating a shift from capitated to fee-for-service, there should be an increase in health reserves in proportion to incurred claims. A shift in the other directions should have the opposite effect.

Procedures/Data

- Loss ratio for each product line.
- Change in the loss ratio from the prior year.

Additional Review Procedures

- Compare the direction of any changes in the loss ratio to the direction of changes in membership.
- Review the ratio of claims unpaid plus aggregate health reserve to incurred claims by line of business for past years to determine unusual fluctuations or trends between years.
- Compare the annual per member per month medical claims expense increased from last year-end compared to similarly situated health entities.
- Compare the ratio of claims unpaid plus aggregate health reserve to incurred claims to similar companies in the industry to determine any significant deviations from the industry average.
- Review the percentage of claims paid on a capitated basis.

Understatement of Reserves due to Delayed Claims Adjudication/Payment

The ratio of claims in process of adjudication to the average incurred non-capitated claims per day measures the average number of days of reported unpaid claims in inventory by reducing annual incurred claims to a daily average. An unusual result may indicate problems with claims administration or cash flow.

To determine the size of the backlog you must first determine the average daily-incurred claim expense less capitation. Once you have determined this amount, then determine the amount of claims in the process of adjudication, excluding capitation, divided by the average daily-incurred claim expense, to determine the average number of days of claims backlog.

Results for a recently licensed or rapidly growing health entity may have a high ratio because the growth of the numerator will be faster than the growth of the denominator. Reporting inventory valuation problems may also skew results for this ratio. Also, any IBNR changes will affect any results of this ratio.

Please note that a similar ratio might be calculated based on average daily paid claims instead of average daily incurred medical expense less capitation.

Procedure(s)/Data

- Determine if the amount of claims in process of adjudication to the average incurred non-capitated claims per day is greater than 30.

High Unpaid Claims Adjustment Expenses

Assess unpaid claims adjustment expenses.

Procedures/Data

- Ratio of unpaid claims adjustment expenses to claims unpaid.
- Ratio of unpaid claims adjustment expenses to incurred claims adjustment expenses.

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Reasonableness of Actuarial Methodologies and Assumptions

Reasonableness may be identified through follow-up to the examination, review of actuarial filings that summarize changes in assumptions/methodologies, discussions with the company, etc. Assess the lines of business written by the health entity, business plans, policy benefits offered, and RBC information in order to gain an understanding of the impact differences in the types of plans may have on reserving risk.

Procedures

- Determine which health lines of business are being written by the insurer.
- Review the insurer's risk-based capital filing to better understand the types of risk and risk management techniques being used, such as the types of managed care arrangements being used.
- Request a copy of the insurer's business plan and review the insurer's plans to assess and mitigate reserve risks.
- Review the Annual Financial Statement, Notes to Financial Statements, MD&A or other correspondence with the insurer to determine if the insurer initiated any internal changes that may impact the reserve estimates.
- Review the insurer's health insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific features and benefits.
- Contact the policy forms section of the insurance department and inquire as to whether the insurer has filed any new and unusual health policy forms during the past year.

Additional Review Procedures

- Request and review assumptions for reserve, utilization and benefit costs projected in the development of the contracts.
- Request information regarding any significant changes in reserve methodologies and assumptions, underwriting practices, case reserving, or claims handling practices with the potential to affect reserve setting.

Adequacy of Long-Term Care (LTC) Insurance Reserves (Risk of Understatement of Reserves)

Review the LTC Experience Reporting Form of the Annual Financial Statement and the Actuarial Guidelines 51 reporting filed to the department if the insurer writes LTCI to gain an understanding of the reserve adequacy of the LTC line of business. If concerns exist, consider requesting additional information as necessary to assess actual vs. projected results, legacy vs. newer blocks of business separately, any recent rate increases and capital support. If the insurer has recently filed for rate increases on LTCI blocks, consider intra-departmental discussion with the rate increase analysis and outcome with the rate review staff (if a different person than the analyst/actuary performing the valuation reserve analysis).

Procedures

- Review the information reported in the LTC Experience Reporting Form of the Annual Statement, the *Actuarial Guideline LI -The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG51)* reporting, actuarial memorandum or any other related actuarial information filed to the department, and identify any concerns with reserve adequacy of the LTC insurance business. Request a department actuary to assist in the review, if available.
    - Gain an understanding of the asset adequacy and cash-flow testing for LTCI on a stand-alone basis.

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- Consider any negative development in total LTCI reserve, asset adequacy reserves (if available), active life reserves, disabled lives reserves and premium deficiency reserves over the last five years.
    - Evaluate the appropriateness of investment return assumptions factoring in the status of the current economic and low interest rate environment.

- If concerns exist:
    - Evaluate actual results vs. original or revised assumptions and financial projections to identify trends and concerns.
    - Consider evaluating legacy blocks of business separately from newer blocks of business.
    - Rate Increases: Obtain and review the following information related to the status of rate increases and reduced benefit options. Consider that some information may be available from rate review staff for recent rate increase filings:
        - Track the progress of rate increases across states where a material amount of business is written.
        - Review projections illustrating the impact of proposed rate increases or reduced benefit options on the company's future profitability.
        - Determine the extent that future rate increases are included in the amount ($) of reserve offsets, asset adequacy/cash-flow testing and the reasonableness of the assumptions.
        - Consider the impact of historical approvals on the company's ability to obtain the rate increases presented in the projections. If concerns are identified in this area, obtain and review information on the company's plans to address these issues.
        - Compare the average percent of rate increases requested to the average approved.
        - Identify the amount of written premium change due to approved rate increases.
    - Regarding the adequacy of internal capital to support the LTCI business, compare the current total LTC reserves (active life and other), net of reinsurance, to the amount of internal capital the company has set aside for LTCI (e.g., internal capital per ORSA if applicable, or rating agency if higher than internal). If necessary, request information to gain an understanding of the degree of conservatism in such capital assumptions.

Impact of Changes in Valuation Bases of Reserves

Review the Annual Financial Statement to determine whether there has been a change in the valuation basis of the health policies during the year. Consider a review of changes that result in a decrease in health reserves in an amount greater than 5% of capital and surplus.

Procedures

- Review the insurer's description of the valuation standards used in calculating the additional contract reserves (which is required to be attached to and filed with the Annual Financial Statement) and consider whether the reserve bases, interest rates, and/or methods appear reasonable.

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ADDITIONAL PROCEDURES

Examination Findings

Consider a review of the recent examination report, summary review memorandum (SRM) and communication with the examination staff to identify if any reserving risk issues were discovered during the examination. If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

Own Risk and Solvency Assessment (ORSA)

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing reserving risks faced by the insurer.

- Determine if the ORSA Summary Report analysis conducted by the lead state indicated any reserving risks that require further monitoring or follow-up.
- Determine if the ORSA Summary Report analysis conducted by the lead state indicated any mitigating strategies for existing or prospective reserving risks.

Holding Company Analysis

Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing reserving risks that could impact the insurer.

- Determine if the Holding Company analysis conducted by the lead state indicated any reserving risks impacting the insurer that require further monitoring or follow-up.
- Determine if the Holding Company analysis conducted by the lead state indicated any mitigating strategies for existing or prospective reserving risks impacting the insurer.

QUARTERLY RESERVING RISK ASSESSMENT

The quarterly reserving risk procedures are intended to identify if an understatement in reserves would have a potential impact on the health entity's solvency and if significant changes in health reserves or health benefits have occurred since the prior year Annual Financial Statement.

Determine whether health policies appear to have been adequately reserved. A change in reserves of greater than 10% may indicate reserves should be looked at more closely. Actual claim payments and the current reserve for prior periods are reviewed in relationship to the prior year-end reserves to determine if the year-end reserve was adequate in light of subsequent experience.

Enrollment, premium, and utilization are reviewed to determine if there have been large changes in these key elements. Increasing utilization may lead to increasing loss ratios if premiums are not increased adequately. Large increasing enrollment may require increasing reserves and large decreases in enrollment may result in increasing loss ratios due to the loss of healthier individuals. This particularly happens when there are large rate increases and healthier individuals, families, and groups shop for better rates elsewhere. If healthier individuals are leaving, there may be a need for deficiency reserves on medical policies. Other types of coverage experience a release of contract reserves when enrollment drops resulting in increasing surplus.

Consider reviewing the Underwriting and Investment Exhibit to determine which lines of business are being written by the health entity and which health lines of business may have been under reserved at the prior year-end. Also consider reviewing: 1) the health entity's health insurance plan descriptions and/or policy forms to

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better understand the types of plans offered and the specific policy features and benefits; 2) the health entity's RBC filing to better understand the types of managed care arrangements being used; and 3) contacting the policy forms section of the insurance department and inquiring as to whether the health entity has filed any new and unusual health policy forms during the past year. In addition, review the health entity's description of the valuation standards used in calculating the additional contract reserves and consider whether the reserve bases, interest rates, and methods used appear reasonable. (The health entity's description of the valuation standards used is required to be attached to the filed Annual Financial Statement.) Contact the qualified actuary who signed the health entity's actuarial opinion to discuss the nature and scope of the valuation procedures performed and/or request a copy of the qualified actuary's actuarial memorandum to review for comments regarding the analysis of reserves performed and the conclusions reached.

Understatement of Health Reserves

Determine whether an understatement of health reserves would be significant.

Procedures/Data

- Ratio of net claims unpaid and net aggregate health reserves to capital and surplus.
- Determine if the current estimate of the insurer's claims unpaid and aggregate claim reserves would drop the insurer's prior year risk-based capital ratio below 200%.

Changes in Health Reserves and Reserve Adequacy

Determine whether health policies appear to have been adequately reserved.

Procedures/Data

- Change in claims unpaid, the aggregate policy reserves, or aggregate claim reserves from the prior year-end.
- Change in the claim reserve and claim liability as a percent of incurred claims since prior year-end. [Quarterly Financial Statement, Underwriting and Investment Exhibit]
- Change in member months for any line of business from the prior year, same period. [Quarterly Financial Statement, Exhibit of Premiums, Enrollment, and Utilization]
- Point change in the medical loss ratio for any product line from the same period in the prior year.
- Compare the direction of any changes in loss ratio to the direction of changes in membership. Determine if there is an indication that increased loss ratios may be resulting from falling membership.
- Compare to peer health entity results.
    - Increase in the annual per member per month hospital and medical claims expense since last year-end and/or since last quarter, more than similarly situated health entities.

For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

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ACTUARIAL OPINION ASSESSMENT OVERVIEW

The Table of Key Indicators included in the SAO notes where prescribed language has not been used, as well as if the Statement is other than unqualified. Generally, analysts can focus on the following four steps to compose much of the initial Actuarial Opinion Assessment Procedures.

1. Review Table of Key Indicators for use of other than prescribed language.
2. Review Table of Key Indicators for use of an unqualified opinion.
3. Determine if the Company has provided a notification letter to the domiciliary state describing the appointment of the actuary.
4. Determine if a certification letter is attached if the actuary has relied upon someone for data.

As noted in the discussion of the Actuarial Opinion Assessment Procedures below, in most instances proper review and analysis of the SAO beyond the Actuarial Opinion Assessment Procedures will use in-depth knowledge of actuarial science where most SAOs will be reviewed in detail by actuarial staff members. However, it is up to each state to determine how best to address this review with available resources.

The following provides an in-depth description of elements of the SAO.

The Health Annual Statement instructions contain 10 sections that provide instructions for the SAO, including instructions relevant to the Actuarial Memorandum that supports the SAO. These 10 sections are summarized below.

Section 1 requires a Qualified Health Actuary (actuary) to render the SAO. For this SAO, an actuary means a member of the American Academy of Actuaries (Academy), or a person recognized by the Academy as qualified for such actuarial valuation. The actuary must be appointed (Appointed Actuary) by the board of directors (or a committee of the board) to render the SAO. Section 1 includes specific responsibilities of the insurer regarding the appointment of the Appointed Actuary and addresses documentation, and replacement requirements. Requirements include notification of any replacement of the Appointed Actuary to the commissioner with disclosure of any disagreements with the prior actuary relevant to the SAO. Requirements are also provided regarding a responsive letter from the prior actuary addressing agreement or disagreement to reasons for replacement provided by the company. When reviewing compliance with Section 1, note that the publication of the changes to the Health Actuarial Opinion Annual Statement Instructions in September 2009 may impact the timeliness of notification and compliance. Section 1 also provides for reporting and documentation requirements between the Appointed Actuary and the board of directors or the Audit Committee. Section 1A provides definitions, Section 1B discusses exemption options and Section 1C provides requirements for the Actuarial Memorandum which supports the SAO.

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 Dec. 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to Dec. 31 of the same year if he or she deems the exemption inappropriate. A copy of the approved exemption must be provided in lieu of the SAO with the Annual Statement in all jurisdictions in which the company is authorized.

To qualify for an exemption, an insurer must meet one of the four following criteria:

1. An insurer that reports less than $1,000,000 total gross written premiums during a calendar year, and less than $1,000,000 total gross loss and loss adjustment expense reserves at year-end, in lieu of filing the SAO required for the calendar year, may instead file an affidavit under oath of an officer of the insurer that specifies the amounts of gross written premiums and gross loss and loss adjustment reserves.
2. Unless ordered by the domiciliary commissioner, an insurer that is under supervision or conservatorship is exempt from the filing requirements.

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3. An insurer otherwise subject to the requirement and not eligible for any of the exemptions previously described, may apply to its domiciliary commissioner for an exemption based on the nature of business written.

4. An insurer otherwise subject to this requirement and not eligible for any of the previously discussed exemptions may apply to the commissioner for a financial hardship exemption. A financial hardship exists if the projected reasonable cost of the SAO would exceed the lesser of:

   a) 1% of the insurer's capital and surplus as stated in the insurer's latest quarterly statement for the calendar year for the calendar year for that the exemption is sought; or

   b) 3% of the insurer's gross premium 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.

Section 2 requires that the SAO contain four clearly designated sections: Identification, Scope, Reliance, and Opinion. A fifth section, Relevant Comments, may be provided at the option of the actuary. A Table of Key Indicators must be provided which indicate whether these five sections use prescribed wording only, prescribed wording with additional wording, or revised wording. The Table of Key Indicators also provides whether the SAO is unqualified, qualified, adverse, or inconclusive.

Section 3 provides a Table of Key Indicators, which indicates whether the sections of Identification, Scope, Reliance, or Opinion use prescribed wording only, prescribed wording with additional wording, or revised wording. The Relevant Comments section provides boxes to be checked that indicate if there is revised wording or if any of the actuary's work, as detailed in the Actuarial Memorandum deviates from Actuarial Standards of Practice. The Table of Key Indicators also provides whether the SAO is unqualified, qualified, adverse, or inconclusive.

Section 4 (Identification section) is self-explanatory.

Section 5 (Scope section) is also self-explanatory where all actuarial items listed in the instructions should be provided even if amounts are zero.

Section 6 (Reliance section) requires the actuary to identify any person upon whom the actuary relied for data used in the reserve analysis. A statement from the person relied on is also required by this section. The actuary may choose to accept responsibility for the data without reliance on another. The actuary would state this by using prescribed language in this section.

Section 7 (Opinion section) provides the prescribed statements the actuary is to make that opine on the items identified in Section 5. This is a key section to review for deviations from prescribed language that form the basis for whether the SAO is unqualified, qualified, adverse, or inconclusive as indicated in Section 3.

Section 8 (Relevant Comments section) is optional. The actuary may use this section to state a qualification of his or her opinion or provide greater explanation of that qualification. The actuary may also address topics of regulatory importance or explain some aspect of the annual statement. Examples may include explanations of any material changes in assumptions or methods that were made during the year.

Section 9 of the SAO instructions provides additional guidance to the actuary regarding adverse, qualified, or inconclusive opinions. The determination of adverse, qualified, or inconclusive must be explicitly stated in the Table of Key Indicators provided in the Opinion. It is expected that adequate explanation of this determination be provided in the Opinion.

Section 10 of the Opinion provides for signatures which is self-explanatory.

Considerations

Requirements for the SAO provide for conformance with specific Standards of Practice adopted by the Actuarial Standards Board (ASB) of the Academy, including standards relating to follow-up studies and standards of what should be included in a SAO. For managed-care health plans, ASB standards for SAPs (ASOP 5, "Incurred Health

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and Disability Claims" or ASOP 42," Determining Health and Disability Liabilities Other than Liabilities for Incurred Claims") require consideration by the actuary of any capitated risk contracts that exist. Such consideration should also include or indicate whether the actuary has evaluated the financial position of the provider entities.

There is a significant difference between the SAO requirements as found in the Life, Accident & Health or Property & Casualty Annual Financial Statements and the Health Annual Financial Statement. Effective for 2003 Statutory Statements, companies with over 95% of specific types of health insurance would file the Health Annual Financial Statement regardless of their state license. Such companies must comply with not only the SAO requirements of the Health Annual Financial Statement but also with the SAO requirements based on their state license. For example, life insurance companies who file the Health Annual Financial Statement are still subject to any asset adequacy SAO requirements as required by the SAO and Memorandum Regulation pursuant to the Standard Valuation Law.

The NAIC *Health Insurance Reserves Model Regulation* (#10) if implemented by a state with respect to health entities defines the minimum reserve requirements. The NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) Appendix A-010 defines minimum health reserve requirements when there are no other state specific requirements[1]. Although Appendix A-010 describes the separate minimum standard for each type of reserve separately, *Statement of Statutory Accounting Principles (SSAP) 54—Individual and Group Accident and Health Contracts* requires a health entity's health insurance reserves to also be tested in total using the gross premium valuation method. The SAO for the Health Annual Financial Statement is required to address certain other liabilities as well as these specific reserves. The *Annual Financial Statement Instructions* specifically include:

A. Claims unpaid (Page 3, Line 1).

B. Accrued medical incentive pool and bonus payments (Page 3, Line 2).

C. Unpaid claims adjustment expenses (Page 3, Line 3).

D. Aggregate health policy reserves (Page 3, Line 4) including unearned premium reserves, premium deficiency reserves, and additional policy reserves from the Underwriting and Investment Exhibit – Part 2D.

E. Aggregate life policy reserves (Page 3, Line 5).

F. Property/casualty unearned premium reserves (Page 3, Line 6).

G. Aggregate health claim reserves (Page 3, Line 7).

H. Any other loss reserves, actuarial liabilities, or related items presented as liabilities in the annual statement.

I. Specified actuarial items presented as assets in the annual statement.

Although the instructions specifically identify the above actuarial items for review, certain other actuarial items also require review as provided in the general item H above. Some actuarial items are often incorporated into the required items while others have not been incorporated in the required list.

Actuarial reserves and liabilities that are incorporated into the required items above are as follows (note items 1a & 1b are specifically referenced in item D in the list above):

1. Aggregate Health Policy Reserves (Page 3, Line 4) includes:
    a. Unearned Premium Reserve (Underwriting and Investment Exhibit – Part 2D, Line 1).
    b. Additional Policy Reserves (Underwriting and Investment Exhibit – Part 2D, Line 2).

[1] The NAIC *Accounting Practices and Procedures Manual Appendix A-010* incorporate minimum reserve requirements from the *Health Insurance Reserves Model Regulation.*

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c. Reserve For Future Contingent Benefits (Underwriting and Investment Exhibit – Part 2D, Line 3).

d. Reserve For Rate Credits or Experience Rating Refunds (Underwriting and Investment Exhibit – Part 2D, Line 4).

e. Aggregate Write-ins for Other Policy Reserves (Underwriting and Investment Exhibit – Part 2D, Line 5).

2. Aggregate Health Claim Reserves (Page 3, Line 7) includes:

a. Present Values of Amounts Not Yet Due on Claims (Underwriting and Investment Exhibit – Part 2D, Line 9).

b. Reserve For Future Contingent Benefits (Underwriting and Investment Exhibit, Part 2D, Line 10).

c. Aggregate Write-ins for Other Claim Reserves; Actuarial Reserves Should Be Included in the SAO (Underwriting and Investment Exhibit – Part 2D, Line 11).

Note that additional policy reserves include premium deficiency reserves. Premium deficiency reserves are identified in Underwriting and Investment Exhibit – Part 2D, Footnote a.

Scope section, discussed above for Section 5 of the Annual Statement SAO Instructions, should specifically identify those items and amounts to which the actuary is expressing an opinion, including but not limited to the above specifically identified lines from the Annual Financial Statement. Where the actuary determines that no liability exists, the value $0.00 should be entered. Lines should not be deleted.

If there has been a material change in the actuarial assumptions from those previously employed, that change should be described in the Annual Financial Statement and in the Relevant Comments section of the SAO. (See Section 8 of the Annual Statement SAO Instructions and summarized above.)

If the actuary has not examined the underlying records, but has relied upon product definitions, computer listings and summaries of enrollment and claims payments prepared by the health entity, a prescribed statement to this effect is required by the Reliance section of the SAO. A signed statement by the person relied on is also required by this Reliance section for items provided, confirming the accuracy, completeness, and/or reasonableness of the items. Instructions for the Reliance section of the SAO are provided in Section 6 of the Annual Statement SAO Instructions.

Most health coverages do not require extensive cash flow testing, due to the short duration of the claim liabilities. The ASB has issued Actuarial Standards of Practice to guide actuaries in determining when an asset adequacy analysis should be performed and methods of asset adequacy analysis to consider. One of these is a prospective gross premium valuation. There is also guidance in the *AP&P Manual*, Appendix A-822 Asset Adequacy Analysis Requirements. If required by either regulation or professional standards, the actuary should have included an opinion of the asset adequacy.[2] Unlike life insurance opinions, there is currently no specific guidance for health asset adequacy opinions.

As provided in the instructions and mentioned above, the SAO can take four forms:

- Unqualified SAO
- Qualified SAO
- Adverse SAO
- Inconclusive SAO

2 *Accounting Practices and Procedures Manual, Appendix A-822* provides guidance for Asset Adequacy Analysis Requirements. The only companies filing the Health Annual Financial Statement that are subject to the requirements of Appendix A-822 are those licensed as life insurance companies.

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In cases where the SAO is other than unqualified, analysts should determine what the weakness is that prevents an unqualified SAO. A qualified SAO would state that the reserves may be adequate, but there are somewhat likely circumstances under which they would not be adequate. An adverse SAO is one in which the amounts reviewed do not satisfy opining statement "D" in the SAO section of the SAO. This opining statement "D" reads as, "Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements." An adverse SAO implies that amounts reviewed are not adequate under state regulations and/or actuarial standards. If the actuary's SAO is adverse or qualified, the actuary should specifically state the reason(s) for such an SAO in the Opinion section and/or Relevant Comments section of the SAO. If the actuary is unable to form an opinion, the actuary should issue an inconclusive SAO and specifically state the reason(s) for this.

RESERVING RISK ASSESSMENT OVERVIEW

Health reserves are intended to: 1) cover claims payments for claims that have been incurred prior to the valuation date and have not yet been paid; or 2) to retain a portion of current revenues to cover future incurred claims that the company anticipates it will be obligated to pay. The NAIC *Annual Financial Statement Instructions* and the AP&P Manual contain specific guidance for distinguishing between certain types of claim liabilities. Specifically, SSAP No. 54 and *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* differentiate between claims that have accrued costs (claim liabilities) and claims that may have been incurred but for which costs will be accrued in the future (claim reserves). For this handbook the term reserve will be used in its broader sense to include items denoted as reserves as well as other items called liabilities.

When there are reserves and liabilities for claim amounts to be paid in the future there will also be expenses associated with paying these claims. The liability for the administrative expense associated with paying these claims is entered in "Unpaid Claims Adjustment Expenses."

The incurred date of a claim is the first date on which the company has an obligation to pay for a contracted benefit. The incurred date of a claim depends on the type of product and the contract language. Some examples of incurred date determination would include:

- Hospital claims are incurred on the date of admission.
- Some claims related to one diagnosis may be grouped and considered incurred on first date of service.
- Maternity claims are incurred on the date of the first service related to the maternity.
- Other medical, dental and vision services are incurred on the date of service.
- Disability income claims are incurred on the date of disability.
- Long term care claims are incurred on the date of eligibility for benefits or date of first service, depending on the reserving method.
- Stop loss claims are incurred based on the contract specifications.

Other reserves are associated with provider contracts and experience rating contracts with employer groups. Provider contracts often result in funds being held for future payment based on claims experience for the members assigned to a provider group. Similarly, some contracts with employer groups result in future premium due or premium refunds owed based on actual claims experience.

Health reserves and methods used for their estimation are discussed in detail in the NAIC *Health Reserve Guidance Manual*. Analysts should be familiar with the information addressed in that manual and should use it as a reference when looking for guidance about a particular item under review. Before contacting a company or a company's actuary, analysts should review the NAIC *Health Reserves Guidance Manual* to become more familiar with the terms and techniques for reserve estimation.

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Due to the variety of types of health policies issued and the complexity of determining the aggregate reserves and liabilities for health policies, most health entities rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some health entities do not use actuaries to actually set the health reserves, health entities are required to annually obtain an opinion regarding the reasonableness of the established health reserves by a qualified actuary. Therefore, qualified actuaries are involved in setting and/or reviewing the health reserve liabilities established for virtually all health entities.

There are eight categories of health reserves and liabilities:

1. **Unearned premium reserves**

   The unearned premium reserve is the amount of paid premium covering future periods. For example, an annual premium paid on January first is 75% unearned at the end of the first quarter. Health products often have monthly premiums that do not require unearned premium reserves if coverage is from the first of the month to the end of each month (typically the case for employer-based coverage).

   If a premium is paid before it is due it is considered an advanced premium. For example, if January's monthly premium is paid on December 15 of the prior year it is advanced premium. Advanced premiums are entered in premiums received in advance on the Annual and Quarterly Financial Statements. See SSAP No. 54 for further guidance on this distinction.

2. **Claim reserves**

   Claim reserves are intended to cover claims that have been incurred but have not been paid. They can be further divided into three categories based on where the claim is in the process of being reported, approved and paid. The allocation among these categories is usually based on past statistics and they are usually not estimated separately. In general, incurred claims are estimated using one of the techniques described in the NAIC *Health Reserves Guidance Manual* and paid claims are deducted from the incurred claims to get a claim reserve. Other methods may be used for non-medical lines of business.

   Claim reserves can fluctuate as a percentage of incurred claims. A possible reason for this fluctuation is a large increase or decrease in the health entity's claims inventory. This often happens when a new claims system is installed. Other reasons for fluctuations in claims inventory can include a larger than normal turn over in claims processors, changes in the percentage of claims submitted electronically, changes in provider agreements such as moving to or from capitation arrangements and adding large amounts of new business. One concern may be that a change in the ratio of claim reserve to incurred claims could indicate that reserves are being lowered to improve profits or raised to justify rate increases.

   a. <u>Claims reported and in process of adjudication:</u>

      Claims reported and in process of adjudication may be waiting for additional information or may be ready for payment. States have different laws and regulations concerning the maximum number of days between the time that a claim is received and paid or otherwise adjudicated. An average backlog can be very roughly estimated by comparing the Reported in Process of Adjustment in the Underwriting and Investment Exhibit – Part 2A to the average daily-incurred claims amount (incurred claims divided by 365).

      i. Due and unpaid claims:

         These are claims that have been received, approved and adjudicated, but have not yet been paid. They generally represent a very small part of the claim reserve compared to the incurred-but-not-reported liability. Typically claims are considered paid when the check is issued.

      ii. Claims in course of settlement:

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These are claims that have been received by the company but have not been paid. They are often claims that are waiting for some additional information before they can be adjudicated and approved for payment.

b. Incurred but not reported (IBNR) claims:

Although claim reserves are often called IBNR, technically the only part of the reserve that is IBNR is the part that represents claims that have NOT been reported to the company. This is almost always the largest part of the claim reserve.

Historically, physician claims take longer to be reported than hospital claims, but electronic filing of claim information is shortening the lag between the date of service and the date that a claim is submitted to the health entity.

The amount of claim reserve per member or per incurred claim dollar differs significantly between types of companies. If a company pays most of its claims on a capitated basis, its claim reserve will result only from services that are not covered by the capitation. Claims not covered by the capitation generally include claims for out-of-area emergencies and claims for referrals to non-capitated specialists. Also, because some companies pay a budgeted amount to the largest hospitals providing services to their insured's with a periodic reconciliation for actual claims, there are additional reporting rules for these payments. *SSAP No. 84—Health Care and Government Insured Plan Receivables* defines these payments as advances or loans to providers and distinguishes between advances to hospitals and advances to non-hospital providers. Regarding advances to hospitals, as long as a reconciliation is performed within the strict parameters set forth in SSAP No. 84, these advances are admitted assets up to the estimated amount of incurred claims still unpaid to the hospital (includes IBNR). For non-hospital providers, and when the advances to a hospital do not meet the specific reconciliation requirements of SSAP No. 84, the admitted asset is limited to the amount of claims due and unpaid or in course of settlement (does not include IBNR) to that particular provider. The claim reserve is not to be reduced in either situation. Accounting guidance found in *SSAP No. 25—Affiliates and Other Related Parties* should be followed for loans and advances to related party providers.

When companies contract with providers on a capitated basis, they may consider it appropriate to include an amount in the IBNR reserve for the contingency that the provider group becomes insolvent and is not able to perform under its contract. For example, if a capitation has been paid to a provider group for medical services and the provider group becomes insolvent and does not have the funds to pay member doctors, then the company may have to pay doctors directly for services rendered to members.

Claim reserves are estimated with some level of conservatism based on the health entity's and the actuary's determination of the amount of margin needed for potential adverse experience. Factors affecting the need for conservatism in reserve estimates include: 1) statistical fluctuation in incurred claims; 2) data problems due to system changes or inadequate data reporting; 3) new or growing product lines; and 4) changes in plan design or provider arrangements that may affect claims payment patterns. Conservatism can be achieved by using a tabular method based on a conservative table, by using conservative assumptions and/or by adding explicit margins to reserve estimates. The conservatism of past claim reserve estimates can be observed by comparing Claims Incurred in Prior Years with the Estimated Claim Reserve and Claim Liability December 31 of the Prior Year in the Annual Financial Statement from the Underwriting and Investment Exhibit Part 2B.

c. Disabled life reserves:

Disabled life reserves are reserves for individuals who are currently eligible for claim payment on coverage such as disability income and long-term care (LTC). These claims will continue to be paid even if the contract ends until the individual is no longer eligible for claim payments due to an improvement in health status. More guidance can be found in SSAP No. 54 under claim reserves.

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3. Reserves for future contingent benefits

In some situations and for some types of products, benefits resulting from an incurred claim can extend beyond the valuation date and may extend even beyond the end of the contract period. For a hospitalization that extends past the end of the contract period, either the contract itself or state law may require payment of charges up to a specific time past the end of the contract period. Maternity claims may also result in a reserve for future contingent benefits, if the delivery is covered even if the contract is terminated. The federal Health Insurance Portability and Accountability Act (HIPAA) places restrictions on pre-existing condition exclusions resulting in new policies being responsible for continuing hospitalizations and maternity benefits, thus reducing the need for future contingent benefit reserves, but under state laws the prior carrier may still remain liable for the claim. A contingency benefit reserve may still be needed since there may be no replacement policy or the replacement policy may not cover all of the benefits of the old policy. Company experience and tabular methods are used to calculate these types of reserves.

Future benefits for disability income and LTC claims are included in disabled life reserves rather than as reserves for future contingent benefits.

4. Claims or LAE liability

When incurred claims have not been paid as of the valuation date and a reserve is set up for their future payment, there will generally be an expense to process and pay the claims. This expense, although paid in the future, is associated with claims incurred prior to the valuation date. To achieve consistent financial reporting a liability is set up for the future claims payment expense.

Also, when provider contract provisions require a payment at the end of the contract period for financial and/or operational performance, there will be a cost of determining and paying the contingent payment. A liability should be included for the expense of processing the provider liability.

5. Contract reserves

Contract reserves are in addition to claim and premium reserves. A contract reserve is a reserve set up when a portion of the premium collected in the early years is meant to help pay for higher claim costs arising in later years. The reserve is calculated using actuarial assumptions and techniques, and in general, equates to the amount that the present value of future benefits exceeds the present value of a consistent portion of future premiums (the portion of the "gross premium" used for contract reserves is called the "net premium").

Contract reserves are needed when premiums are collected in the early years of a policy and are intended to offset increasing claims in later years. This is usually seen when premiums are level over the life of a policy, but can occur when premiums are structured to increase, but still are not proportional to expected claims. Issue age rated policies often fall into this category where premiums can increase, but the ratio of expected claims to premiums are lower in early durations, by design, in order to avoid rate increases at later durations (or at least reduce their size).

The types of products that generally require contract reserves include: 1) individual disability income (if premiums are not based on attained age); 2) LTC; and 3) issue age rated medical policies (including those for specified diseases). Issue age rated medical policies are rare except for issue age Medicare Supplement and some issue age hospital indemnity policies. Many other types of health policies (accident coverage or AD&D coverage) may not need contract reserves because the likelihood of claims is the same for each age. Those contracts (most employer-based coverage) that are re-rated each year to cover the expected claims for the year do not need contract reserves.

Contract reserves may be needed for policies with multi-year rate guarantees. Many medical policies with multi-year rate guarantees have built in rate increases to cover anticipated increases in claims cost, but if premiums are level, contract reserves will be needed.

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Appendix A-010, *Minimum Reserve Standards for Individual and Group Health Insurance Contracts*, (Appendix A-010) of the AP&P Manual prescribes the minimum standards used in determining the health policy reserves and specify some of the assumptions to use such as morbidity tables, maximum interest rate and valuation method. Health entities may establish health policy reserves that equal or exceed these minimum standards. Analysts should review that all changes to contract reserve assumptions for in force policies have been approved in accordance with State regulations.

6. Premium stabilization reserves

These are reserves set aside to reduce the potential for large rate increases and smooth out the underwriting cycle. They are often associated with retrospectively rated contracts that require additional premium if claims are more than a specific percentage over expected or a premium refund if claims are less than a specific percentage of expected claims. The use of premium stabilization reserves due to retrospectively rated contracts is described in *SSAP No. 66—Retrospectively Rated Contracts*.

There are other experience rating arrangements besides retrospectively rated contracts that build up premium stabilization reserves. These reserves are used in years of higher-than-expected claims cost and result in a smoothing effect on premiums since premiums will not have to be increased to compensate for one year of poor experience.

Most premium stabilization reserves are determined by contract, but a company may use a similar concept on a block of business. Care should be taken to ensure that positive reserves from one contract are not used to offset material claims on other contracts that should be recognized. The reserve would be used to smooth out the need for large rate increases by building up a reserve in years when claims are less than expected and then drawing it down in years of larger than expected claims.

7. Provider liabilities

There are many types of provider contracting arrangements in the marketplace today. Many of these arrangements base some portion of the amount paid to the provider on financial and/or operational goals that are measured periodically. Under these types of arrangements, payment for reaching goals is not dependent on any specific service, but rather is based on overall performance. As of the valuation date, a payment for performance under a provider contract may have been earned but not paid. This payment must be set up as a liability to the company.

If a contract period has ended and there has not been a final settlement, any potential settlement with respect to provider liability should be included. If the valuation date occurs during a contract period, then an appropriate liability should be determined that represents the time period from the beginning of the contract period through the valuation date. When provider risks are minimized using stop-loss arrangements that take large claims out of the calculation, the effect of the stop-loss coverage should be estimated and included in the claim reserve calculation. In some situations, the provider contracts may allow for an additional provider payment to the company. These payments, which may be determined in a similar manner should be separated (not netted against the company's liability) and may be admitted if recorded in accordance with SSAP 84.

Some conservatism for adverse fluctuations should be included when estimating provider liabilities. The level of conservatism depends on the variability of the liability, time period being estimated, and the quality of the data being used. Please note, conservatism that increases the claim reserve estimate and anticipates higher incurred claims can lower the estimate for provider payments under a risk-sharing contract. The health entity's actuary should consider the total liability when doing his or her estimate.

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8. **Premium deficiency reserves**

When future premiums and current reserves are not sufficient to pay future claims and expenses, a premium deficiency reserve is required. HIPAA requires that all individual and small group medical products be issued on a basis that allows termination only of an entire line of business. These requirements may increase the number of instances where premium deficiency reserves will need to be reported for blocks of business. Analysts should be aware that some states have stricter termination rules than those imposed by HIPAA.

If contracts not protected by HIPAA or state termination restrictions are not profitable, they can be canceled. The contracts with many large groups allow them to be canceled. Also, certain lines of business can be canceled in total. In spite of contractual provisions, companies may decide not to cancel and therefore a deficiency reserve may be required. A company may not want to cancel a large group or a line of business in a state either because of the effect on its reputation or because the membership represented gives it bargaining power with providers.

A reserve may even be required for an Administrative Service Only (ASO) or Administrative Services Contract (ASC) agreement if administrative fees are not sufficient to cover administrative expenses. An insufficient administrative fee may be acceptable to the health entity when the importance of writing a large group due to prestige or bargaining power is provided to the health entity. Analysts should refer to *SSAP No. 5—Liabilities, Contingencies and Impairments of Assets* for a discussion of the reporting of loss contingencies.

In instances where future premiums can be increased to cover projected claim levels for a block of business, these increases may cause better risks to drop coverage. This will result in even higher claims costs and potentially continuing deficient premiums. It is difficult to predict the effect of this type of selection, but the health entity's actuary should attempt to include the effect of selection in his or her determination of the need for a deficiency reserve.

There is some state variation concerning limits on the assumptions that can be used in calculating premium deficiency reserves. Since these variations are not currently documented, analysts should contact the department actuary for input on any guidance that has been given to health entities in the state.

Areas of confusion and inconsistency include:

- How to define a block of business for calculation of deficiency reserves.
- The time period to use for calculation of deficiency reserves.
- Assumptions to use concerning enrollment changes, premium increases, and marginal versus allocated expenses.
- The level of claim reserves and claim reserve conservatism to be available at the end of the time period and thus included in the deficiency reserve.

For a thorough discussion of deficiency reserves and an up-to-date position on issues surrounding deficiency reserves analysts should refer to SSAP No. 54 and the *Health Reserves Guidance Manual*.

LONG-TERM CARE INSURANCE (LTCI) RESERVES OVERVIEW

"Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than

an acute care unit of a hospital[3]. Historically, insurers that wrote LTCI encountered difficulties accurately projecting claims costs, lapse rates, investment returns and other factors associated with LTCI, and subsequently many writers have experienced unprofitability in older (legacy) blocks of LTCI business. This has led many companies to request significant rate increases, modify product benefits, or exit the product line altogether. Therefore, many insurers continue to experience significant solvency challenges related to this line of business, and state insurance regulators should continue to carefully evaluate and monitor the solvency position of all insurers with a material amount of LTCI business.

These same risks also affect reinsurers, because the reinsurance contract may not arbitrarily allow for ceded premium increases. Additionally, in order to effectuate a true transfer of risk, the reinsurer may not have the ability to require the direct writer to request rate increases[4]. As some insurers look for avenues to minimize or eliminate its risk from the LTCI block, they may look to new reinsurance opportunities or non-traditional buyers.

In addition, periods of economic downturn and low interest rates increase the risk that LTCI writers will be challenged to generate sufficient returns to support this line. In addition, declines in projected investment returns could have a significant impact on LTCI reserve assumptions.

Actuarial Guideline 51—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51)

Effective for reserves reported with the Dec. 31, 2017, financial statement, Actuarial Guideline 51 — The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) now applies. The *Health Insurance Reserves Model Regulation* (#10) and the *Valuation Manual* VM-25, Health Insurance Reserves Minimum Reserve Requirements, contain requirements for the calculation of LTCI reserves. AG 51 requires companies with more than 10,000 LTCI enrollees to submit standalone LTCI asset adequacy analyses to the state. AG 51 is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to a company's LTCI block of contracts. AG 51 requires reporting to the department within the appointed actuary's actuarial memorandum required by VM-30, Actuarial Opinion and Memorandum Requirements, or in a special actuarial memorandum containing LTCI-specific information on the results of the analysis, assumptions on mortality, voluntary lapse, morbidity, investment returns and rate increase assumptions.

Factors Impacting LTCI Reserves and Rates

This following guidance provides additional information that may assist state insurance department staff in understanding the differences in premium rate review and approval, and valuation review of reserve adequacy assumptions in order to maintain or improve state insurance departments' current intra-departmental coordination/communication practices between the states' rate reviewers, valuation actuaries and analysts/examiners.

Reserve Increase Factors

1. Background

Ever since asset adequacy testing became a requirement for life insurers in the 1980s, actuaries have been required to analyze reserve adequacy assumptions on an annual basis and make the assumptions more conservative when experience or expectations become more adverse. If the result of the more

[3] Definition per NAIC *Long-term Care Insurance Model Act* (#640) Section 4.A.

[4] Refer to the NAIC *Life and Health Reinsurance Agreements Model Regulation* (#791) with respect to qualifying for risk transfer and reinsurance accounting within life and health reinsurance agreements.

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conservative assumptions was inadequate reserves, companies have been required to establish higher reserves to ensure future claims could be paid in the more adverse environment.

In some cases, the chain of events is straightforward. For instance, for life insurance, if more people die at earlier ages than expected and the experience is highly credible, then the actuary increases mortality rates in the upcoming year-end filing, leading to higher reserves being established.

In other cases, the chain of events is less straightforward. For instance, it is expected that cash surrenders on deferred annuity products will increase if interest rates rise. However, most deferred annuities have been sold during a period of decreasing interest rates. Actuarial and regulatory practice require reserves to be adequate in moderately adverse conditions, even if those conditions have not been recently experienced. There is typically judgment by the company actuary and another layer of judgment by regulators in play in this type of complex situation. The *Standard Valuation Law #820* (SVL), the Valuation Manual, and the *Actuarial Standards Board's* (ASB's) *Actuarial Standards of Practice* (ASOPs) describe how these complex situations should be handled.

2. Long-Term Care Insurance

For LTCI blocks of business that experience higher morbidity than expected, this experience will likely lead to changes in expectations on future morbidity for both the observed block and other blocks.

With LTCI, some factors are likely to play out in a straightforward manner. A combination of higher life expectancy and lower lapses will lead to more people than expected reaching prime LTCI claims ages of 80 and above, which leads to companies holding higher reserves than originally anticipated. Similarly, all companies have experienced the decreasing interest rate environment, which has led to lower-than-expected investment returns and the need to hold higher reserves, because investment income is relied upon to help pay claims.

Mortality, lapse, and interest rate factors become observable and can develop credibility during the premium-paying years prior to policy years when significant claims tend to occur.

3. Morbidity Assumptions:

Morbidity, however, has tended to fall into the category of a complex factor. The three main aspects of LTCI morbidity are: (1) incidence, the percentage of people at a given age who start a claim; (2) average length of claim; and (3) utilization, which is less than 100% if, e.g., the daily nursing home cost is lower than the maximum daily benefit in the insurance policy.

There has not been uniform experience development in morbidity, except that length of claim has tended to increase, likely because cognitive (e.g., dementia and Alzheimer's disease) claims tend to be longer than average and incidence has been higher than expected, likely due to more people reaching the age when cognitive claims tend to occur.

Because of divergent experience among companies and because morbidity becomes observable and credible during the later claim-paying years, establishing and regulating LTCI morbidity assumptions has not been straightforward. However, as with other factors and other products, the handling of these situations is addressed in *Model #820, Valuation Manual, and ASOPs*. Examples of these standards include:

- Model #820 12A(3)(a): "Assumptions shall, to the extent that company data is not available, relevant, or statistically credible, be established using other relevant, statistically credible experience."
- Model #820 Section 12A (4): "Provide margins for uncertainty … such that the greater uncertainty the larger the margin and resulting reserve."
- AG 51 (providing guidance on VM-30) Section 4.B.: "The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks. Material assumptions associated with the LTCI business shall be determined testing moderately adverse deviations in actuarial assumptions."

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- *Acounting Practices and Procedures Manual (AP&P Manual)*, Appendix A-010 paragraph 48.e (referenced in VM-30): "The total contract reserve established shall incorporate provisions for moderately adverse deviations."
- AP&P Manual, Appendix A-010 paragraph 51 (referenced in VM-30): "Annually, an appropriate review shall be made of the insurer's prospective contract liabilities… and make appropriate increments… if such tests indicate that the basis of such reserves is no longer adequate."

The result is that whether credible experience exists or not, the company actuary needs to set assumptions underlying reserves, and the factors underlying the assumptions are often complex and frequently changing. Company and regulatory actuaries are experienced in working in this complex, changing environment with many life insurer products, such as variable annuities, indexed products, and LTCI having product features and factors underlying reserves that are complex and changing.

4. Rate Increases:

A unique aspect of LTCI products is being a long-term product with rate increases that require review by states. Besides states with the largest insurance departments, the actuaries reviewing LTCI reserves are often the same staff reviewing LTCI rate increases. For larger states, there is typically coordination or training to ensure the reserve and rate teams are on the same page regarding developments in for example, life expectancy and morbidity. State insurance regulator experience in reviews of LTCI reserves and rate increase filings show that reserve increases and requests for rate increases are due to similar factors including higher life expectancy, lower lapses, lower investment returns, and worsened morbidity.

There has been additional regulatory attention on ensuring the companies asking for rate increases based on adversity of certain factors are holding reserves based on at least the same level of adversity in those factors. The questions used in many states' rate increase reviews require the company to explain the consistency between the rate increase filing assumptions and reserve adequacy assumptions.

To date, the most common complex, non-straightforward case is the applicability of a company's adverse morbidity experience of an older LTCI block to morbidity assumptions on a newer block. This complex dynamic comes into play when establishing reserve and rate increase assumptions.

The reserve assumption changes can occur with initiation by the company, through formal or informal agreement between regulators or companies, or by relying on Model #820 Section 11.6., which allows a commissioner to require a company to change reserve assumptions and adjust reserves.

Example:

> A typical example of a chain of events would first involve a block issued in 1995 to 1998 to policyholders with issue ages ranging from 52 to 62. By 2019, enough policyholders have reached prime LTC claim ages of 80+. This experience is what drives reserve assumption changes. As policyholders enter ages in the upper 80s and 90s, additional experience will be attained that will predict future LTCI costs and result in further changes in reserve assumptions. The development of older-age morbidity experience is expected to generate volatility in LTCI reserves. For some companies, the older-age morbidity experience will likely be unfavorable, with increased reserves needed. For most other companies, the older-age morbidity experience will likely be as expected, leading to no significant, unforeseen reserve increases.

Companies will be expected to apply lessons learned from older blocks of business to their newer blocks. Those lessons will likely differ by situation. For example, to the extent underwriting is different, the newer and older blocks may experience different morbidity trends.

5. Rate Increase Factors

Factors impacting LTC reserves, including higher life expectancy, lower lapses, lower investment returns, and changes in morbidity, also potentially impact LTC rate increases.

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If a company's reserve adequacy testing is dependent upon assumption of future LTC rate increases, the state insurance department staff performing reserve valuation should evaluate that assumption for reasonableness. The company's rate increase assumptions and documentation should be consistent with the requirements specified in AG 51 related to rate increase plans. The state insurance department staff performing reserve valuation may wish to coordinate and communicate with the state's rate review staff to help evaluate the appropriateness and reasonableness of the company's future rate increase assumption.

6. Intra-Department Communication and Coordination of Actuarial Review Work

While every state insurance department may be structured differently, many state insurance departments have the same staff members perform work on both LTCI reserve valuation analysis and rate increase reviews, while other have separate staff perform these functions. In the latter instance, department staff should be aware of or coordinate the intra-department review work related to each function.

The following are suggested steps a state may consider to ensure that actuarial assumptions associated with the rate increase request are consistent with the assumptions embedded in the asset adequacy testing.

- Inquire of the company's actuary or senior management regarding:
  - The relationship of the actuarial assumptions embedded in the rate filing versus those made for annual statement reporting.
  - Explanation if there is inconsistency between assumptions reported.
  - How AG 51 affects the company's rates and reserves.
  - Affirmation that the assumptions underlying the projections are consistent with the assumptions used in asset adequacy analysis.
  - A copy of the company's rate increase plan when rate increase filings disclose that future rate increase filings, beyond what is currently being requested, are planned.
- Consider reviews of different filings for consistency. For example:
  - Compare reserving assumptions to rate increase assumptions,
    - e.g., review the RAAIS and the Actuarial Opinion and Memorandum (AOM) to ensure that assumptions used for pricing and reserving are similar in nature.
  - Identify assumptions underlying the asset adequacy testing memorandum that appear.

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STRATEGIC RISK: Inability to implement appropriate business plans, make decisions, allocate resources or adapt to changes in the business environment that will adversely affect competitive position and financial condition.

The Strategic Risk Assessment is focused primarily on risks inherent in the company's business strategy and plans. As such, risks in this area are often prospective in nature and may require additional investigation and information requests to understand and assess their potential impact. For example, analysts may require an up-to-date business plan from the insurer to assess emerging risk exposures and prospective risks that could prevent the insurer from meeting its strategic goals. In addition, information presented in the Enterprise Risk Report (Form F) and Own Risk and Solvency Assessment (ORSA) Summary Report (if available) which the lead state reviews and documents risks, may assist analysts in identifying and assessing the insurer's exposure to strategic risks.

In analyzing strategic risk, analysts may analyze a wide range of risk exposures related to the insurer's business plan and overall strategy. An analyst's risk-focused assessment of strategic risk should take into consideration the following areas (but not be limited to):

- Industry and market factors
- Risk management and governance challenges
- Changes in officers and directors
- Recent and pending merger and acquisition activity
- The insurer's strategic planning process
- Significant recent or pending changes in business plan and strategy
- Underwriting strategy and plans
- Investment strategy and use of investment advisors
- Reinsurance strategy, including adequacy of coverage
- Affiliate relationships and transactions
- Capital planning and adequacy

ANNUAL STRATEGIC RISK ASSESSMENT

Impact of News, Press Releases and Industry Reports on Insurer Strategy

Identify and assess concerns from news, press releases or industry reports with the potential to affect the insurer or insurance group. The intent s for analysts to identify issues that could affect an insurer's ability to effectively implement its strategy. For example, if the insurer's strategy is focused on a particular line of business that is facing challenging economic conditions, analysts may be able to identify this concern through NAIC Industry Snapshots and Reports or NAIC Risk Alerts. Another example might be a news release or press release from the company indicating shifts or changes in strategy that could affect the insurer's financial condition. If concerns exist with respect to a potentially damaging report issued on the insurer or group, analysts

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should inquire about the overall financial impact on the insurer and the steps the insurer plans to implement to mitigate the circumstances.

Procedures

- Review any insurance, marketplace or economic industry reports, news releases, press releases, and emerging issues to identify if any issues have the potential to negatively impact the insurer's strategy.
    - Examples: NAIC "Insurance Industry Snapshots" and "Insurance Industry Analysis Reports;" NAIC Capital Markets Bureau reports, rating agency reports, insurance news sources, NAIC Risk Alerts, etc.
- Review movements and trends in the insurer's or group's stock price and trading volume to assist in identifying and assessing strategic risk.

Additional Review Considerations

- If concerns exist regarding a recent industry report, news release, stock movement or emerging issue, determine if the news or industry issue has the potential to impact the insurer's strategy, operations or financial solvency.
- Perform additional non-routine procedures where applicable (e.g., survey or questionnaire, stress testing, etc.).
- Inquire of the Insurer:
    - The financial impact to the insurer and/or group's operations and surplus
    - Disclosures of financial impact to the public and agent distribution force
    - The insurer's efforts to mitigate any impact of the risk. For ORSA filers, this may be identified in the ORSA Summary Report for certain risks.
    - Policies and procedures in place to mitigate adverse publicity
    - Revised business plan

Insufficient Risk Management and Governance Practices

Determine whether the risk management practices of the insurer are sufficient to provide for the establishment, implementation and oversight of an effective business strategy. Weaknesses or immaturity in the insurer's risk management practices may limit its ability to identify, track, assess and manage significant strategic risks. In completing this procedure, analysts must first determine whether the insurer is subject to ORSA requirements. If the insurer is subject to ORSA requirements, analysts are directed to obtain and review work performed by the lead state to evaluate the insurer's risk management framework.

For insurers that are not subject to ORSA reporting requirements, analysts may need to gather additional information regarding the insurer's risk management processes in order to assess their impact on strategic risk. A review of the entity's risk-management function should be conducted through discussions with senior management and the board of directors, and through gaining an understanding of the risk-management function including inspection of relevant risk management documentation. An effective risk-management function is essential in providing effective corporate governance over financial solvency.

Procedures

- If the insurer or insurance group is subject to Own Risk and Solvency Assessment (ORSA) requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk and Solvency Assessment (ORSA) of the Handbook. Document

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any concerns regarding the insurer's risk management practices and effects on the insurer's ability to establish, implement and oversee an effective business strategy.

- If the insurer or insurance group is not subject to ORSA requirements:
  - Communicate with the examiner or obtain the recent examination work papers, including Exhibit M and C-Level interview results, to gain an understanding of the insurer's enterprise risk management (ERM) program.
  - Inquire as to whether the company prepares an ERM assessment or similar risk assessment program. If "yes," request a copy. If not, request an explanation or lead a discussion on how the insurer identifies risks.
  - Evaluate the impact of such ERM practices on the insurer's business strategy.
- Review information provided on the company's ERM assessment or similar risk assessment program and/or follow-up on the work performed by the examiners regarding assessment of risk management, and evaluate any changes in the following or other areas:
  - The risk management culture demonstrated throughout the organization.
  - The importance of risk management to the organization.
  - How risk tolerances and "appetites" are defined and communicated throughout the organization.
  - How existing risks are identified, tracked, assessed and mitigated.
  - How emerging and/or prospective risks are identified, tracked, assessed and managed.
  - How the organization uses the risk information to determine capital needs.
  - Whether internal models are utilized and regularly updated to ensure appropriate risk management decisions.
  - How responsibilities for risk-management functions are delegated and monitored.
  - The level of involvement of the board of directors in the risk management function.
  - How risk management processes and results are incorporated into ongoing strategic planning and decision making.

Additional Review Considerations

- If not already included in ORSA or other ERM filings, inquire of the insurer:
  - Risk management policies and procedures
  - Risk monitoring and reporting tools
  - The impact of significant changes in board and executive leadership on the insurer's strategy and business plans
  - Information on significant recent or pending changes to organizational structure or operations

Change in Strategic Direction,

OR

Lack of Experienced Leadership

Evaluate the effects of changes in officers, directors or organizational structure on the strategic direction of the insurer. The following procedures are intended to assist analysts in assessing the potential impact on strategic risk from changes in directors, senior management, and organizational structure or operations. At times it is

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impossible to avoid director and management turnover. Whether the change is a result of retirement or term limits, performance, promotion, or termination, the end result is a new individual being placed in a position that could affect the strategy of the insurer. For example, new management may institute changes in future business plans that could have a significant impact on the insurer or group (e.g., new types of business, new geographic areas of writings, staff changes, or new affiliations). The lack of experienced leadership at the board and senior management level may make it difficult to set, maintain and achieve strategic goals. Changes in organizational structure and operations may have a similar impact and should be considered and evaluated for their potential to affect the insurer's ability to achieve its business strategy.

Procedures

- Review the changes in officers, directors or trustees and any concerns noted during a review of biographical affidavits.
    - Ascertain whether new directors and officers have the required knowledge, experience and training to perform their duties.
    - Determine whether the new board of director members are sufficiently independent from management and adequately engaged in performing their duties.
    - Determine whether new directors and officers have ever been officers, directors, trustees, key employees or controlling stockholders of an insurance company that, while they occupied any such position or served in any such capacity with respect to it. If yes, any the following, explain:
        - Been placed in supervision, conservation, rehabilitation or liquidation;
        - Been enjoined from, or ordered to cease and desist from, violating any securities or insurance law or regulation;
        - Suffered the suspension or revocation of their certificate of authority or license to do business in any state.
    - Evaluate and summarize the insurer's policies and procedures regarding performance of background checks on new management.
- If a significant amount of turnover and/or changes in key positions (i.e., chairperson of the board of directors, chief executive officer [CEO]) are identified, gain an understanding of and evaluate the impact of such changes on the insurer's strategic direction. Consider requesting updated business plans, holding in-person meetings, conducting conference calls, or taking other steps to understand and address significant changes.
- Identify any changes in the organization's structure. Request the reasons for the changes and the impact on future business plans and strategy from the insurer.
- Determine whether there have been any significant operational or business changes that have resulted in significant changes to staffing levels, consolidations of operations with affiliates, outsourcing of key functions, or placing blocks of business into run-off (closed) blocks.

Lack of Due Diligence in Mergers and Acquisitions,

OR

Integration Challenges

Consider how recent and pending merger and acquisition activity may affect the current and prospective solvency position of the insurer. Merger and acquisition activities have the potential to move the company into new lines of business and new geographical areas, and may result in significant staffing turnover and integration activities. Failure to adequately conduct due diligence in evaluating the financial condition and compatibility of

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merger and acquisition candidates may lead to strategic difficulties. The insurer may experience problems in integrating people, culture, systems and business plans as a result of business combinations and merger/ acquisition activity. All of these elements have the potential to significantly affect the business strategy of the insurer. In addition, analysts should be mindful of the fact that mergers and acquisitions do not always yield the desired results. As such, post-acquisition procedures comparing projections to actual results and evaluating the effectiveness of system integration and cost-cutting measures may help identify prospective risks and concerns that merit ongoing monitoring.

Procedures

- Determine whether the insurer has been a party to a merger or consolidation as indicated in General Interrogatories, Part 1, #5.1 of the Annual Financial Statement.

Additional Review Considerations

- If the insurer has been a party to a merger or consolidation, note any observations or concerns, ensure Form A or additional filings have been approved, and assess if the insurer is meeting the expectations set forth in the Form A business plan, consider the following additional procedures (as necessary):
    - If regulatory approval of the merger or acquisition was subject to ongoing conditions or restrictions, verify compliance with those requirements.
    - Compare actual results to pre- and post-transaction projections to determine whether results are meeting expectations. If not, gain an understanding of why projections have not been achieved and the company's planned actions to address issues.
    - Request and review information regarding the integration of the new business into the company's processes and systems (systems transition plan), the insurer's process and controls over integration, as well as the steps taken to ensure that adequate cybersecurity precautions are taken during the integration process.
    - Gain an understanding of and consider the impact of planned cost-cutting activities, including the nature and magnitude of cuts and their potential impact on risk exposures.
- Inquire as to whether the company is actively investigating or pursuing merger and acquisition opportunities. If "yes," consider the following additional procedures (as necessary):
    - Obtain an understanding of and consider the company's motivation for pursuing acquisition opportunities (e.g., gain market share, increase producer fees/commissions, diversification, etc.) and how that motivation may affect strategic planning and prospective risk exposures.
    - Gain an understanding of and evaluate the company's processes to perform due diligence when investigating mergers and acquisitions.

Lack of Strategic Business Planning,

OR

Overly Aggressive or Overly Optimistic Business Strategies

Evaluate the effectiveness of the insurer's business/strategic planning process and whether the current plan adequately addresses the significant solvency risks facing the insurer. Analysts should consider the overall planning process (e.g., who is involved, how frequently it occurs, etc.) and how the overall initiatives are determined. In addition, analysts may consider discussing with the insurer any assumptions used in establishing the goals. Through communication with the insurer, analysts should document any detailed explanations regarding variances in projected financial results and the insurer's intended plan to address variances. If analysts

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determine the goals of the business plan previously provided are not attainable and/or projections are unreasonable, a revised business plan may be requested.

Special consideration should be given to startup insurers that project rapid growth and significant underwriting and net losses. In many cases, startups rely heavily on the parent company's capital contributions to finance operations until the insurer can achieve profitability. The analyst should evaluate the reasonableness of the insurer's business plan and projections and determine whether the plan is attainable.

Procedures

- Review previous business plans and financial projections filed with the state insurance department, Determine the following:
  - Whether significant changes in business plan or philosophy have occurred.
  - Assess if initiatives outlined in the business plan have been accomplished.
  - Compare actual with projected financial results and determine whether actual results are consistent with management's expectations.
  - Request an explanation for the variance including an explanation of whether management believes it has achieved its goals for the period and if any noted risks or challenges were not considered in the business plan.
  - Describe any events, transactions, market conditions and/or strategic management decisions that have occurred (or are planned) that may cause a significant positive or negative variance from projections, including new product development or enhancements, changes in sales volume, product mix, or geographical locations.
  - Determine whether there are internal and/or external prospective risks that have the potential to impact the overall business plan.
- If based on the review of the previously provided plan, it appears no longer current or relevant, as appropriate, request a revised business plan. Review the updated strategic business plan, noting any areas of concern and, if necessary, request additional explanations from the insurer.
  - Whether the new business plan reflects significant changes in the strategic goals or philosophies compared to the prior plan.
  - Describe the insurer's strategic and annual planning process.
  - Describe the board of directors' involvement in developing and implementing the business plan.
  - Assess the insurer's ability to attain the expectations of the business plan and projections and determine whether the business plan reflects changes that appear unrealistic for the current market environment, financial position of the insurer or other circumstances. If so, evaluate the following:
    - Reasonableness of underwriting assumptions
    - Current and anticipated interest rate and economic environment
    - Growth objectives
    - Stability of capital and ability to access additional capital, if needed
    - Quality and sources of earnings (trends and stability)
    - Dividends and dividend payout policy
- For startup insurers that project rapid growth and material losses, consider the following:

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- Obtain a five-year business plan and assess the insurer's current and projected capital adequacy relative to its growth plans.
- If future growth is to be funded by capital contributions from the parent, assess the parent's ability to meet future funding expectations.
- Determine whether growth and capital financing expectations are sustainable until the insurer becomes profitable.

Additional Review Considerations

- If concerns exist regarding the business plan, further inquire of the insurer:
  - Information on strategic planning processes and board approval
  - Investment policies and strategy documentation
  - Derivative use plan and information on hedging strategies
  - Investment management agreements
  - Information on reinsurance program structure
  - Significant reinsurance contracts and agreements
  - Reinsurance intermediary agreements
  - Strategies for limiting the financial impact of a pandemic event on the company's solvency position (Health)

Overly Aggressive Investment Strategy,

OR

Lack of Investment Expertise and Oversight

Determine whether the insurer's investment strategies and holdings are appropriate to support its ongoing business plan and strategy. Analysts should review tool results (e.g., financial profile, investment snapshot, etc.) to get a basic understanding of the insurer's investment holdings/strategy and any changes noted. If changes or concerns are noted, analysts may need to request a copy of the insurer's formal adopted investment plan. This should be evaluated to determine if the plan appears to result in investments that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs and to determine whether the insurer appears to be adhering to its plan. The plan should also specify investment guidelines for the company to follow in asset allocation addressing quality, maturity/duration and diversification (by issuer, industry, geographic location, etc.). If concerns are identified regarding the insurer's investment plan or strategy, analysts should consider requesting a portfolio analysis from the NAIC's Capital Markets Bureau or use other investment expertise to address the issues.

Procedures

- Review the asset section of the Financial Profile Report to identify material shifts in investment percentages between asset categories, which may indicate the insurer has increased its investment risk exposure.
- Request a copy of the insurer's investment plan that discusses investment objectives and strategy, with specific guidelines as to quality, maturity, and diversification of investments and:
  - Evaluate whether the investment plan appears to result in investments and practices that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs.

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- Review the guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity and geographic location.
- Determine who is authorized to purchase and sell investments and what approvals are required for investment transactions.
- Evaluate the involvement of the board of directors and senior management in overseeing the investment strategies of the insurer.
- Consider the level of knowledge and expertise of asset managers used by the insurer in making investment decisions and evaluate the level of oversight provided to any third-party asset managers.
- Determine whether the insurer appears to be adhering to the investment plan.

- If the insurer allocates a significant amount of its portfolio to structured securities, request information from the insurer regarding its background and expertise in structured securities of its investment advisers (in-house and/or contractual) and its analytical systems capabilities. Determine whether the advisers and systems are adequate to allow the insurer to continuously monitor its structured securities investments.
- If the insurer's investment plans and strategies include the use of derivatives for hedging purposes, request and review a comprehensive description of the insurer's hedge program in order to gain an understanding of how derivative instruments are used to hedge against the risk of a change in value, yield, price, cash flow, quantity or degree of exposure with respect to assets, liabilities or future cash flows that the insurer has acquired or incurred or anticipates acquiring or incurring and:
  - Evaluate whether the hedge program appears to result in hedges that are appropriate for the insurer based on its assets, liabilities and cash flow risks, and are consistent with the insurer's overall strategy.
  - Note anything unusual or any variances from the insurer's current hedging program description.
  - Determine whether the insurer appears to be adhering to the description of the hedge program.
  - For significant derivative instruments that are open at year-end, consider requesting and reviewing:
    - A description of the methodology used by the insurer to verify the continued effectiveness of the hedge provided,
    - A description of the methodology to determine the fair value of the derivative instrument,
    - A description of the determination of the derivative instrument's book/adjusted carrying value, to determine whether the requirements of the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) have been met.
  - Consider having the insurer's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.
- If concerns related to the investment strategy or portfolio are identified, consider requesting and reviewing a preliminary portfolio analysis from the NAIC's Capital Markets Bureau.

Adequacy of the Reinsurance Strategy,

OR

Reinsurance Cost and Availability

Determine whether the insurer has established and maintained appropriate levels of reinsurance to support the insurer's business plan and strategy, in consideration of its capital and surplus position and risk exposure. As risks related to reinsurance strategy may vary somewhat according to business type, the procedures in this area include both considerations applicable to all business types and those specifically associated with Property/Casualty (P/C), Life and Health business.

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In general, to assess the adequacy of the reinsurance program in place, analysts should evaluate the insurer's leverage position (on both a gross and net basis), as well as identify risk concentrations that could expose the insurer to significant loss events. An in-depth understanding of the insurer's lines of business and business strategy is most likely to result in the identification of risk concentrations, and a number of tools and reports can be beneficial in supporting and supplementing that understanding. Many of the most relevant tools and metrics are highlighted in the procedure, such as Schedule T premium data, risk-based capital (RBC) RCAT disclosures, disclosures in the Annual Financial Statement and various tool results and ratios (e.g., Largest Net Amount Insured in a One Risk to Surplus). In addition, information provided in ORSA reporting and rating agency reports (i.e., A.M. Best Supplemental Ratings Questionnaire – Reinsurance Section) may provide additional information on risk concentrations and exposures.

If concerns related to the insurer's leverage position and significant risk concentrations/exposures are identified, analysts should evaluate the adequacy of the insurer's reinsurance program to mitigate those exposures. In so doing, analysts should use information in the Annual Financial Statement and other available information (e.g., actuarial opinion, Management's Discussion and Analysis (MD&A), Form B, business plan, reinsurance contracts filed with the department, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy, including adequate protection for large losses. After reviewing information on reinsurance included in the business plan and the various regulatory filings available, analysts should request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. In so doing, analysts should evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, reinstatement provisions, or use of non-traditional reinsurance etc.) on the insurer's business plan and strategy.

In addition to considerations regarding the insurer's current reinsurance program and its adequacy, analysts may want to evaluate the longer-term sustainability of the insurer's reinsurance strategy. This is particularly true for entities that are subject to significant catastrophic risk exposures with the potential to be impacted by climate change. The analyst may find information provided in the NAIC's Climate Risk Disclosure Survey, ORSA Summary Reports, and/or U.S. Securities and Exchange Commission (SEC) 10-K and 10-Q filings valuable in identifying and assessing risks in this area.

Procedures/Data – P/C

- Leverage ratios
  - Gross premium written to surplus [IRIS #1]
  - Net premium written (NPW) to surplus [IRIS #2]
- Net retention
- Gross premium written (liability lines) to surplus
- Net premium written (liability lines) to surplus
- NPW (long-tail) to total NPW
- Change in NPW (long-tail) to total NPW from prior year
- Largest net amount insured in any one risk (excluding WC) to surplus
- Ceded loss ratio

Additional Review Considerations – P/C

- If the insurer or insurance group is subject to ORSA requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk and Solvency Assessment (ORSA) of the Handbook. Document any concerns and conclusions reached regarding the insurer's reinsurance strategy and program structure.

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- Obtain a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section to identify any risks or concerns.
- Review and compare the insurer's ceded loss ratio to its overall loss ratio to evaluate the effectiveness and sufficiency of reinsurance coverage.
- Briefly scan the individual reinsurers and related financial data provided in the Annual Financial Statement and:
    - Identify any significant changes in the primary reinsurers during the year compared to the prior year.
    - Determine if there are any significant new reinsurers known to engage in financial reinsurance or surplus relief transactions that may trigger concerns as to transfer of risk with respect to this specific insurer.
    - Determine if there are specific situations noted or overall trends that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies.
    - Determine if there are any unusual items noted, such as significant amounts of reinsurance with alien reinsurers.
    - If concerns are identified, contact the company to discuss and evaluate the effect on the company's business plan and strategy.
- After reviewing information on reinsurance included in the business plan and the various regulatory filings available to analysts, request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. Evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, etc.) on the insurer's business plan and strategy.
- Review the Annual Financial Statement and other available information (e.g., actuarial opinion, Management's Discussion and Analysis (MD&A), Form B, business plan, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy, including adequate protection for large losses.
- Request the Department Actuary review the available information regarding the reinsurance program to identify any concerns.
- Consider the following specific procedures related to the Annual Financial Statement, General Interrogatories, Part 2:
    - Determine whether any concerns exist regarding the provision the company has made to protect itself from any excessive loss in the event of a catastrophe under a workers' compensation contract issued without limit of loss. [General Interrogatory #6.1].
    - Determine whether any concerns exist regarding the provision the company has made to protect itself from an excessive loss arising from the types and concentrations of insured exposures composing its probable maximum property insurance loss. [General Interrogatory #6.3].
    - Determine whether any reinsurance contract considered in the calculation of the largest net aggregate risk amount includes an aggregate limit of recovery without also including a reinstatement provision. [General Interrogatory #13.2].
    - Ascertain whether the number of reinsurance contracts considered in the calculation of the largest net aggregate risk amount are cause for concern. [General Interrogatory #13.3].
- Review the insurer's gross and net writings leverage positions to assist in evaluating the adequacy of the insurer's reinsurance strategy. Consider the following specific procedures in this area:

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- Compare the gross writings leverage ratio and the net premium written to surplus ratio to the industry averages to determine any significant deviations from the industry averages.
- If the insurer is a member of an affiliated group of insurers, compute the gross premium written to surplus ratio and the net premium written to surplus ratio on a consolidated basis to determine if the affiliated group of insurers appears to be excessively leveraged.
- Obtain an explanation from the insurer for unusual results for P/C IRIS ratios #1 and #2.

- Review, for each line of business included in the Annual Financial Statement, Schedule P, the trends in accident year loss ratios, on both a gross and net basis, for indications of deteriorating underwriting results that may warrant reinsurance consideration.
- Review the Annual Financial Statement, Schedule T and determine whether there appears to be large geographic concentrations of premiums in areas especially prone to catastrophic events. If so, consider requesting and reviewing information from the insurer regarding its catastrophic reinsurance coverage to evaluate its sufficiency.
- Review information provided by the insurer in the RCAT (PR027) section of its risk-based capital (RBC) filing to identify and assess the insurer's current exposure to catastrophic events at modeled worst year in 50, 100, 250, and 500 levels on both a gross (direct and assumed) and net basis (after reinsurance). Evaluate the adequacy of the company's catastrophic reinsurance coverage at various modeled loss levels, including the potential impact on capital and surplus and RBC position.
- Review information provided in the insurer's response to the NAIC's Climate Risk and Disclosure Survey (if available) on its exposure to physical losses impacted by climate change, as well as its potential impact on reinsurance decision-making.
  - Determine whether any of the company's responses require further investigation and inquiry.
- Review relevant information provided in the Own Risk and Solvency Assessment (ORSA) Summary Report and/or U.S. Securities and Exchange Commission (SEC) 10-K or 10-Q filings (if available) discussing the insurer's exposure to physical losses impacted by climate change, as well as its potential impact on reinsurance decision making.
- Utilize the information gathered and/or request additional information as necessary to evaluate and assess the adequacy of the insurer's catastrophic reinsurance coverage to limit its exposure to large loss events and/or the attritional costs of multiple smaller events.
  - Gain an understanding of and evaluate the company's process to incorporate catastrophe modeling results into its reinsurance decision-making processes (e.g., retention levels, coverage limits, exclusions, reinstatement provisions, or use of nontraditional reinsurance).
  - Gain an understanding of and evaluate the potential impact of climate change on the company's reinsurance decision-making processes.

<u>Procedures/Data – Life, A&H</u>

- Leverage ratios:
  - A&H: Gross A&H premium written to capital and surplus
  - A&H: Net A&H premium to capital and surplus
- Net retention
- Ceded loss ratio

<u>Additional Review Considerations – Life, A&H</u>

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- If the insurer or insurance group is subject to ORSA requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk and Solvency Assessment (ORSA) of the Handbook. Document any concerns and conclusions reached regarding the insurer's reinsurance strategy and program structure.
- Obtain a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section to identify any risks or concerns.
- Review and compare the insurer's ceded loss ratio to its overall loss ratio to evaluate the effectiveness and sufficiency of reinsurance coverage.
- Briefly scan the individual reinsurers and related financial data provided in the Annual Financial Statement and:
    - Identify any significant changes in the primary reinsurers during the year compared to the prior year.
    - Determine if there are any significant new reinsurers known to engage in financial reinsurance or surplus relief transactions that may trigger concerns as to transfer of risk with respect to this specific insurer.
    - Determine if there are specific situations noted or overall trends that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies.
    - Determine if there are any unusual items noted, such as significant amounts of reinsurance with alien reinsurers.
    - If concerns are identified, contact the company to discuss and evaluate the effect on the company's business plan and strategy.
- After reviewing information on reinsurance included in the business plan and the various regulatory filings available to analysts, request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. Evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, etc.) on the insurer's business plan and strategy.
- Review the Annual Financial Statement and other available information (e.g., actuarial opinion, Management's Discussion and Analysis (MD&A), Form B, business plan, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy, including adequate protection for large losses.
    - Request the Department Actuary review the available information regarding the reinsurance program to identify any concerns.
    - Consider the insurer's surplus level and leverage position in evaluating the adequacy of reinsurance.
- Review, for each line of business included in the Annual Financial Statement, Analysis of Operations by Lines of Business, the trends in loss ratios for indications of deteriorating underwriting results that may warrant reinsurance consideration.

Procedures/Data – Health

- Leverage ratios:
    - Premium & risk revenue to capital and surplus
- Net retention
- Ceded loss ratio

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- Ascertain whether the insurer reported they do not have stop-loss reinsurance as indicated on General Interrogatories, Part 2, #5.1 and #5.2 of the annual financial Statement

Additional Review Considerations – Health

- If the insurer or insurance group is subject to ORSA requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk and Solvency Assessment (ORSA) of the Handbook. Document any concerns and conclusions reached regarding the insurer's reinsurance strategy and program structure.
- Obtain a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section to identify any risks or concerns.
- Review and compare the insurer's ceded loss ratio to its overall loss ratio to evaluate the effectiveness and sufficiency of reinsurance coverage.
- Briefly scan the individual reinsurers and related financial data provided in the Annual Financial Statement and:
    - Identify any significant changes in the primary reinsurers during the year compared to the prior year.
    - Determine if there are any significant new reinsurers known to engage in financial reinsurance or surplus relief transactions that may trigger concerns as to transfer of risk with respect to this specific insurer.
    - Determine if there are specific situations noted or overall trends that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies.
    - Determine if there are any unusual items noted, such as significant amounts of reinsurance with alien reinsurers.
    - If concerns are identified, contact the company to discuss and evaluate the effect on the company's business plan and strategy.
- After reviewing information on reinsurance included in the business plan and the various regulatory filings available to analysts, request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. Evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, etc.) on the insurer's business plan and strategy.
- Review the Annual Financial Statement and other available information (e.g., actuarial opinion, Management's Discussion and Analysis (MD&A), Form B, business plan, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy, including adequate protection for large losses.
    - Request the Department Actuary review the available information regarding the reinsurance program to identify any concerns.
    - If the insurer reported that they do not have stop-loss reinsurance, review the insurer's maximum retained risk in Annual Financial Statement, General Interrogatories, Part 2, #5.3. Determine whether any concerns exist regarding the health entity's level of maximum retained risk.
- Review, for each line of business included in the Annual Financial Statement, Analysis of Operations by Lines of Business, the trends in loss ratios for indications of deteriorating underwriting results that may warrant reinsurance consideration.

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Affiliated Reinsurance Concerns

Determine how changes in affiliate relationships may affect the insurer's business plans and strategy. This procedure focuses largely on affiliate reinsurance relationships and transactions (both ceded and assumed) and their impact on business strategy. As risks related to affiliated reinsurance may vary somewhat according to business type, this area includes both considerations applicable to all business types and those specifically associated with P/C, Life and Health business. Reinsurance transactions and relationships with affiliates may fail to transfer risk, contain inequitable or unprofitable provisions and/or mask true financial performance.

It is important to note that a group of affiliated insurance companies may use reinsurance as a mechanism to diversify the portfolios of individual companies and to allocate premiums, assets, liabilities, and surplus among affiliates. Intercompany pooling, where each company reinsures a fixed proportion of business written by pool members, is a standard practice among companies under common management. From an economic standpoint, reinsurance transactions between affiliated insurance companies do not reduce risk for the group but instead shift risk among affiliates. Reinsurance between affiliated companies presents opportunities for manipulation and potential abuse. In a group of affiliated insurers, intercompany reinsurance may serve to obscure one insurer's financial condition by shifting loss reserves from one affiliate to another or improperly supporting or subsidizing one affiliate at the expense of another.

As the placement of risks within a group due can have a drastic effect on an insurer's strategy, analysts should identify and assess risks in this area. In addition, as affiliated reinsurance contracts are typically subject to department review and approval, significant concerns over risk concentrations and/or the reasonableness/equity of terms in significant affiliated reinsurance contracts should be identified and addressed with the insurer, as necessary. Such discussions may occur during both the initial department review of the contract (Form D filing) and/or on an ongoing basis as necessary, as the results of affiliated reinsurance arrangements indicate a need to reassess the reasonableness of contracts.

Procedures/Data – P/C

- Premiums assumed from affiliates to gross premiums ratio
  - Change from prior year
  - Change over past five years
- Premiums ceded to affiliates to gross premiums ratio
  - Change from prior year
  - Change over past five years
- Total reinsurance recoverables from affiliates to surplus ratio
  - Change from prior year
  - Change over past five years

Additional Review Considerations – P/C

- Obtain and review the underlying agreements that support the transaction(s) in question. Critically assess the substance of the transaction in terms of the following criteria:
  - The transaction must be economic-based and at arm's length
  - The transaction must result in transfer of risk and represent a consummated or permanent act
  - Any assets transferred to an affiliate must be transferred at fair value in an economic-based transaction
  - In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approval

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- Determine whether there are any changes in intercompany pooling agreements during the year. [Annual Financial Statement, Notes to Financial Statements, Note #10 and Note #26]
- Determine whether there are any premium portfolio transfers involving affiliates. [Annual Financial Statement, Schedule F – Part 2]

Procedures/Data – Life, A&H

- Premiums assumed from affiliates to gross premiums ratio
  - Change from prior year
  - Change over past five years
- Premiums ceded to affiliates to gross premiums ratio
  - Change from prior year
  - Change over past five years
- Total reinsurance recoverables from affiliates to capital and surplus ratio
  - Change from prior year
  - Change over past five years

Additional Review Considerations – Life, A&H

- Obtain and review the underlying agreements that support the transaction(s) in question. Critically assess the substance of the transaction in terms of the following criteria:
  - The transaction must be economic-based and at arm's length
  - The transaction must result in transfer of risk and represent a consummated or permanent act
  - Any assets transferred to an affiliate must be transferred at fair value in an economic-based transaction
  - In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approval
- Ascertain whether any of the reinsurers, listed in Annual Financial Statement, Schedule S as non-affiliated, are owned in excess of 10% or controlled, either directly or indirectly, by the insurer or any representative, officer, trustee, or director of the insurer [Annual Financial Statement, Notes to Financial Statement, Note #23, Schedule S – Part 3 – Section 1]. If yes, review Annual Financial Statement, Schedule S – Part 2 and Schedule S – Part 3 – Section 2 to determine if any unusual items are noted regarding the nature or magnitude of these non-affiliated relationships.
- Determine whether any policies issued by the insurer have been reinsured with an alien insurer owned or controlled, directly or indirectly, by the insured, a beneficiary, a creditor of the insured, or any other person not primarily engaged in the insurance business [Annual Financial Statement, Notes to Financial Statements, Note #23, Schedule S – Part 3 – Section 1].

Procedures/Data – Health

- Premiums assumed from affiliates to gross premiums [Health]
  - Change from prior year
  - Change over past five years
- Premiums ceded to affiliates to gross premiums [Health]
  - Change from prior year

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- Change over past five years

- Total reinsurance recoverables from affiliates to surplus [Health]
  - Change from prior year
  - Change over past five years

Additional Review Considerations – Health

- Obtain and review the underlying agreements that support the transaction(s) in question. Critically assess the substance of the transaction in terms of the following criteria:
  - The transaction must be economic-based and at arm's length
  - The transaction must result in transfer of risk and represent a consummated or permanent act
  - Any assets transferred to an affiliate must be transferred at fair value in an economic-based transaction
  - In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approval

Concerns with Reinsurance Contracts

Determine how any significant or unusual third-party reinsurance transactions, including loss portfolio transfers and commutations, as well as relationships with reinsurance intermediaries may affect the insurer's business plan and strategy. As risks related to unusual reinsurance transactions may vary somewhat according to business type, this area includes both considerations applicable to all business types and those specifically associated with P/C, Life and Health business. The insurer may participate in significant third-party reinsurance contracts that distort its surplus position, mask true financial performance, or raise questions related to risk-transfer and ongoing obligations.

Risk Transfer: Identify and assess unusual reinsurance transactions where a review of the transfer of risk criteria may be important. The essential ingredient of a reinsurance contract is the shifting of risk. The reinsurer must indemnify the ceding company in form and in fact, against loss or liability relating to the original policy. Unless the contract contains this essential element of risk transfer, the ceding company may not account for it as a reinsurance recoverable. Determining whether a contract involves true transfer of risk requires a complete understanding of the contract between the ceding company and the reinsurer. All contractual features that limit the amount of insurance risk to the reinsurer (such as through experience refunds, cancellation provisions, adjustable features, or additions of profitable lines of business to the reinsurance contract) or delay the timely reimbursement of claims by the reinsurer (such as through payment schedules or accumulating retentions from multiple years) should be thoroughly understood. Transfer of risk requires that the reinsurer assumes significant insurance risk under the reinsured portions of the underlying insurance contracts, and that it is reasonably possible that the reinsurer may realize a significant loss from the transaction.

Types of Reinsurance: Analysts should be particularly alert to certain types of unusual reinsurance transactions where risk transfer issues may be more prevalent and/or where the transaction involves the transfer of a large block of business, such as bulk reinsurance (Life/Health), assumption reinsurance (Life/Health), surplus relief transactions (all business types), commutations (P/C) and loss portfolio transfers (P/C).

Bulk reinsurance (Life/Health) is when an insurer cedes all or part of a block of insurance business. Such bulk cessions may or may not be in the ordinary course of business and may or may not require prior regulatory approval. Under an indemnity reinsurance arrangement, the ceding insurer remains liable to the policyholders and the reinsurer has no obligations to them. Typically, the ceding insurer will continue to perform all functions in connection with claims and other policyholder services. Under an assumption reinsurance arrangement, the liability to policyholders is assumed by the reinsurer, although in some cases, the ceding insurer retains a contingent liability. Assumption reinsurance requires that the reinsurer issue assumption certificates to the

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existing policyholders and take over responsibility for policyholder services. On occasion, the reinsurer will contract with the original insurer to continue to provide such services on a fee basis. Regulatory approval of all assumption reinsurance arrangements is normally required. Typically, because a block of in-force business has value, the sale transaction will result in a gain to the ceding insurer. If the policies are somewhat mature and have reasonably large reserves, the transaction probably will result in a transfer of cash or other assets by the ceding insurer. In this case, the reserves released by the ceding insurer will be greater than the value of the assets transferred, with the resulting credit being a gain and an increase in surplus. If the policies are young and have very small reserves, the assuming insurer may pay some amount in the purchase. If the ceding insurer has an obligation to buy back the block of insurance or to repay the reinsurer's losses, the intent of the transaction has usually been to create surplus in the ceding insurer and a transfer of risk has not occurred. In these situations, the accounting for the transaction must look beyond the intent and record the obligation. Therefore, there is no gain or surplus increase to be recognized, but the credit would be recorded as a liability to reflect the obligation to repay the difference to the reinsurer.

Surplus relief, or financial reinsurance, is a method of accelerating future profits on a block of insurance business. With conventional reinsurance agreements, the ceding insurer receives a ceding fee that covers the acquisition costs plus a profit. A transfer of risk is completed, and the reinsurer retains all future profits on the block of business reinsured. In surplus relief reinsurance, however, the reinsurer normally returns the majority of the profits, less a fee, to the ceding insurer through an experience refund. Since surplus relief transactions merely represent a financing arrangement, statutory accounting principles do not allow a credit to surplus until the risk has been transferred.

Assumption reinsurance agreements (Life/Health) occur when the insurer transfers, with the consent of the policyholder, responsibility for policyholder obligations to another insurer. These types of transactions are of concern to the policyholder, particularly where the assuming company has a weaker financial position than the ceding insurer. They may also indicate financial difficulties of the ceding insurer and may be motivated by pressure to generate surplus.

A commutation (P/C) is a transaction that results in the complete and final settlement and discharge of all present and future obligations between parties to a reinsurance agreement. With regard to commutation agreements, the present value of the reinsurer's estimated ultimate losses is paid by the reinsurer to the ceding insurer. The ceding insurer immediately establishes the ultimate loss reserve liability, and the cash received as a negative paid loss, thus creating a reduction in surplus equal to the difference between the ultimate and present value of the loss reserve. The reasons for commutations differ from insurer to insurer, however, some of the key reasons include:

- Exit of Business**:** The cedant may strategically exit a specific line of business or the reinsurer may withdraw from the reinsurance marketplace.
- Perceived Financial Instability: The cedant or reinsurer may have concerns regarding the other party's solvency. Commutation in this case would reduce credit risk, provide immediate cash infusions to cedant and/or allow the reinsurer to avoid future issues with the assigned liquidator.
- Disputes: The cedant and reinsurer may have significantly different evaluations of ultimate loss costs, claims resolution, or contract provisions and would prefer a single negotiation over commutation than continued disputes over issues.
- Underwriting Risk: The reinsurer may wish to eliminate underwriting and pricing risks relating to the cedants underwriting practices. Or the reinsurer may determine that the price of the commutation is less than carried reserves and the commutation improves the reinsurer's underwriting results.

Commutations require a thorough financial and actuarial review of the business being commuted. The cedant will need to have a clear understanding of the book of business to ensure that it receives adequate settlement from the reinsurer to pay all future claims and expenses and not lose the original value of the reinsurance and commutation agreements.

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A loss portfolio transfer (P/C), or LPT, is an agreement that is applied retroactively, in which the ceding company transfers a portfolio of losses (i.e., loss reserves) to another company along with consideration for assuming such loss reserves. LPTs are complicated transactions, and it is often difficult to distinguish between those that provide indemnification through transfer of risk and those that are merely financing arrangements. LPT agreements are normally executed because it is the objective of the ceding company to record, as a credit to surplus, the difference between the loss reserves transferred and the consideration paid. However, statutory accounting practices do not allow such a credit to surplus until the risk has been transferred, and the liability of the ceding company has been terminated.

Additional procedures assist analysts in evaluating the significant or unusual reinsurance transactions identified. Analysts should analyze these types of transactions closely to determine whether a transfer of risk has been consummated. Even when transfer of risk has been consummated, analysts should evaluate the impact of the transaction on future financial performance of the insurer.

Reinsurance Intermediaries: Determine whether any significant and/or unusual reinsurance intermediary or reinsurance assumed agreements exist. While some major professional reinsurers are direct marketers, intermediaries (e.g., brokers, managers, or managing general agents) may arrange reinsurance agreements between a ceding company and a reinsurer in exchange for commissions or fees. A reinsurance broker negotiates agreements for a ceding company but does not have the authority to bind the insurer to a reinsurance agreement. On the other hand, a reinsurance manager acts as the agent for a reinsurer and has the authority to bind a reinsurer to an agreement. Finally, a managing general agent may have authority both to underwrite primary insurance and to bind reinsurance agreements on that business for the ceding company. An intermediary has an incentive to place reinsurance with sound reinsurers when its commission is tied to the success of the business being reinsured. However, when commissions are based on volume of business, reinsurance placed through an intermediary may be subject to conflicts of interest and potential abuse. To generate more income, a managing general agent may cede business to reinsurers who later are unable or unwilling to pay losses, or a reinsurance manager may assume poor, underpriced risks. The intermediary bears no financial risk in the event of underpriced or poor underwriting or placement with a troubled reinsurer. But poor performance by an intermediary can affect both ceding companies and reinsurers.

Reinsurance Fronting: Determine whether reinsurance is being used for fronting purposes and, if so, whether any potential abuse exists. Fronting also can be subject to potential abuse by either the ceding company or the reinsurer. For example, where fronting commissions received by the ceding company from the reinsurer exceed the ceding company's costs of selling policies, the insurer has incentive to write additional business to generate commissions and profits. An insurer may underwrite poor risks at underpriced rates because it believes it will not have to pay all the resulting losses. In fact, the ceding insurer may not have adequate details about the business being written by its representatives to assess its potential losses. This practice may be used to circumvent state licensing requirements and thus avoid regulatory oversight. Although an insurance company must first be licensed in a state to sell insurance directly to the public, a reinsurer may assume reinsurance without a license in that state. Through a fronting arrangement, a company not licensed in a state may reinsure all or nearly all of the liabilities for policies that it cannot directly write.

P/C Reinsurance

Procedures/Data – P/C

- Surplus aid to policyholders' surplus [IRIS ratio #4]
- Ratio of assumed premiums written from non-affiliates to total gross premiums written
- Assumed loss ratio compared to gross loss ratio where the assumed premiums written are materials to gross premiums written
- Ratio of ceded premiums written to gross premiums written for any significant line of business, defined as a line of business where gross premium is material to total gross premium written

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- Ceded commissions to ceded premiums written as percentage of expense ratio
- Determine whether the company reinsured any risk under a quota share reinsurance contract that would limit the reinsurers' losses below the stated quota share percentage. [Annual Financial Statement, General Interrogatories, Part 2, #7.1]
- Determine whether the reporting entity ceded any risk under any reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which, during the period covered by the statement: (1) it recorded a positive or negative underwriting result greater than 5% of current year-end surplus as regards to policyholders, or it reported calendar-year written premium ceded or year-end loss and loss expense reserves ceded greater than 5% of current year-end surplus as regards policyholders, (2) it accounted for the contract as reinsurance and not as a deposit, and (3) the contract(s) contain(s) one or more of the following [Annual Financial Statement, General Interrogatories, Part 2, #9.1]:
    - A contract term longer than two years, and the contract is non-cancelable by the reporting entity during the contract term;
    - A limited or conditional cancellation provision under which cancellation triggers an obligation by the reporting entity, or an affiliate of the reporting entity, to enter into a new reinsurance contract with the reinsurer, or an affiliate of the reinsurer;
    - Aggregate stop loss reinsurance coverage;
    - An unconditional or unilateral right by either party (or both parties) to commute the reinsurance contract, whether conditional or not, except for such provisions which are only triggered by a decline in the credit status of the other party;
    - A provision permitting reporting of losses, or payment of losses, less frequently than on a quarterly basis (unless there is no activity during the period); or
    - Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.
- Determine whether the reporting entity, during the period covered by the statement, ceded any risk under a reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which it recorded a positive or negative underwriting result greater than 5% of prior year-end surplus as regards policyholders, or for which it reported calendar-year written premium ceded or year-end loss and loss expense reserves ceded greater than 5% of prior year-end surplus as regards policyholders, excluding cessions to approved pooling arrangements or to captive insurance companies that are directly or indirectly controlling, controlled by, or under common control with (1) one or more unaffiliated policyholders of the reporting entity, or (2) an association of which one or more unaffiliated policyholders of the reporting entity is a member where [Annual Financial Statement, General Interrogatories, Part 2, #9.2]:
    - The written premium ceded to the reinsurer by the reporting entity or its affiliates represents 50% or more of the entire direct and assumed premium written by the reinsurer based on its most recently available financial statement; or
    - 25% or more of the written premium ceded to the reinsurer has been retroceded back to the reporting entity or its affiliates in a separate reinsurance contract.
- Except for transactions meeting the requirements of paragraph 36 of *SSAP No. 62–Property and Casualty Reinsurance*, determine whether the reporting entity ceded any risk under a reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement and either accounted for that contract as reinsurance (either prospective or retroactive) under statutory accounting principles (SAP) and as a deposit under generally accepted accounting principles (GAAP), or accounted for that contract as reinsurance under GAAP and as a deposit under SAP. [Annual Financial Statement, General Interrogatories, Part 2, #9.4]

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- Ascertain whether there were any agreements to release reinsurers from liability during the year. If yes, explain. [Annual Financial Statement, General Interrogatories, Part 2, #8.1]
- If the insurer assumed risks from another company during the period covered by the financial statement, determine whether the company failed to establish a reserve equal to that which the original company would have been required to establish had it retained the risks. If yes, provide an explanation. [Annual Financial Statement, General Interrogatories, Part 2, #10]
- Ascertain whether the insurer guaranteed any policies issued by another company and determine how many are now in force. If yes, provide an explanation. [Annual Financial Statement, General Interrogatories, Part 2, #11.1]

Additional Review Considerations – P/C

- Review the Annual Financial Statement, including the reinsurance schedules and related footnotes, as well as other regulatory filings (e.g., actuarial opinion, MD&A, Form B, etc.) to determine whether any significant and/or unusual reinsurance transactions were completed during the year. Such transactions may include portfolio transfer transactions; commutation agreements; surplus relief or financial reinsurance; bulk or assumption reinsurance; or material non-renewal, cancellation or revisions of ceded reinsurance agreements or changes in the primary reinsurers.
    - Did the insurer enter into any assumption reinsurance agreements whereby the responsibility for the insurer's policyholder obligations passes to an assuming insurer?
    - Are there any concerns expressed in the actuarial opinion relating to surplus relief reinsurance, loss portfolio transfers or financial reinsurance, etc.?
- If concerns exist relating to significant and/or unusual reinsurance transactions, consider the following additional procedures:
    - Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief or financial reinsurance agreements.
    - Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements.
    - Determine whether transfer of risk criteria have been met.
    - Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly "mirrored"
    - Determine whether proper policyholder consents received before the assumption reinsurance transfer was consummated.
    - Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.
- Determine whether the insurer reported during the year, in accordance with the *NAIC Disclosure of Material Transactions Model Act* (#285), any material non-renewals, cancellations, or revisions of ceded reinsurance agreements.
    - If yes, obtain and review supporting documentation of such material transactions.
    - Determine if, in the analyst's opinion, additional procedures are considered necessary.
- Obtain and review underlying documents relating to the use of the reinsurance intermediary or reinsurance assumed. Determine whether agreements are at arm's length and have economic substance.

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- Determine whether the requirements of the *NAIC Reinsurance Intermediary Model Act* (#790) have been met. If not, list the requirements that the insurer has not met.
- Determine whether the requirements of the *NAIC Managing General Agents Act* (#225) have been met. If not, draft a list of the requirements that the insurer has not met.
- If the insurer is engaged in reinsurance for fronting purposes:
    - Determine whether the requirements of the state's statutes and regulations regarding fronting disclosure have been met.
    - Review the types of reinsurance being used and the specific products involved.
    - Perform procedures to evaluate collectability (see Credit Risk)
- Ascertain whether there were any portfolio transfer transactions consummated that, individually or in the aggregate, resulted in an increase in surplus greater than 5%.
- Review the Annual Financial Statement, Notes to Financial Statements, Note #23E:
    - Determine whether there were any commutation agreements consummated that, individually or in the aggregate, resulted in a significant change in surplus (+/-5%).
    - Determine whether there is a trend of annual commutations and if a trend is identified, obtain a detailed rationale for the transactions.
    - If annual trending of commutations is noted, determine any favorable/unfavorable financial impact on the insurer.
- Review the Annual Financial Statement, Schedule F, Part 3, Note A (footnote disclosure of the five highest commission rates relating to reinsurance treaties). Determine whether any of the commission rates are greater than 40%.
- If the insurer utilizes financial reinsurance:
    - Review a summary of the reinsurance contract terms.
    - Review the discussion of management's principal objectives for entering into the reinsurance contract, as well as the economic purpose achieved.
    - Review the aggregate financial impact gross of all ceded reinsurance contracts on the balance sheet and statement of income.
    - Determine whether the reinsurance contract has been accounted for properly, and note any special accounting treatment, including any difference in treatment between GAAP and SAP.

Life/A&H Reinsurance

Procedures/Data – Life/A&H

- Surplus relief of >10% [IRIS #8].
- Ratio of total assumed premiums written to gross premiums.
- Ratio of total assumed premiums written to gross premiums written for any significant line of business, defined as a line of business where gross premium is material to total gross premium written.
- Ratio of assumed premiums written from non-affiliates to total gross premiums written.
- Determine whether any agent, general agent, or broker controls a substantial part of new or renewal business. [Annual Financial Statement, General Interrogatories, Part 1, #4.11 and #4.12].

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- Ratio of ceded premiums written to gross premiums written for any significant line of business, where a line of business's gross premium is material of total gross premium written.

Additional Review Considerations – Life/A&H

- Review the Annual Financial Statement, including the reinsurance schedules and related footnotes, as well as other regulatory filings (e.g., actuarial opinion, MD&A, Form B, etc.) to determine whether any significant and/or unusual reinsurance transactions were completed during the year. Such transactions may include portfolio transfer transactions; commutation agreements; surplus relief or financial reinsurance; bulk or assumption reinsurance; or material non-renewal, cancellation or revisions of ceded reinsurance agreements or changes in the primary reinsurers.
    - Determine whether the insurer entered into any assumption reinsurance agreements whereby the responsibility for the insurer's policyholder obligations passes to an assuming insurer.
    - Ascertain whether there are any concerns expressed in the actuarial opinion relating to surplus relief reinsurance, loss portfolio transfers or financial reinsurance, etc.
- If concerns exist relating to significant and/or unusual reinsurance transactions, consider the following additional procedures:
    - Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief or financial reinsurance agreements.
    - Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements.
    - Determine whether transfer of risk criteria have been met.
    - Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly "mirrored"
    - Determine whether proper policyholder consents received before the assumption reinsurance transfer was consummated.
    - Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.
- Determine whether the insurer reported during the year, in accordance with the *NAIC Disclosure of Material Transactions Model Act* (#285), any material non-renewals, cancellations, or revisions of ceded reinsurance agreements.
    - If yes, obtain and review supporting documentation of such material transactions.
    - Determine if, in the analyst's opinion, additional procedures are considered necessary.
- Obtain and review underlying documents relating to the use of the reinsurance intermediary or reinsurance assumed. Determine whether agreements are at arm's length and have economic substance.
- Determine whether the requirements of the *NAIC Reinsurance Intermediary Model Act* (#790) have been met. If not, list the requirements that the insurer has not met.
- Determine whether the requirements of the *NAIC Managing General Agents Act* (#225) have been met. If not, draft a list of the requirements that the insurer has not met.
- If the insurer is engaged in reinsurance for fronting purposes:
    - Determine whether the requirements of the state's statutes and regulations regarding fronting disclosure have been met.

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- Review the types of reinsurance being used and the specific products involved.
- Perform procedures to evaluate collectability (see Credit Risk)

Life Principles Based Reserving: While state insurance departments have enacted principals-based reserving laws that are effective Jan. 1, 2020, some life insurers continue to establish reinsurance agreements to cede longevity risks (e.g., fixed annuities with guaranteed lifetime withdrawal benefits (GLWBs) and other products such as variable annuities and long-term care insurance to non-U.S. affiliates or U.S. captive insurance companies. State insurance regulators should review this reinsurance activity through the Form D approval process, if affiliated, and through the annual solvency analysis process when new transactions are identified in the annual statement. A potential area of concern would be if such transactions result in an unlevel playing field between insurers, or if the state insurance regulator regime of the captive's jurisdiction results in reduced policyholder protection and regulatory arbitrage. Specifically,

- Where a captive affiliate is domiciled in an international jurisdiction, the regulatory regime of that jurisdiction may not have the same conservatism as the U.S. statutory framework. For example, it may not require asset adequacy analysis which may create material differences in reserves, or it may not require capital charges for longevity risk.
- With regard to appropriate documentation of the agreement, some ceding insurers may not fully document their assessment of the reinsurance within the Actuarial Opinion and Memorandum (i.e., gross reserve cash flow testing) or require a true-up of the reserve credit.
- If transactions are not at arms-length, it may result in questionable invested assets and activities within funds withheld/modified coinsurance (MODCO) trust agreements. For example, assets in the trust agreement may include non-investment grade assets, mortgage loans, complex and non-rated BA assets, securities lending, etc., which may also indirectly impact the ceding insurer's RBC calculation.

Additional Review Considerations

- If the insurer cedes gross premium to captive (non-traditional) reinsurers, utilize the information in Form D for affiliated captive transactions and other annual reporting i.e., annual statement, actuarial reporting, and if necessary, ask the company to gain an understanding of the purpose of the use of captive (non-traditional) reinsurance to better assess the insurer's overall reinsurance strategy.

Health Reinsurance

Procedures/Data – Health

- Ratio of ceded premiums written to gross premiums written

Additional Review Considerations - Health

- Review the Annual Financial Statement, including the reinsurance schedules and related footnotes, as well as other regulatory filings (e.g., actuarial opinion, MD&A, Form B, etc.) to determine whether any significant and/or unusual reinsurance transactions were completed during the year. Such transactions may include portfolio transfer transactions; commutation agreements; surplus relief or financial reinsurance; bulk or assumption reinsurance; or material non-renewal, cancellation or revisions of ceded reinsurance agreements or changes in the primary reinsurers.
    - Determine whether the insurer entered into any assumption reinsurance agreements whereby the responsibility for the insurer's policyholder obligations passes to an assuming insurer.
    - Ascertain whether there are any concerns expressed in the actuarial opinion relating to surplus relief reinsurance, loss portfolio transfers or financial reinsurance, etc.

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- If concerns exist relating to significant and/or unusual reinsurance transactions, consider the following additional procedures:
  - Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief or financial reinsurance agreements.
  - Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements.
  - Determine whether transfer of risk criteria have been met.
  - Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly "mirrored"
  - Determine whether proper policyholder consents received before the assumption reinsurance transfer was consummated.
  - Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.
- Determine whether the insurer reported during the year, in accordance with the *NAIC Disclosure of Material Transactions Model Act* (#285), any material non-renewals, cancellations, or revisions of ceded reinsurance agreements.
  - If yes, obtain and review supporting documentation of such material transactions.
  - Determine if, in the analyst's opinion, additional procedures are considered necessary.
- Obtain and review underlying documents relating to the use of the reinsurance intermediary or reinsurance assumed. Determine whether agreements are at arm's length and have economic substance.
- Determine whether the requirements of the *NAIC Reinsurance Intermediary Model Act* (#790) have been met. If not, list the requirements that the insurer has not met.
- Determine whether the requirements of the *NAIC Managing General Agents Act* (#225) have been met. If not, draft a list of the requirements that the insurer has not met.
- If the insurer is engaged in reinsurance for fronting purposes:
  - Determine whether the requirements of the state's statutes and regulations regarding fronting disclosure have been met.
  - Review the types of reinsurance being used and the specific products involved.
  - Perform procedures to evaluate collectability (see Credit Risk)

Capital Adequacy Management – Concerns with RBC Position

Risk-Based Capital: Evaluate the adequacy of the insurer's risk-based capital (RBC) position in light of its business/strategic plans and risk exposures. The various metrics and considerations outlined under this procedure address the causes of significant changes in the RBC ratio, as well as follow-up procedures that may be necessary to investigate and address the issues identified. Some examples that may cause the RBC ratio to fall into an RBC Action Level include, but are not limited to, increased writings, heightened investment risk, catastrophic loss events, or an unexpected surplus decline. This also identifies insurers with an RBC ratio below 300% that have recorded significant increases or decreases from the prior year. Additionally, the procedure identifies insurers that have recorded RBC ratio declines over two successive years and a broader trend (e.g., five or more years decline) and the insurer's plans to mitigate. If a downward trend is identified, analysts should review the insurer's projections and document its plan to improve the capital position.

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Total Adjusted Capital: Determine if the change in the insurer's RBC ratio was due to Total Adjusted Capital. Total Adjusted Capital is computed by subtracting the value of any reserving discounts from policyholders' surplus and adjusting for asset valuation reserve (AVR) and half of any dividend liability of the insurer's life insurance affiliates in addition to applying credit for capital notes. Otherwise, determine if the change in the insurer's RBC ratio was due to the Authorized Control Level.

RBC Trend Test: Determine whether the insurer triggered the RBC Trend Test. For P/C insurers, the RBC Trend Test is triggered when an insurer has an RBC ratio between 200% and 300% and a combined ratio greater than 120%. For life insurers, the RBC Trend Test is triggered when an insurer has an RBC ratio between 200% and 300%. The trend test calculates the greater of the decrease in the margin between the current year and the prior year and the average of the past three years. Any insurer that trends below 190% could be placed in a Company Action Level - Trend Test. For Health insurers, the RBC Trend test is triggered when a health entity has an RBC ratio between 200% and 300% and has a combined ratio greater than 105%. Companies that trigger an action level are placed in code 5, Company Action Level - Trend Test.

After considering the reasons for triggering the trend test and their potential impact on the solvency of the insurer, analysts should determine whether the state should place the insurer in RBC Company Action Level to deal with the violation and the underlying issues.

The RBC plan is a comprehensive financial plan that:

1) Identifies the conditions in the insurer that contribute to the Company Action Level event;
2) Contains proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the Company Action Level event;
3) Provides projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and/or surplus (the projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component);
4) Identifies the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions;
5) Identifies the quality of and problems associated with the insurer's business including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance in each case, if any.

Analysts should also monitor, on a periodic basis, the insurer's progress in achieving the initiatives included in the RBC plan and the impact of those initiatives on Total Adjusted Capital and the risk factors in the Authorized Control Level RBC. The goal of any RBC plan is the improvement of the underlying causes that led to an RBC Action Level, and an improvement in subsequent RBC ratio results that will remove the insurer from Action Level status.

Procedures/Data

- RBC ratio.
- Significant change in RBC ratio from prior year.
- Change in Total Adjusted Capital from prior year.
- Change in Authorized Control Level from prior year.
- Ascertain whether the RBC trend test has been triggered.
- Determine whether there has been a decrease in RBC over the last two years.

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Additional Review Considerations

- If there has been a downward trend in RBC over the last two years, document the cause(s) of the decline. If a broader trend (e.g., five or more years decline) has been noted, document how the insurer plans to mitigate this continued decline.
- If the insurer reported an increase in Total Adjusted Capital due to special surplus or capital infusions, etc., document the source and plan for continued support.
- Review the RBC risk component(s) and document the underlying causes of any significant changes.
- If the insurer triggered the RBC Trend Test, review and document the reason(s).
- If the insurer has triggered an RBC Action Level event and if authorized by state statute, obtain and review a copy of the insurer's RBC plan and monitor the overall progress.
- If reviewing an RBC plan take the following steps:
    - Verify the accuracy of all historical information provided
    - Review the plan's assumptions for reasonableness
    - Estimate the impact of the proposed corrective actions on financial results, and review the projected experience in the plan for reasonableness
    - Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results
    - Identify any internal or external problems not considered in the plan that may affect future financial results. Examples of such problems include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company's product designs; or 3) the loss of key marketing personnel.
- If the insurer has an RBC plan, monitor, on a periodic basis, the insurer's progress in achieving the initiatives included in the RBC plan and the impact of those initiatives on Total Adjusted Capital and the risk factors in the Authorized Control Level RBC.

Adequacy of Capital and Surplus

Evaluate the adequacy of the insurer's overall capital and surplus position in light of its business/strategic plans and risk exposures. The RBC ratio is designed to calculate a minimum threshold of capital and surplus based on each insurer's unique mix of asset risk, credit risk, off-balance sheet risk, business risk, and underwriting (premium and loss) risk. A measure of surplus adequacy that is commonly considered is the ratio of surplus to assets. Gross change in surplus and change in adjusted surplus (P/C IRIS ratio #7 and #8) and net/gross change in capital and surplus (Life IRIS ratio #1 and #2), measure the improvement or deterioration in the insurer's financial condition from the prior year. Even insignificant increases in the change in surplus ratio may indicate instability or mask financial problems attributable to fundamental changes in the insurer.

Procedures/Data – P/C

- Surplus to assets ratio
    - Compare to industry averages
- Change in adjusted policyholders' surplus [IRIS #8]
- Gross change in policyholders' surplus [IRIS #7]
- Decrease in surplus (capital and surplus) from any of the prior four years
- Unassigned funds

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- Capital Notes and Surplus Notes to surplus
- Change in Capital Notes and Surplus Notes from prior year
- Capital/surplus notes to policyholders' surplus
- Change in capital/surplus notes from prior year
- Review footnote (h) in the Annual Financial Statement, Exhibit of Net Investment Income to determine whether the insurer reported interest expense on capital or surplus notes during the year.
- Note any stockholder dividend payments or declarations
    - Confirm if required approvals were obtained
- Write-ins for special surplus funds or other than surplus funds to surplus
- Absolute value of current year change to current year surplus for any of the following:
    - Net unrealized capital gains/losses
    - Net unrealized Foreign Exch. capital gains/losses
    - Net deferred taxes
    - Non-admitted assets
    - Provision for reinsurance
    - Surplus notes
    - Change in accounting principle

Procedures/Data – Life/A&H

- Capital and surplus to total admitted assets (excluding separate accounts)
- Net change in capital and surplus [IRIS #1]
- Gross change in capital and surplus [IRIS #2]
- Decrease in capital and surplus from any of the prior four years
- Unassigned funds
- Capital Notes and Surplus Notes to capital and surplus
- Change in Capital Notes and Surplus Notes from prior year
- Review footnote (h) in the Annual Financial Statement, Exhibit of Net Investment Income to determine whether the insurer reported interest expense on capital or surplus notes during the year.
- Note any stockholder dividend payments or declarations
    - Confirm if required approvals were obtained
- Identify stockholder dividend payments or declarations to determine if any necessary approvals were obtained. Also Identify significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds, as well as other activities during the year related to capital and surplus notes.
- Write-ins for special surplus funds or other than surplus funds to surplus
- Absolute value of current year change to current year surplus for any of the following:
    - Net unrealized capital gains/losses
    - Net unrealized Foreign Exch. capital gains/losses

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- Net deferred taxes
- Non-admitted assets
- Liability for unauthorized reinsurance
- Reserve valuation basis
- AVR
- Surplus notes
- Change in accounting principle

Procedures/Data - Health

- Change in capital and surplus
- Decrease in capital and surplus from any of the prior four years
- Unassigned funds
- Capital Notes and Surplus Notes to capital and surplus
- Change in Capital Notes and Surplus Notes from prior year
- Review footnote (h) in the Annual Financial Statement, Exhibit of Net Investment Income to determine whether the insurer reported interest expense on capital or surplus notes during the year.
- Note any stockholder dividend payments or declarations
  - Confirm if required approvals were obtained
- Identify stockholder dividend payments or declarations to determine if any necessary approvals were obtained. Also Identify significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds, as well as other activities during the year related to capital and surplus notes.
- Write-ins for special surplus funds or other than surplus funds to surplus
- Absolute value of current year change to current year surplus for any of the following:
  - Net unrealized capital gains/losses
  - Net unrealized Foreign Exch. capital gains/losses
  - Net deferred taxes
  - Non-admitted assets
  - Liability for unauthorized reinsurance
  - Reserve valuation basis
  - Surplus notes
  - Change in accounting principle

Additional Review Considerations – All Statement Types

- If the insurer or insurance group is subject to ORSA requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk Solvency Assessment (ORSA) of the Handbook. Document any concerns or conclusions regarding the insurer's capital modeling and capital position and their effects on the insurer's ability to establish, implement and oversee an effective business strategy.

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- Review the Capital and Surplus section in the Financial Profile Report and/or the Capital and Surplus Analysis (roll forward) in the Annual Financial Statement for unusual fluctuations or trends in the changes in surplus between years. Investigate any significant or unexplained items.
- Compare the surplus (capital and surplus) to assets ratio to the industry average to determine any significant deviation.
- If there has been a change in capital or surplus notes compared to the prior year-end, indicate the current and prior year-end balances and the amount of the change. Also, review any notes issued, principal or interest paid, or any other changes that have been made and whether any necessary approvals were obtained.
- If a significant portion of policyholders' surplus (capital and surplus) is made up of capital/surplus notes, consider performing the following additional procedures (as necessary):
    - Review the Annual Financial Statement, Notes to Financial Statements, Note #13 and Note #11 to identify any unusual terms (e.g., interest rate, date of maturity, assets received, conditions, etc.) and evaluate the impact on the insurer's surplus position.
    - Recalculate important ratios, excluding the amount of surplus notes, to determine the effect of surplus notes on the ratio results.
- Review the write-ins for special surplus and for other than special surplus funds for reasonableness.
- Review the detail of unrealized gains or (losses) in Annual Financial Statement, Exhibit of Capital Gains (Losses) for reasonableness.
- If the insurer declared dividends to stockholders during the year, consider the following procedures:
    - Review Annual Financial Statement, Notes to Financial Statements and Extraordinary Dividend approvals to determine what assets were used to pay dividends:
        - Ascertain whether the amount of the dividend was at a level that required regulatory approval.
        - Determine whether the insurer failed to obtain proper regulatory approvals.
        - If the shareholder dividends paid were at a significant amount that required the liquidation of assets to cash, determine whether there were any liquidity concerns noted.
    - Review the trend of stockholder dividends along with the results of the Holding Company analysis performed by the lead state. Determine whether the insurer has been relied upon for dividend payments to meet holding company business needs.
- Inquire of the insurer:
    - Information on capital/surplus notes and dividends (if not already received)
    - Information on guarantees and other financial obligations
- Ascertain whether the insurer has historically required capital contributions from its parent to offset operating losses or other decreases in capital and surplus.
- If the insurer is subject to ORSA reporting requirements, review information on the insurer's capital/surplus position in the Lead State's evaluation of the ORSA Summary Report.
- If the insurer issued surplus or capital notes, consider reviewing the information in the Annual Financial Statement, Notes to Financial Statements #11 and Note #13.
- If either were issued or repaid, or if interest was paid during the year, analysts should consider determining that these transactions were approved by the domiciliary state insurance department.

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- If surplus notes represent a significant portion of surplus, analysts should consider recalculating important ratios, excluding the surplus notes, to determine their effect on the ratio results. Other steps to consider include the review of the detail of unrealized gains (losses), assessment of any parental guarantees in place and the review of other components of surplus.

Concerns with Parental Guarantees and/or Capital Maintenance Agreements

Assess current and prospective risk related to existing Parental Guarantees and/or Capital Maintenance agreements.

Parental Guarantees and Capital Maintenance Agreements are commitments aimed at providing assurance that the insurer will be able to meet minimum financial obligations if financial or liquidity issues arise. These documents should be carefully reviewed along with the financial background of the entity required to fund the guarantee or agreement. Analysts may also inquire of the insurer if a contingency plan is in place in the event the parental guarantee or capital maintenance agreement is not honored.

Review and assess any parental guarantees, capital maintenance agreements or other commitments in place and determine if concerns exist regarding financial support or failures to act on these commitments. Analysts should thoroughly review the terms related to the agreement to gain a clear understanding of what is covered in the agreement (e.g., limit on lines of business, commitment to pay policyholder claims, commitment to maintain RBC level, etc.) and the impact to the insurer.

Additional information on Capital and Surplus notes can be found in IV.A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations.

Analysts should also consider the following:

- Expected source and form of liquidity should guarantees be called upon.
- If the parental guarantee or capital maintenance agreement specifically addresses the concerns identified and provides adequate support to the insurer.
    - If concerns exist, consider requesting additional information, as necessary, to understand the level of commitment.
- Whether the document contains detailed requirements or expectations for capital support.
- The financial stability of the parent holding company to determine if the parent is adequately capitalized to support maintenance of capital in the insurer above certain thresholds.

If a holding company analysis group profile summary (GPS) is available, analysts should review the GPS for insight into the parent company or ultimate controlling person (UCP) and its ability to meet the financial demands of the guarantee currently or prospectively. Review pertinent data on the holding company and its organizational structure as well as the operations and financial condition of the holding company or UCP. Determine if there are liquidity or other concerns identified within the GPS that warrant additional information from the company.

Procedures

- Review Annual Financial Statement, Notes to Financial Statements, Note #14 to identify any parental/affiliated guarantees, of any form, in place between the company and any member within its holding company system, or non-affiliate.
    - If guarantees are in place, review the ratio of capital notes or surplus notes to total capital and surplus to understand the significance of the note(s).

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Additional Review Procedures

If the level of concern warrants further review, consider:

- Review and discuss with the company and evaluate the potential effect of capital notes or surplus notes on the insurer's surplus position.
- If the insurer is subject to ORSA reporting requirements, there may be a great deal of information on the insurer's capital/surplus position to be reviewed and evaluated in the ORSA Summary Report.
- Review the ratio of surplus to assets compared to the industry average to determine any significant deviation.
- Review the information in the Annual Financial Statement, Notes to Financial Statements #11 and Note #13. If either capital and surplus notes were issued or repaid, or if interest was paid during the year, determine that these transactions were approved by the domiciliary state insurance department.
- If surplus notes represent a significant portion of surplus, analysts should consider recalculating important ratios, excluding the surplus notes, to determine their effect on the ratio results.
- Review the detail of unrealized gains (losses).
- Gain an understanding of other components of surplus.

Financial Impact of the Federal Affordable Care Act on Capital & Surplus and RBC

Assess the impact of the Federal Patient Protection and Affordable Care Act (ACA) assessments, Risk Adjustment Program and medical loss ratio (MLR) rebates on the financial solvency of the insurer. This procedure is relevant for reporting entities that wrote accident and health insurance premium that is subject to Section 9010-Health Insurance Providers Fee (Section 9010) of the ACA. If so, the insurer is required to provide information in the Annual Financial Statement, Notes to Financial Statements, Note #22.

Analysts should review the net receivable/payable effect of the Risk Adjustment Program and determine what the impact they would have on capital and surplus. Also determine what the impact would be on the company's RBC. In conjunction with the review of strategic risk related to ACA business, consider any related Credit Risk for the collectability of admitted assets related to ACA Risk Adjustment Program payments, including those receivables from the Federal Government. Also consider any cross-over risk impacting pricing and underwriting assumptions in the Pricing & Underwriting Risk Assessment.

Analysts may also consider performing a comparison of the components of the MLR as reported in the Annual Financial Statement Supplement Health Care Exhibit and the U.S. Department of Health and Human Services MLR Annual Reporting Form to identify any material differences in line items. If, in the analyst's judgment, any material differences require explanation, consider requesting such explanation from the health entity.

The MLR rebates are mandated by the Federal Public Health Service Act to be returned to the policyholders if the ratio of medical losses and various other items paid to the ratio premiums paid (with various adjustments) is below specified thresholds (80% for individuals or small group employers or greater than 85% for large group employers, or a threshold established in state law, and 85% for Medicare plans).

As stated above, analysts should be aware that the preliminary MLR is **not** the MLR to be used for federal rebate calculations and payment purposes. For example, for federal rebate purposes issuers that have blocks of business less than a given size can make a credibility adjustment to their MLR on the Federal MLR Annual Reporting Form. A credibility adjustment refers to the adjustment to account for random statistical fluctuations in claims experience for smaller plans. Blocks of business with less than 1,000 life years are considered non-credible and will not be required to pay rebates in most cases. Blocks of business with greater than 1,000 (but less than 75,000) life years may add a credibility adjustment to the calculated MLR. Blocks of business with greater than 75,000 life years are considered fully credible and cannot use a credibility adjustment. For specific

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details regarding the credibility adjustment calculation see Issuer Use of Premium Revenue: Reporting and Rebate Requirements, 45 C.F.R. §§ 158.230-158.232 (2016).

If concerns are identified related to ACA assessments, Risk Adjustment Premium or MLR rebates, analysts should perform additional procedures as necessary to evaluate the impact of these concerns on the current and long-term solvency position of the insurer. For example, analysts may request an updated business plan or projections from the insurer in light of concerns in this area.

Procedures/Data

- Determine whether the insurer wrote accident and health insurance premium that is subject to the ACA Risk Adjustment Program.
- Determine what impact the net receivable/payable effect of the Risk Adjustment Program would have on capital and surplus.
- Ratio of MLR rebate liability to capital and surplus

Additional Review Considerations

- Evaluate the impact of ACA fee assessments, risk sharing mechanisms and MLR rebate liabilities on the insurer's current and long-term solvency position.
- Review the Annual Financial Statement, Notes to Financial Statements, Supplemental Health Care Exhibit Part 1 and the final rebate reporting to the U.S. Department of Health and Human Services (HHS). If the amount of MLR rebate liability reported is material (greater than 5% of capital and surplus), determine whether there are concerns regarding the insurer's liability for rebates.
- If risk sharing provisions have an impact on capital and surplus, determine the impact of the ACA Risk Adjustment Program on RBC.

ADDITIONAL PROCEDURES

Examination Findings

Review the most recent examination report, Summary Review Memorandum (SRM) and communication with the examination staff to identify if any strategic risk issues were discovered during the examination.

Own Risk and Solvency Assessment (ORSA) Summary Report

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing strategic risks faced by the insurer.

If the insurer is required to file ORSA or part of a group that is required to file ORSA:

- Determine whether the ORSA Summary Report analysis conducted by the lead state indicates any reputational risks that require further monitoring or follow-up.
- Determine whether the ORSA Summary Report analysis conducted by the lead state indicates any mitigating strategies for existing or prospective reputational risks.

Holding Company Analysis

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Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

- Determine whether the Holding Company analysis conducted by the lead state indicates any reputational risks impacting the insurer that require further monitoring or follow-up.
- Determine whether the Holding Company analysis conducted by the lead state indicates any mitigating strategies for existing or prospective reputational risks impacting the insurer.

QUARTERLY STRATEGIC RISK ASSESSMENT

The quarterly strategic risk assessment procedures are designed to identify the following. For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Impact of News, Press Releases and Industry Reports on Insurer's Strategy

Determine if concerns exist regarding news, press release or industry reports involving the insurer or insurance group.

Procedures

- Review any insurance, marketplace or economic industry reports, news releases, press releases and emerging issues to identify if any issues have the potential to negatively impact the insurer's strategy.
    - Examples: NAIC "Insurance Industry Snapshots" and "Insurance Industry Analysis Reports;" NAIC Capital Markets Bureau reports, rating agency reports, insurance news sources, NAIC risk alerts, etc.
- If concerns exist regarding a recent industry report, news release or emerging issue, determine if the news or industry issue has the potential to impact the insurer's strategy, operations or financial solvency.
- Perform additional non-routine procedures where applicable (e.g., survey or questionnaire, stress testing, etc.).

Insufficent Risk Management and Governance Practices

Evaluate the effects of changes in officers, directors or organizational structure may have on the strategic direction of the insurer.

Procedures/Data

- Determine whether there have been any substantial changes in the organizational chart since the prior quarter end as indicated in General Interrogatories, Part 1, #3.2, of the quarterly financial statement.

Additional Review Considerations

- Review the changes in officers, directors or trustees and any concerns noted during a review of biographical affidavits.
    - Ascertain whether new directors and officers have the required knowledge, experience and training to perform their duties.
    - Determine whether new board of director members are sufficiently independent from management and adequately engaged in performing their duties.

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- Ascertain whether new directors and officers ever been officers, directors, trustees, key employees or controlling stockholders of an insurance company that, while they occupied any such position or served in any such capacity with respect to it (if yes, to any of the following, explain):
  - Been placed in supervision, conservation, rehabilitation or liquidation;
  - Been enjoined from, or ordered to cease and desist from, violating any securities or insurance law or regulation;
  - Suffered the suspension or revocation of its certificate of authority or license to do business in any state.
- Summarize the insurer's policies and procedures regarding performance of background checks on new management.

- If a significant amount of turnover and/or changes in key positions (i.e., chairperson of the board of directors, chief executive office [CEO]) are identified, gain an understanding of and evaluate the impact of such changes on the insurer's strategic direction. Consider requesting updated business plans, holding in-person meetings, conducting conference calls, or taking other steps to understand and address significant changes.
- Determine if there have been any changes in the organization's structure. If so, request the reasons for the changes and the impact on future business plans and strategy.
- Ascertain whether there have been any significant operational or business changes that have resulted in significant changes to staffing levels, consolidations of operations with affiliates, outsourcing of key functions, or placing blocks of business into run-off (closed) blocks.

Lack of Due Diligence in Mergers and Acquisitions,

OR

Integration Challenges

Determine how recent and pending merger and acquisition activity affects the current and prospective solvency position of the insurer and impactsits ability to achieve its business strategy;

Procedures/Data

- Ascertain whether the insurer has been a party to a merger or consolidation as indicated in General Interrogatories, Part 1, #4.1, of the quarterly financial statement.

Additional Review Considerations

- If the insurer has been a party to either a merger or consolidation, note any observations or concerns, ensure Form A or additional filings have been approved, and assess if the insurer is meeting the expectations set forth in the Form A business plan, consider the following additional procedures (as necessary):
  - If regulatory approval of the merger or acquisition was subject to ongoing conditions or restrictions, verify compliance with those requirements.
  - Compare actual results to pre-transaction projections to determine whether results are meeting expectations. If not, gain an understanding of why projections have not been achieved and the company's planned actions to address issues.
  - Request and review information regarding the integration of the new business into the company's processes and systems (systems transition plan), as well as the steps taken to ensure that adequate cybersecurity precautions are taken during the integration process.

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- Gain an understanding of and consider the impact of planned cost-cutting activities, including the nature and magnitude of cuts and their potential impact on risk exposures.

Lack of Strategic Business Planning,

OR

Overly Aggressive or Overly Optimistic Business Strategies

Note: *The following does not contemplate repeating analysis of the business plans that may have been performed as part of the annual analysis. However, if timing of the receipt of business plans coincides with quarterly reviews or if business plans contain quarterly financial projections or other mid-year plans, consider including assessment of business plan in the quarterly review.*

Evaluate the effectiveness of the insurer's business/strategic planning process and whether the current updated business plans and projections result in new or emerging strategic risks;

Procedures

- Review previous business plans and financial projections filed with the state insurance department, and determine the following:
  - Have significant changes in business plan or philosophy occurred? If "yes," explain.
  - Assess if initiatives outlined in the business plan have been accomplished.
  - Compare actual with projected financial results to determine whether actual results are consistent with management's expectations.
  - Request an explanation for the variance including an explanation of whether management believes it has achieved its goals for the period and if any noted risks or challenges were not considered in the business plan.
  - Request a revised business plan.
  - Describe any events, transactions, market conditions and/or strategic management decisions that have occurred (or are planned) that may cause a significant positive or negative variance from projections, including new product development or enhancements, changes in sales volume, product mix, or geographical locations.
  - Determine whether there are any internal and/or external prospective risks that have the potential to impact the overall business plan.
- If necessary, request and review an updated strategic business plan, note any areas of concern and if necessary, request additional explanations from the insurer.
  - Determine whether the new business plan reflects significant changes in the strategic goals or philosophies compared to the prior plan. If so, provide an explanation.
  - Describe the insurer's strategic and annual planning process.
  - Describe the board of directors' involvement in developing and implementing the business plan.
  - Assess the insurer's ability to attain the expectations of the business plan and projections. Determine whether the business plan reflects changes that appear unrealistic for the current market environment, financial position of the insurer or other circumstances. If so, provide an explanation including the following:
    - Reasonableness of underwriting assumptions

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- Current and anticipated interest rate and economic environment
- Growth objectives
- Stability of capital and ability to access additional capital, if needed
- Quality and sources of earnings (trends and stability)
- Dividends and dividend payout policy

Adequacy of Reinsurance Strategy

Determine whether any significant changes may have been made to the insurer's reinsurance program or how any significant new reinsurance transactions may affect the insurer's strategic risk.

Procedures/Data – P/C

- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis
- Gross writings leverage (rolling year)
- Net writings leverage (rolling year)
- Change in leverage ratios from prior year-end
  - Gross writings leverage (rolling year)
  - Net writings leverage (rolling year)
  - Paid reinsurance recoverables to surplus
  - Reserve leverage
  - Change in ceded premiums earned from prior year-to-date
- Change in ceded premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- Change in assumed premiums earned from prior year-to-date
- Change in assumed premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- If the company is a member of a pooling arrangement, determine whether there was any change in agreement or the company's participation as indicated in General Interrogatories, Part 2, #1 of the quarterly financial statement.
- Ascertain whether there were any new reinsurers added since the prior quarter as indicated on Schedule F of their respective quarterly financial statements.
- If so, determine whether any were unauthorized.
- Determine whether there has been a change in provision for reinsurance from prior year-end

Procedures/Data – Life/A&H

- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis
- Change in ceded premiums to gross premiums written

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- From prior quarter
- From prior year-end

- Change in assumed premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- Ascertain whether there is a balance sheet liability for reinsurance in unauthorized and certified companies.
- Change in balance sheet liability, reinsurance in unauthorized and certified companies
  - From the prior quarter
  - From prior year-end
- Change in capital and surplus account line item relating to the change in liability for reinsurance in unauthorized and certified companies
  - From the prior quarter
  - From the prior year-end
- Ascertain whether there were any new reinsurers added since the prior quarter as indicated on Schedule S of their respective quarterly financial statements.
- If so, determine whether any were unauthorized.

Procedures/Data – Health

- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis
- Ascertain whether there were any new reinsurers added since the prior quarter as indicated on Schedule S of their respective quarterly financial statements.
- If so, determine whether any were unauthorized.

Additional Review Considerations – All Statement Types

- If new reinsurance is reported, obtain a copy of the new reinsurer's A.M. Best Supplemental Ratings Questionnaire, and review the reinsurance section to identify any risks or concerns.

Concerns with Reinsurance Transactions

Determine whether any unusual reinsurance transactions were completed during the quarter.

Procedures/Data – P/C

- Ascertain whether there were any agreements to release reinsurers from liability during the quarter as indicated in the General Interrogatories, Part 2, #2 of the quarterly financial statement. [P/C only]
- Determine whether there were any cancellations of primary reinsurance contracts during the quarter as indicated in the General Interrogatories, Part 2, #3.1 and #3.2 of the quarterly financial statement. [P/C only]
- Determine whether the insurer experienced any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile as required by the Model Act as indicated in the General Interrogatories, Part 1, #1.1 of the quarterly financial statement.

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- If so, determine whether the insurer failed to make the appropriate filing of a Disclosure of Material Transactions with the state of domicile as indicated in the General Interrogatories, Part 1, #1.2 of the quarterly financial statement.

- Determine whether the change in the ceded pure loss ratio from the prior year-end is significantly greater than the change in the gross pure loss ratio. [P/C only]
- Determine whether the change in the assumed pure loss ratio from the prior year-end is significantly greater than the change in the gross pure loss ratio. [P/C only]

Procedures/Data – Life/A&H, Health

- Determine whether the insurer experienced any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile as required by the Model Act as indicated in the General Interrogatories, Part 1, #1.1 of the quarterly financial statement.
    - If so, determine whether the insurer failed to make the appropriate filing of a Disclosure of Material Transactions with the state of domicile as indicated in the General Interrogatories, Part 1, #1.2 of the quarterly financial statement.

Additional Review Considerations – All Statement Types

- If the insurer reported material reinsurance transactions as indicated in General Interrogatory #1.1 of the quarterly financial statement, General Interrogatory #1.1] and if concerns exist relating to significant and/or unusual reinsurance transactions during the quarter, consider the following additional procedures:
    - Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief, or financial reinsurance agreements.
    - Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements.
    - Determine whether transfer of risk criteria have been met.
    - Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly “mirrored.”
    - Determine whether proper policyholder consents received before the assumption reinsurance transfer were consummated.
    - Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.

Adequacy of Capital and Surplus

Determine whether concerns exist regarding the insurer’s Risk-Based Capital (RBC) position and the adequacy of the insurer's total capital and surplus position in light of its business/strategic plans and risk exposures.

Procedures/Data – P/C

- Change in surplus from the prior year-end %
- Absolute value of the current year change to capital and surplus for any of the following items:
    - Net unrealized capital gains/losses
    - Net unrealized foreign exchange capital gains/losses
    - Net deferred taxes

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  - Non-admitted assets
  - Provision for reinsurance
  - Surplus notes
  - Change in accounting principle
- Surplus to assets ratio
- Ratio of capital and/or surplus notes issued during the quarter to capital and surplus
- Write-ins for special surplus funds or other than surplus funds to capital and surplus
- Stockholder dividends declared during the quarter
- Unassigned funds

Procedures/Data – Life/A&H

- Change in capital and surplus from the prior year-end [Life]
- Change in capital and surplus from the prior year-end [Health]
- Absolute value of the current year change to capital and surplus for any of the following items:
  - Net unrealized capital gains/losses
  - Net unrealized foreign exchange capital gains/losses
  - Net deferred taxes
  - Non-admitted assets
  - Liability for unauthorized reinsurance
  - Reserve valuation basis
  - AVR
  - Surplus notes
  - Change in accounting principle
- Capital and surplus to total admitted assets (excluding separate accounts)
- Ratio of capital and/or surplus notes issued during the quarter to capital and surplus
- Write-ins for special surplus funds or other than surplus funds to capital and surplus
- Stockholder dividends declared during the quarter

Procedures/Data - Health

- Change in capital and surplus from the prior year-end
- Absolute value of the current year change to capital and surplus for any of the following items:
  - Net unrealized capital gains/losses
  - Net unrealized foreign exchange capital gains/losses
  - Net deferred taxes
  - Non-admitted assets
  - Liability for unauthorized reinsurance

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  - Reserve valuation basis
  - Surplus notes
  - Change in accounting principle
- Capital and surplus to total admitted assets (excluding separate accounts)
- Ratio of capital and/or surplus notes issued during the quarter to capital and surplus
- Write-ins for special surplus funds or other than surplus funds to capital and surplus
- Stockholder dividends declared during the quarter

Additional Review Considerations

- Given the current level of RBC and any significant balance sheet or operational changes, consider the impact to RBC. If there are concerns, consider completing and/or requesting an interim RBC projection.
- If the insurer triggered an RBC Action Level event in the prior period and if an RBC plan was filed, review the insurer's RBC plan and monitor the overall progress to-date.
- Review the Capital and Surplus section in the Financial Profile Report and/or the Capital and Surplus Analysis (roll forward) in the Annual Financial Statement for unusual fluctuations or trends in the changes in surplus between years. Investigate any significant or unexplained items.
- If stockholder dividends were declared during the quarter, ascertain whether the amount of stockholder dividends was at a level that required prior regulatory approval?
  - If yes, determine whether the insurer failed to obtain proper prior regulatory approval for stockholder dividends.
- Review the Quarterly Financial Statement, Notes to Financial Statements and Extraordinary Dividend approvals to determine what assets were used to pay dividends. If the shareholder dividends paid were at a significant amount that required the liquidation of assets to cash, determine whether there were any liquidity concerns.
- Determine whether the insurer repaid any principal and/or paid any interest on capital or surplus notes during the quarter.
- For any newly issues capital or surplus note, consider reviewing any notes issued, principal or interest paid, or any other changes made, and whether any necessary approvals were obtained.
- Review the write-ins for special surplus and other than special surplus funds for reasonableness.

For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

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Note: These procedures are designed for insurers filing on a U.S. generally accepted accounting principles (GAAP) (or modified GAAP) basis, to assist in the completion of the traditional Risk Assessment Procedures.

Balance Sheet Assessment

	Risks
a. If risk-based capital is required, reassess the impact of total adjusted capital if the insurer recorded assets typically non-admitted according to the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual). If risk-based capital is not required, consider various methods to assess the capital sufficiency of the insurer.	OP, ST
i. Consider the potential impact differences between GAAP and SAP investments, and/or deferred acquisitions costs could have on the total adjusted capital component of the RBC calculation.	OP, ST
b. Have there been any changes in assets permitted by the state, such as letters of credit compared to the prior period? If "yes," indicate the line item that changed, current and prior period balances, the amount of the change, and any resulting impact on the insurer.	CR, MK, ST
c. Review any new letters of credit, principal or interest paid and whether any necessary approvals were obtained, if required.	LG, ST
d. Review the Annual Financial Statement, Notes to Financial Statements, Note 1 and document any individual asset category that is greater than 5% of total admitted assets that would typically be non-admitted according to the AP&P Manual. Indicate the asset category (e.g., deferred acquisition costs, fixed assets, prepaid expenses, and deferred taxes), current period-end balance, and the percentage change from the prior period-end. In addition, identify any potential impact these balances may have on liquidity.	LQ
e. Under U.S. GAAP, FAS 113 requires insurers to present reinsurance recoverables on unpaid claims as an asset, as opposed to a contra liability. Consider the impact this presentation has while reviewing the balance sheet of the reporting entity and document the components that are presented differently as well as any significant period-to-period changes.	LQ
f. If the insurer has presented its reinsurance recoverables in accordance with FAS 113, consider the impact this presentation may have on liquidity and the ratio of total liabilities to surplus.	LQ
g. Under U.S. GAAP, reserves can be discounted in some instances. i. Determine if the reporting entity has discounted any reserves that would not be discounted under NAIC SAP and consider the impact of such difference on the overall evaluation of the insurer's financial position. ii. Determine whether permission regarding the discount was received from the Department of Insurance and if the rate of the discount was approved.	LG, RV
h. Under U.S. GAAP, insurers are <u>not</u> required to establish a liability for "provision for reinsurance," but instead are required to establish a contra asset for an allowance for doubtful accounts. Consider the impact this may have on liquidity and the ratio of total liabilities to surplus.	LQ

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Operations Assessment

	Risks
a. Under U.S. GAAP, FAS 115 provides that debt and equity securities that are "being traded" (i.e., trading securities) and are reported at fair value with the change presented through the statement of income. Also under U.S. GAAP, in some cases reserves are allowed to be discounted. Document the impact these differences, as well as any other known differences have on the reporting entity's profitability.	MK, OP, RV

Investment Practices

	Risks
a. Under U.S. GAAP, FAS 115 provides that debt and equity securities that are "available for sale" are reported at fair value with the change presented as unrealized gains and losses through equity (capital and surplus). Document any significant impact of "available for sale" or "trading securities" on the capital and surplus or statement of income of the reporting entity.	OP, MK

Review of Disclosures

	Risks
a. Review the Annual Financial Statement, Notes to Financial Statements to assess the adequacy of disclosures regarding the reconciliation from the AP&P Manual to U.S. GAAP, as well as NAIC validation cross/checks to ensure cross checks failures were adequately explained. Document any inconsistencies with disclosures and validation cross/checks and consider follow-up with the company, if necessary.	LG

Assessment of Results from Prioritization and Analytical Tools

	Risks
a. Analysts should be aware that the Financial Analysis Solvency Tools were designed to assess potential risks within statutorily filed financial statements in conformity with the AP&P Manual and not in conformity with GAAP. Based on the reconciliation found in the Annual Financial Statement, Notes to Financial Statements, Note #1 as well as observations made with the aforementioned questions; review any key ratios for factors that may influence the calculation. Provide an explanation for any unusual or significant fluctuations or trends noted. (A few examples include liquidity ratio, investment yield, etc.)	

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XXX/AXXX Captive Reinsurance Transactions

Review the Annual Statement Supplemental Term and Universal Life Insurance Reinsurance Exhibit to determine if the insurer has any in force reinsurance transactions reported. The analyst may wish to refer to the guidance in section V.C. Domestic and/or Non-Lead State Analysis - Form D Procedures, Assessment of Form D Captive Reinsurance Transactions, procedure #17. Although procedure #17 applies only to affiliate transactions filed for review on Form D, the concepts and regulatory review goals are the same.

Although the analyst should perform a general review of Part 1 to obtain an overview of the insurer's use of reinsurance with respect to XXX/AXXX reserves, the analyst's primary focus should be on the transactions identified in Part 2, as those are the transactions that do not qualify for any of the exemptions identified in Part 1. If there are reinsurance transactions reported in Part 2, complete the following:

1. For all transactions listed in Part 2 and entered into prior to Jan. 1, 2015, and exempt from Actuarial Guideline 48, the following analysis should be performed:

	Other Risks
a. Review security standards for reinsurance of "Grandfathered Policies" to ensure that any credit for alternative reinsurance arrangements must be dependent on security that meets reserve valuation and asset quality requirements, as initially approved by the domiciliary regulator, that are at least as protective as those in place at the time the arrangement received its grandfathered status (12/31/14).	RV, ST, OP, CR
b. Obtain information from the insurer to review the actual experience on the ceded business in order to assess how the transaction is tracking relative to the initial or most recently provided projections and underlying assumptions. Although the actual experience data should be updated annually, the analyst should review three to five years of actual experience, if available, as some level of annual deviation is expected and should be viewed in a broader context.	RV, ST, OP, CR
c. If the information contained within item 1.a. above shows material adverse deviations from the initial or most recently provided projections and/or expected experience and the reinsurer is an affiliate of the ceding insurer, require the insurer to submit five years of pro forma financial statements of the affiliate (assets, liabilities, equity and income) including specifically projected statutorily required reserves as well as any capital requirements imposed by the external finance provider on the reinsurer.	RV, ST, OP, CR
d. Review the investments of the reinsurer, as reflected in the statutory financial statements and any additional information filed by the reinsurer with the reinsurer's domestic regulator, and consider the extent to which they comply with the state's investment laws for non-captive insurers and are admitted assets under the NAIC Accounting Practices and Procedures Manual, as well as whether the overall investment portfolio would be disadvantaged if held directly by a domestic insurer. Review any funds held by or on behalf of the ceding insurer as security for the reinsurance contract to determine that, at a minimum, they comply with state investment laws for non-captive insurers and are admitted assets under the NAIC Accounting Practices and Procedures Manual. Specifically determine that none of the capital requirements imposed by an external financial provider are supported by any type of letter of credit which would not meet the definition of an admitted asset under statutory accounting principles.	LG, ST, CR
e. Involve a department actuary or consulting actuary wherever necessary.	RV

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2. For all transactions listed in Part 2 and entered into on or after Jan. 1, 2015, or otherwise subject to Actuarial Guideline 48 and using the definitions set forth in Actuarial Guideline 48, the following analysis should be performed:

	Other Risks
a. Obtain information from the insurer to review the actual experience on the ceded business in order to assess how the transaction is tracking relative to the initial or most recently provided projections and underlying assumptions. Although the actual experience data should be updated annually, the analyst should review three to five years of actual experience, if available, as some level of annual deviation is expected and should be viewed in a broader context.	RV, ST, OP
b. Review Parts 2 and 3 of the "Supplemental Term and Universal Life Insurance Reinsurance Exhibit" to determine if: i. funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis; and, ii. funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (1) above, are held by or on behalf of the ceding insurer as security under the reinsurance contract. If not, request a detailed explanation from the insurer.	RV, ST, OP, CR
c. Involve a department actuary or consulting actuary wherever necessary.	RV
d. At least once every five years: i. If the reinsurer is an affiliate of the ceding insurer, require the insurer to submit five years of pro forma financial statements of the affiliate (assets, liabilities, equity and income). ii. Require the insurer to submit current and five-year projected calculations, and support therefore, of (a) the statutory reserves with respect to the cession and (b) the Required Level of Primary Security. iii. Review the funds held by or on behalf of the ceding insurer to determine whether such funds are properly classified as a Primary Security or Other Security. iv. Have a department actuary, or consulting actuary engaged by the department, review the Actuarial Opinion to determine if the insurer has followed the Actuarial Method for this business consistent with the requirements of Actuarial Guideline 48.	RV, ST, OP, CR

Analyst:	Date:
Supervisor Review:	Date:
Supervisor Comments:	

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Note: The worksheet is not an all-inclusive list of possible procedures. Therefore, analysts may refer to the branded risk guidance as appropriate. Additionally, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk**.**

Analysis Documentation: Risk exposures identified through the use of the title insurer worksheet should be documented in Section III: Risk Assessment of the insurer.

Capital Adequacy

1. Evaluate the adequacy of the insurer's surplus position in light of its business strategy/strategic plans and risk exposures.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Net change in surplus	ST,OP	>25% or <-15%	[Data]	[Data]
b. Change in surplus notes	ST,OP	<>0	[Data]	[Data]
				Other Risks
c. Review the Capital and Surplus Account section in the Annual Financial Statement, Operations and Investment Exhibit for unusual fluctuations or trends in the changes in surplus between years. Investigate any significant or unexplained items.				ST, OP

Liquidity

2. Determine if there are any concerns regarding the liquidity of the insurer's asset portfolio and overall liquidity.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Liquidity ratio	LQ	>105%	[Data]	[Data]
b. Change in liquid assets	LQ	>50% or <-15%	[Data]	[Data]
				Other Risks
c. Review the five-year trend for the liquidity ratio within the Financial Profile Report and document any unusual fluctuations.				LQ
d. If concerns are identified regarding overall liquidity of the asset portfolio, identify and assess other sources of liquidity available to the insurer.				LQ

Cash Flow from Operations

3. Determine whether concerns exist regarding the insurer's cash flow.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Ratio of net cash from operations to surplus	LQ	< -5%	[Data]	[Data]
				Other Risks

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b. Review the Cash from Operations section in the Annual Financial Statement, Cash Flow to determine the underlying cause of the negative cash flow.	LQ
c. Review the trend in net cash from operations within the Financial Profile Report for the past five years and note any unusual fluctuations or negative trends between years.	LQ

Operating Performance

4. Determine whether concerns exist regarding the insurer's Statement of Income or operating performance.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Combined ratio	OP	>105% or <80%	[Data]	[Data]
b. Change in combined ratio	OP	>10 pts or <-25 pts	[Data]	[Data]
i. Change in premiums earned	OP, PR/UW	>25% or <-25%	[Data]	[Data]
ii. Change in losses and loss adjustment expense (LAE) incurred	OP, PR/UW	>25% or <-25%	[Data]	[Data]
iii. Change in operating expenses incurred	OP	>25% or <-25%	[Data]	[Data]
c. Change in net income when net income is greater than 10% or less than -10% of surplus	OP	> 30% or < -15%	[Data]	[Data]
				Other Risks
d. Review the five-year trend with the Financial Profile Report for the following measures of operating performance, and note any unusual fluctuations or trends between years for each ratio: • Combined ratio • Loss and LAE ratio • Expense ratio				OP, PR/UW
e. If concerns exist regarding operating performance, consider the following procedures: i. Review the Annual Statement, Insurance Expense Exhibit, identify any expense allocation concerns or unusual operating results by line of business. ii. Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses. iii. Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations.				OP, PR/UW

Premium Production

5. Determine whether concerns exist regarding changes in the volume of premiums written or changes in the insurer's geographic location.

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	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Change in total direct premiums written (DPW)	PR/UW	>25% or <-25%	[Data]	[Data]
i. Change in DPW through direct operations	PR/UW	>10% or <-10%	[Data]	[Data]
ii. Change in DPW through non-affiliated agency operations	PR/UW	>10% or <-10%	[Data]	[Data]
iii. Change in DPW through affiliated agency operations	PR/UW	>10% or <-10%	[Data]	[Data]
b. Change in DPW in any one state when DPW is greater than 10% of total DPW in either the current or prior year end	PR/UW	>50% or <-50%	[Data]	[Data]
c. DPW in a new state to total DPW	PR/UW	>5%	[Data]	[Data]
				Other Risks
d. If significant changes in premium volume are identified, consider the following procedures: i. Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume. ii. Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.				PR/UW, ST

Investment Practices

6. Determine whether concerns exist related to investment practices, including purchases and sale of securities and control of assets.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof? [Annual Financial Statement, General Interrogatories, Part 1, #16]	OP	=YES	[Data]	[Data]
b. Are any stocks, bonds and other securities owned, over which the insurer has exclusive control, not in the actual possession of the insurer, other than securities lending programs? [Annual Financial Statement, General Interrogatories, Part 1, #25.01 and #25.02]	OP	=YES	[Data]	[Data]
c. Are any stocks, bonds or other assets owned by the insurer not exclusively under the control of the insurer? [Annual Financial Statement, General Interrogatories, Part 1, #26.1 and #26.2]	OP	=YES	[Data]	[Data]
d. Were there any assets reported subject to a contractual obligation to transfer to another party	OP	=YES	[Data]	[Data]

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without the liability for such obligation being reported? If "yes," comment on the purpose and the amount. [Annual Financial Statement, General Interrogatories, Part 1, #21.1 and #21.2]				
e. Book/adjusted carrying value of total special deposits to assets	LQ	>10%	[Data]	[Data]
				Other Risks
f. Review the Annual Financial Statement, Summary Investment Schedule. Note any unusual valuation methods or areas that indicate further review is necessary.				CR, MK
g. Review the Annual Supplemental Investment Risks Interrogatories and assess any unusual items or areas that indicate a non-diversified portfolio.				MK

Affiliated Investments

7. Determine whether investments in affiliates are significant.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Total of all investments in affiliates to surplus. [Annual Financial Statement, Five-Year Historical Data]	LQ, CR, MK	>20%	[Data]	[Data]
b. Change in total of all investments in affiliates from the prior year-end	LQ, CR, MK	>20% or <-20%	[Data]	[Data]
c. Change in any category of affiliated investments from the prior year-end	LQ, CR, MK	>10% or <-10%	[Data]	[Data]
				Other Risks
d. Are affiliated investments in violation of state statutes?				LG
e. Review the results of the Holding Company Analysis completed by the lead state to determine if any concerns exist regarding affiliated entities.				LQ, CR

Unrealized Capital Gains and Losses

8. Assess unrealized capital gains(losses) including other-than-temporary impairments.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Net unrealized capital gains/(losses) to prior year-end surplus	MK	>10%	[Data]	[Data]
				Other Risks
b. Review the detail of unrealized gains/(losses) in the Annual Financial Statement, Exhibit of Capital Gains/(Losses) for reasonableness.				MK

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IV. Supplemental Analysis Guidance

A. Financial Analysis and Reporting Considerations

B. Analysis of Notes to the Financials

C. Health Insurance Industry

Legend of Abbreviations

Statement Types	
P	Property/Casualty
L	Life/A&H
H	Health
T	Title

Branded Risk Classifications		
Symbol	**Risk**	**Description**
CR	Credit	Amounts actually collected or collectible are less than those contractually due or payments are not remitted on a timely basis.
LG	Legal	Non-conformance with laws, rules and regulations, prescribed practices or ethical standards (in any jurisdiction in which the entity operates) will result in a disruption in business and financial loss.
LQ	Liquidity	Inability to meet contractual obligations as they become due because of an inability to liquidate assets and/or obtain adequate funding without incurring unacceptable losses.
MK	Market	Movement in market rates or prices (such as interest rates, foreign exchange rates or equity prices) adversely affect the reported and/or market value of the investments.
OP	Operational	The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events.
PR/UW	Pricing/ Underwriting	Pricing and underwriting practices are inadequate to provide for risks assumed.
RP	Reputation	Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.
RV	Reserving	Actual losses and/or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
ST	Strategic	Inability to implement appropriate business plan, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

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A. Overview of Invested Assets

Insurers receive premiums from policyholders today in exchange for a promise to pay covered benefits/losses in the future. These premiums, net of operating expenses paid, along with capital and surplus funds, are invested in a variety of different types of investments until needed to pay benefits/losses. State insurance laws regulate an insurer's investments and prescribe the types of investments which may be acquired by insurers. These laws also generally provide limitations on investments by type and issue. However, in most states, a large amount of the insurer's assets may be invested at the discretion of management or the board of directors within the statutory limits. An insurer may become financially troubled if it invests heavily in speculative or high-risk investments that later result in losses or if it invests in securities with maturities that are inappropriately matched with its liabilities.

Investment income is often a key component in the pricing of insurance products (i.e., life & annuity and other long-tailed lines). In some cases, management may be pressured into strategies to maximize investment yields when policy benefits are higher than was anticipated at the time products were priced. Higher investment yields generally involve higher risk and ownership of investments with questionable quality or value.

Another important investment consideration is the proper matching of assets and liabilities. An insurer must manage its investment portfolio to match investment maturities with its cash flow needs to pay benefits/losses. Poor matching may result in the insurer being forced to liquidate long-term investments at a loss to provide the currently needed cash flows.

Investment risk may also involve a failure to adequately diversify an investment portfolio. A concentration of assets in one type of investment may not adequately spread the investment risk and may result in more volatile investment returns. A high concentration of investments that are not readily marketable may also indicate increased investment risk and may raise concerns as to the value of the investments.

Life insurers have historically invested primarily in long-term bonds and mortgage loans. Property/casualty insurers have invested primarily in bonds and common stocks. While this still holds true, the industry's approach to investments has changed significantly in recent years. In the past, when the principal focus of the products sold was insurance, the primary objective of an insurer's investment strategy was the preservation of capital, and life insurers invested in long-term bonds with stable interest rates and predictable cash flows while property/casualty insurers invested in high quality bonds and stocks.

However, insurers are now focusing more on investment returns. This change in focus has prompted insurers to turn to assets of higher risk and lower quality in exchange for higher investment yields. Therefore, insurers may have significant investments in noninvestment-grade bonds, privately placed bonds, residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS) and other loan-backed and structured securities (LBaSS). Investments today are also much more complex and sophisticated than in the past. This requires that insurers have investment advisors (in-house and/or contractual) with appropriate background and expertise as well as analytical systems which are capable of continuously monitoring the constantly changing marketplace. It is also important that the investment advisors communicate with personnel responsible for liability cash flows to help assure that projected asset and liability cash flows are adequately matched.

As a result, investment analysis is more important today than it was in the past. The principal areas of concern to analysts in reviewing an insurer's investment portfolio are: 1) diversification, 2) liquidity, 3) quality, 4) valuation, and 5) asset/liability matching. First, an insurer's investment portfolio should be adequately diversified to prevent an undue concentration of investments by type or issue. Second, the investment portfolio should be structured in such a way that it is appropriately liquid to allow for the cash flows necessary to cover the insurer's benefit commitments as they become due. Sufficient assets should be readily convertible to cash and the sale of necessary assets should not involve significant losses caused by changes in the market. Third, default or credit risk is a function of investment quality. As the quality of an investment decreases, the probability that principal will be returned and that the expected yield will be realized tends to decrease. Fourth, invested assets are generally valued at cost or amortized cost, except for common stocks and perpetual

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preferred stocks which are valued at fair value. However, analysts should be alert for investments which should be written down to fair value due to other than temporary declines in value. Fifth, analysts should be alert for investment portfolios with cash in-flows which do not match with projected liability cash out-flows.

Health Entities

Most health entities typically maintain a fairly conservative investment philosophy. Some of this conservatism can be driven by the health entity's need to maintain liquidity in order to match the generally short-term benefits cycle. The liquidity philosophy may be driven by the health entity's size and level of capital and surplus. In some cases, a small or thinly capitalized health entity may need to maintain additional liquidity and therefore hold mostly cash or cash equivalents. Other health entities, such as Hospital, Medical and Dental Services or Indemnities (HMDIs), may be able to maintain sufficient liquidity while holding some long-term investments. A significant portion of most health entities' invested assets is maintained in cash and short-term investments. Most health entities also hold the majority of remaining invested assets in investment grade bonds with somewhat short-term maturities. Although most health entities will maintain a fairly liquid asset mix, analysts should be aware that an improper matching of assets with liabilities can occur with health entities and can lead to forced liquidations of long-term investments. In some of these cases, it is possible that the health entity may not be able to liquidate its portfolio fast enough when benefits obligations come due. In other cases, the liquidation may result in capital losses, leading to deterioration in the financial solvency of the health entity.

Because of the somewhat conservative investment philosophy used by many health entities, investment yields for most health entities are generally low compared to life or property/casualty insurers. However, some health entities may also write small amounts of life insurance, long-term care (LTC), or other long-tail lines of business. For those health entities, investment income can be a key component in the pricing of these longer-tail lines of business.

Property/Casualty

Although investments have been more of a concern in the past analyses of life insurers than property/casualty insurers, many property/casualty insurers are now investing in riskier investments. Analysts should be alert for property/casualty insurers with concentrations of investments that are riskier and/or less liquid than traditional bonds and common stocks. Analysts should also evaluate whether these investments are appropriate for the insurer based on the lines of business written and the insurer's liquidity and cash flow needs.

B. Primer on Derivatives

Derivative instruments are financial instruments whose value and cash flows are based on other financial instruments, indices or statistics. Based on the current insurance regulatory framework, this definition is too broad. For example, some people call Collateralized Mortgage Obligations (CMOs), "mortgage-backed derivatives," because the value and cash flows of a CMO are based on the value and cash flows of a pool of mortgages. Additionally, securities that are labeled "principal-protected notes" and "structured notes" are captured within the scope of *SSAP No. 86—Derivatives* (paragraph 5g). For insurance regulatory purposes, only options, caps, floors, forwards, futures, swaps, collars and similar instruments are considered derivative instruments. The definitions of these instruments are contained in NAIC *Accounting Practices and Procedures Manual* (AP&P Manual).

This primer will concentrate on options, futures and swaps. It will describe the instruments from an operational standpoint and from a use standpoint. It will also discuss how derivative instruments are reported in statutory financial statements. Accounting will be discussed only in general terms. A discussion of accounting details is provided in SSAP No. 86.

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Derivative Instrument Basics

- **Options**

An option is an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate, or effect a cash settlement based on the actual or expected price level, performance or value of, one or more underlying interest. Underlying interest is the asset(s), liability(ies), or other interest(s) underlying a derivative instrument, including, but not limited to, any one or more securities, currencies, rates, indices, commodities, derivative instruments, or other financial market instruments.

An insurer can either purchase an option or write (sell) an option. When an insurer buys an option, the insurer pays a premium for a right, but not an obligation, to exercise the option at a strike. When an insurer writes (sells) an option, the insurer receives a premium from the other party to the transaction (counterparty). The counterparty has the right, but not the obligation, to exercise the option at the strike. An example will help to illustrate these concepts.

Consider an insurance company that sells equity indexed annuities. The equity indexed annuity provides a floor guarantee as to interest with an additional guarantee that the policyholder will participate in the upside of an equity index if the growth in the equity index exceeds the guaranteed interest.

An insurer can purchase an option to hedge the equity risk in the annuity contract. The option purchased would be based on the same equity index as the annuity contract. The level of the strike in the option would be based on the amount determined by the guaranteed interest rate, the participation rate in the annuity contract, and any cap on index growth. If the index grew at a rate greater than the guaranteed interest rate in the annuity contract, the insurer would exercise the option to cover the equity index-based obligation in the annuity contract. If the holder of the option does not exercise the option, the holder's downside is limited to the initial premium paid for the option.

- **Futures**

A futures contract is an agreement traded on an exchange, board of trade, or contract market, to make or take delivery of, or effect a cash settlement, based on the actual or expected price, level, performance, or value of one or more underlying interests.

Futures contracts are different from options in that an insurer entering a futures contract will participate in both gains and losses in the underlying financial instrument as measured from the date the futures contract is opened. For example, if an insurer takes a long position in U.S. Treasury futures, the insurer will experience any gains or losses in the U.S. Treasury futures (the underlying instrument) as measured from the date of opening the position. If interest rates increase after the futures contract is opened, the U.S. Treasuries will decrease in value and the insurer will have to make a payment to the counterparty. On the other hand, if interest rates move down, the insurer will receive a payment from the counterparty. Since the insurer shares in both the upside and downside of the futures contract, the insurer does not pay a premium when entering a futures contract. If the futures contract is exchange traded, the insurer will typically put up a deposit in cash or securities. This deposit is to protect the counterparty in the event the insurer cannot make required payments.

Insurers exposed to interest rate risk can take short positions in U.S. Treasury futures contracts. In this case, the insurer receives payments if interest rates increase and makes payments if interest rates decrease. This is opposite of the situation when the insurer takes a long position. However, going short U.S. Treasury futures can hedge the interest rate risk exposure on bonds that the insurer holds in its portfolio. This is especially important for GAAP accounting purposes when bonds are reported on a fair value basis.

In the discussion above, taking a "long" position has the same financial characteristics as buying the underlying instrument (in this case a bond). Taking a "short" position has the financial characteristics of short selling the underlying instrument (in this case a bond).

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- **Swaps**

A swap contract is an agreement to exchange or net payments at one or more times based on the actual or expected price, level, performance, or value of one or more underlying interests. A typical example is a fixed or floating swap. An insurer can make payments to a counterparty based on a fixed rate, for example 6%, semi-annually and receive a floating rate SOFR (Secured Overnight Financing Rate), for example, plus a spread. Each six months, the insurer would pay the counterparty 3% times the notional amount, $10,000,000 for example, and would receive an amount equal to $10,000,000 times the then current SOFR rate plus a spread. Of course, the amounts are netted so that a single payment is made by one party to the other party. Depending on the SOFR rate at any payment determination date, the insurer may be making or receiving a payment. In swap transactions, the rates and spread are set so that neither party pays an up-front premium to open the transaction. Also, the notional amount is never exchanged.

The floating rate of a swap transaction can be based on a multitude of different financial indices or rates. For example, in a credit swap transaction, the floating rate can be based on the total rate of return of a junk bond portfolio. In effect, the party that is paying the fixed rate can be exposed to junk bond market risk through a transaction of this type.

- **Caps/Floors**

A cap is an agreement obligating the seller to make payments to the buyer. Each payment is based on the amount, if any, that a reference price, level, performance, or value of one or more underlying interests exceed a predetermined number, sometimes called the strike/cap rate or price. A floor is an agreement obligating the seller to make payments to the buyer. Each payment is based on the amount, if any, that a predetermined number, sometimes called the strike/floor rate or price, exceeds a reference price, level, performance, or value of one or more underlying interests. Caps and floors are similar to options in that one party, the purchaser of the instrument, pays a premium and receives a payment from the other party if an index exceeds the “cap” or falls below the “floor”, a specified value, or “strike”. An insurer might purchase a floor to protect itself against interest rates falling below the guarantees in the annuity contracts it has sold. An insurer can either buy or write (sell) caps or floors.

- **Collars**

A collar is an agreement to receive payments as the buyer of an option, cap, or floor and to make payments as the seller of a different option, cap, or floor. An insurer could buy a collar that includes the purchase of a cap and the sale of a floor. In effect, the insurer is protecting itself against an increase in interest rates and paying for the protection by selling the floor.

- **Forwards**

A forward is an agreement (other than futures) to make or take delivery of or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests. It is an over-the-counter transaction as opposed to a trade on an exchange, which makes it less liquid. It is customized to meet the needs of both parties whereas contracts traded on an exchange are standardized.

- **Warrants**

A warrant is an agreement that gives the holder the right to purchase an underlying financial instrument at a given price and time (or at a series of prices and times) according to a schedule or warrant agreement.

Uses of Derivative Instruments

Besides analyzing derivative instruments from an operational standpoint, they can be analyzed by their use. From an insurance regulatory perspective, derivative instruments can be used in four ways: hedging, income generation, replication of other assets, and speculation. Rules concerning hedging and income generation

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transactions are included in the NAIC *Investments of Insurers Model Act (Defined Limits Version)* (#280) and the AP&P Manual (SSAP No. 86).

- **Hedging**

For a derivative instrument to qualify for hedge accounting the item to be hedged must expose the company to a risk and the designated derivative transaction must reduce that exposure. Examples include the risk of a change in the value, yield, price, cash flow, quantity of, or degree of exposure with respect to assets, liabilities, or future cash flows which an insurer has acquired or incurred or anticipates acquiring or incurring.

Some insurance companies that sell Guaranteed Investment Contracts (GICs) guarantee to the GIC holders an interest rate on future contributions for a specified period of time. The risk associated with this type of guarantee is that interest rates may drop before the GIC contract holder makes an additional contribution. The insurer can hedge this risk by using futures contracts.

- **Income Generation**

Income generation transactions are defined as derivatives written or sold to generate additional income or return to the insurer. They include covered options, caps, and floors (e.g., an insurer writes an equity call option on stock which it already owns).

Because these transactions require writing derivatives, they expose the insurer to potential future liabilities for which the insurer receives a premium up front. Because of this risk, dollar limitation and additional constraints are imposed requiring that the transactions be "covered" (e.g., offsetting assets can be used to fulfill potential obligations). To this extent, the combination of the derivative and the covering asset works like a reverse hedge where an asset owned by the insurer in essence hedges the derivative risk.

An example is the writing (selling) of call options that are covered. Covering the call option means that the insurer writing (selling) the options owns the financial instruments or the rights to the financial instrument that can be called by the option holder. The insurer writing (selling) the option earns a profit (the premium) if the option is not exercised by the other party. If the option is exercised, the financial instrument subject to call is paid to the holder of the option. From a risk/return standpoint, writing a covered call generates income in the same way that a callable bond does as compared to a non-callable bond. As with derivatives in general, these instruments include a wide variety of terms regarding maturities, range of exercise periods and prices, counterparties, underlying instruments, etc.

- **Replication**

The basic idea behind replication transactions is to combine the cash flows from a derivative instrument and another financial instrument to replicate the cash flows of another financial instrument. The following is a typical example of a replication transaction: the insurer holds a high-quality corporate bond that pays one 7% coupon per year. The insurer can enter into a swap transaction with another party in which the insurer receives 2% of the notional amount of the swap each year and, in turn, pays the counterparty the drop in fair value of a specific junk bond that would result if the junk bond would default. The insurer does not own the junk bond, but the combined cash flows of the high-grade corporate bond and the swap transaction replicate the cash flows of a junk bond.

Reporting of Derivative Instruments

On an annual basis, derivative instruments are reported in the Annual Financial Statement, Schedule DB. Options, caps, floors, collars, swaps and forwards are reported in Part A. Future contracts are reported in Part B, replications are reported in Part C, and counterparty exposure for derivatives instruments are reported in Part D.

Schedule DB – parts A and B contain two sections: 1) Section 1 identifies the contracts open as of the accounting date, and 2) Section 2 identifies contracts terminated during the year.

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Schedule DB–Part C – Section 1 contains the underlying detail of replicated assets owned at the end of the year. Schedule DB – Part C – Section 2 is a reconciliation between years of replicated assets.

Schedule DB – Part D – Section 1 of the annual statement is different. It collects information necessary for risk-based capital (RBC) purposes. Currently, the NAIC RBC formula assumes that all derivative instruments are used for hedging purposes and the only risk exposure to the insurer is that the counterparty may not perform according to the terms of the contract. The concepts of Potential Exposure and Off-Balance Sheet Exposure have been defined to quantify the risk of non-performance by the counterparty. The definition of these concepts is contained in the Annual Statement Instructions.

On a quarterly basis, the insurer only reports derivative instruments that are open as of the current statement date. Schedule DB – Part A – Section 1 lists the insurer's open options, caps, floors, collars, swaps and forwards. Open futures are reported in Schedule DB – Part B – Section 1, replications are reported in Schedule DB – Part C – Section 1, and counterparty exposure for derivatives instruments are reported in Schedule DB – Part D.

Accounting

Statutory accounting guidance for derivative instruments used for hedging and income generation transactions is contained in the AP&P Manual. Derivative transactions follow SSAP No. 86. The insurer is to disclose the transition approach that is being used. In order for a derivative instrument to qualify for hedge accounting treatment, the item to be hedged must expose the insurer to a risk and the designated derivative transaction must reduce that exposure.

An insurer should set specific criteria at the inception of the hedge as to what will be considered "effective" in measuring the hedge and then apply those criteria in the ongoing assessment based on actual hedge results. The penalty for failure to meet the effectiveness criteria varies from state to state.

The NAIC accounting guidance includes a discussion of required documentation. One item that is not mentioned is the "term sheet." The term sheet is a document signed by both parties to an over-the-counter derivative transaction such as a swap. The term sheet contains a detailed description of all of the terms and conditions of the swap transaction.

In many cases, an insurer will enter into several over-the-counter transactions with a single party. In this situation, the insurer should have entered into a master netting agreement. The existence of such an agreement has implications for risk-based capital.

Comprehensive Description of a Hedging Program

When an insurer is actively engaged in derivative activity or when concerns exist regarding an insurer's derivative activity it may be necessary to obtain a comprehensive description of the insurer's derivative program.

States may have specific requirements for items to be included in a comprehensive description of an insurer's derivative program. Items may include detailed information on the following:

- Authorization by the insurer's board of directors, or other similar body to engage in derivative activity
- Management oversight standards including risk limits, controls, internal audit, review and monitoring processes
- The adequacy of professional personnel, technical expertise and systems
- The review and legal enforceability of derivative contracts between parties
- Internal controls, documentation and reporting requirements for each derivative transaction

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- The purpose and details of the transaction including the assets or liabilities to which the transaction relates, specific derivative instrument used, the name of the counterparty and counterparty exposure amount, or the name of the exchange and the name of the firm handling the trade
- Management's written guidelines for engaging in derivative transactions, for example:
  - Type, maturity, and diversification of derivative instruments
  - Limitations on counterparty exposures
  - Limitations based on credit ratings
  - Limitations on the use of derivatives
  - Asset and liability management practices
  - The liquidity and capital and surplus needs of the insurer as it relates to derivative activity
- The relationship of the hedging strategies to the insurer's operations and risks
- Guidelines for the insurer's determination of acceptable levels of basis risk, credit risk, foreign currency risk, interest rate risk, market risk, operational risk, and option risk
- Guidelines that the board of directors and senior management comply with risk oversight functions and adhere to laws, rules, regulations, prescribed practices, or ethical standards

C. Health Receivables

Health entities are authorized to report a number of assets in the Annual Financial Statement. According to SSAP No. 4–*Assets and Non-admitted Assets*, an asset has the following three essential characteristics: (a) it embodies a probable future benefit that involves a capacity, singly or in combination with other assets, to contribute directly or indirectly to future net cash inflows, (b) a particular entity can obtain the benefit and control others' access to it, and (c) the transaction or other event giving rise to the entity's right to or control of the benefit has already occurred. Other than invested assets, some of the more significant items that meet the above definition are uncollected premiums and agent's balances, health care receivables, health care delivery assets, amounts receivable relating to uninsured accident and health plans, electronic data processing equipment, and software. Each of the above types of other assets is individually unique and can carry its own risks. This can be particularly of concern for health entities, which may require a more liquid balance sheet than other types of insurers. The following discusses each of these other asset classes in greater detail including some of the unique circumstances and risks to the health entity.

Uncollected Premiums and Agent's Balances

The asset for uncollected premiums includes amounts receivable on individual and group policies that have been billed but have not yet been collected. Uncollected premium balances result from transactions conducted directly with the insured. For most health entities, the primary coverage written is comprehensive group business. While assessing a group's credit risk, if permitted by law, is often an important part of the underwriting process, the credit risk on group business can actually be lower than the credit risk on individual business. This is because most comprehensive group business is written on a monthly installment basis billed and paid in advance of the effective date of the coverage. Said differently, the coverage period is usually one month and is usually due or paid before the coverage period begins. Because of this, a health entity's credit risk is theoretically mitigated by its ability to stop coverage in a short period of time. However, from a practical standpoint, the health entity may desire to retain large or influential groups, either because of the prominence associated with writing to these groups or because the health entity may not want to be viewed as an inhibitor to health care services.

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The sale of health insurance can differ significantly from the sale of other types of insurance. Although agents are used by health entities, they are generally not used as extensively as with property/casualty insurers or even life insurers. Agent's balances are admitted to the extent that the assets conform to the requirements of SSAP No. 6–*Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts due from Agents and Brokers*, which also requires that premiums owed by agents should be reported net of commissions and are non-admitted under a 90-day rule. Remaining amounts that are determined to be uncollectable must be written off. Generally, if a contract with an agent permits offsetting, amounts payable to an agent may be offset against a receivable from that agent. Agents' balances carry credit risk and can have a material impact on the net income and capital and surplus of a health entity if the balances are significant. Significant or growing balances can also lead to liquidity problems if the health entity is unable to convert the receivables into cash to be used to pay claims.

The collectability of amounts reported for uncollected premiums may also be impacted as a result of retroactive additions and deletions that are made subsequent to the date the group was invoiced. There may be a delay (sometimes several months) between the time that a large group adds a new covered employee or deletes an employee that is no longer covered and notice of the change is sent to the health entity. This length of the delay increases since the invoicing of the monthly premium is frequently in advance of the effective date of the coverage. This delay can result in the health entity reporting part of a monthly billing as more than 90 days overdue and ultimately collecting less than what was billed. SSAP No. 6 states that if an installment premium is over 90 days due, the amount over ninety days due plus all future installments that have been recorded on that policy shall be non-admitted. However, for group accident and health contracts, a non-admitted *de minimus* over ninety-day balance would not cause future installments (i.e., monthly billed premiums on group accident & health) that have been recorded on that policy to also be non-admitted. The *de minimus* over 90-day balance itself would be non-admitted and the entire current balance would be subject to a collectability analysis.

The balance for uncollected premium may also result from amounts due from the Centers for Medicare and Medicaid Services or other government plans. Although coverage periods on this type of business are usually the same as comprehensive group business, the payment cycle can be much different due to the longer settlement periods experienced under government contracts. However, collectability of balances associated with government plans is usually not an issue. Because of this, the 90-day rule that is applied to other receivables is not applicable to receivables from these types of government plans.

Irrespective of the type of business written, inadequate systems and controls over the collection process can lead to uncollectable premiums. Uncollected premium balances on non-government business that are over 90 days due are non-admitted under SSAP No. 6. On all business, an evaluation of any remaining asset balance is required to determine any impairment. Amounts deemed uncollectable are required to be written off against income in the period the determination is made. These accounting requirements are designed to limit the total impact that collectability issues can have on a health entity at a given point in time.

Despite the efforts to mitigate the impact of uncollected premiums and agent's balances, write-offs and non-admitted unpaid premium assets can still have a material impact on the net income and capital and surplus of a health entity. These issues can lead to liquidity problems if the health entity is unable to convert the receivable into cash to be used to pay claims. Analysts should monitor the level of this asset as well as the change in the balance to help identify potential collection problems that can ultimately lead to significant decreases in capital and surplus. Since the asset includes agent's balances as well as premiums, an analyst may refer to the Exhibit for Accident and Health Premiums Due and Unpaid to determine if the balance of the asset is primarily due to premiums or due to agent's balances. See SSAP No. 6 for further discussion of uncollectable premiums and SSAP No. 54–*Individual and Group Accident and Health Contracts*.

Health Care Receivables

Health care receivables can include pharmaceutical rebate receivables, claim overpayment receivables, loans and advances to providers, capitation arrangement receivables, risk-sharing receivables and government insured plan receivables. Similar to other assets in general, each of the above types of health care receivables is

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individually unique and can carry its own risks to the health entity. Some of them carry a higher degree of risk because of the use of estimates in establishing them. Others carry a low level of risk because the accounting requirements only allow the receivable to be established in certain circumstances. However, ultimately each of the health care receivables can present the same kind of financial risks as uncollected premiums. Like uncollected premiums, the collectability of health care receivables should be monitored by the health entity, as it could become a source of future problems if write-offs of uncollectable receivables become material.

- **Pharmaceutical Rebate Receivables**

According to SSAP No. 84–*Health Care and Government Insured Plan Receivables*, pharmaceutical rebates are arrangements between pharmaceutical companies and a health entity in which the health entity receives rebates based upon the drug utilization of its subscribers at participating pharmacies. Generally, this receivable can consist of amounts that have actually been billed but usually a significant portion of the receivable is based upon estimates of the health entity or a pharmacy benefits manager (PBM). Because the amounts can be material, SSAP No. 84 does allow these receivables to be admitted to the extent that they conform to certain requirements. Health entities are required to disclose certain information regarding the receivable in Annual Note to Financial Statements #27, Health Care Receivables. Analysts should use the information from the note, along with other knowledge of the health entity's business, to assess whether the balance and the changes in the balance from period to period appear reasonable. See SSAP No. 84 for more specific information related to the determination of the admitted asset.

It should be noted that the disclosures to be included in Note #28 for pharmaceutical rebate receivables should include pharmaceutical rebates of insured and uninsured business. If there are rebates collected pursuant to these uninsured ASO/ASC arrangements, a liability for any payable must be established. Refer to Section IV.B. Notes to Financial Statements, for guidance on reviewing Note #28.

- **Claim Overpayments**

Due to the volume of transactions processed by health entities, the various coverages provided to different employer groups, and the use of deductibles, co-payments and coinsurance, it is not uncommon that claim overpayments may occur as a result of an error or miscalculation. Although the certainty of collection cannot always be estimated or determined, health entities are allowed to admit claim overpayments if certain requirements are met as set forth in SSAP No. 84. The most significant requirement is that the receivable must have been invoiced and specifically identifiable to a claim, and not just an estimate. Although claim overpayments are common, they are generally not material. To the extent they are material, analysts should obtain a better understanding of how the receivable has become so significant and may consider the need to perform more specific procedures to address any collection issues. In addition, analysts may consider the need to understand the processes and procedures the health entity is taking to minimize the balances.

- **Loans and Advances to Providers**

A health entity may make loans or advances to hospitals or other providers. Unlike claim overpayments, these assets can be very material. Although SSAP No. 84 provides that these loans and advances can only be reported as admitted assets in certain circumstances, analysts should obtain a clear understanding of these assets in order to effectively assess the overall financial condition of the health entity. Loans or advances to providers are generally made at the request of the provider to alleviate or prevent cash flow problems or in some cases, to serve as a semi-permanent component of the providers' capital structure. In many cases, these loans or advances are actually paid monthly and are intended to cover one month of fee-for-service claims activity with the respective provider. For large hospitals with many sources of cash flow, these loans and advances can be offset with the reported and unreported claims liability and claims reserve. However, to be admitted assets under SSAP No. 84, loans to hospitals must be reconciled quarterly against actual claim utilization pursuant to contractual terms and is admitted up to the amount payable to the provider for reported claims. The quarterly reconciliation allows for more adequate run-out of claims but is required to avoid potentially material

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uncollectable balances. Clearly, the longer the balance builds without being reconciled the greater potential for material adverse adjustment.

Loans or advances by a health entity to related parties must constitute arm's-length transactions. Loans or advances made by a health entity to related parties (other than its parent or principal owner) that are economic transactions are admissible under SSAP No. 25–*Affiliates and Other Related Parties*. This includes financing arrangements with providers of health care services with whom the health entity periodically contracts. Again, analysts should obtain as good of an understanding as possible of the health entity's loans or advances to providers. This may include communication with the health entity or an examiner.

- **Capitation Arrangement and Risk Sharing Receivables**

A health entity may also admit advances to providers under capitation arrangements under certain circumstances. Under SSAP No. 84, a capitation arrangement is defined as a compensation plan used in connection with some managed care contracts in which a physician or other medical provider is paid a flat amount, usually on a monthly basis, for each subscriber who has elected to use that physician or medical provider. To qualify as admitted assets under SSAP No. 84, among other things, the advances must be made under the terms of an approved provider services contract in anticipation of future services and must not exceed one month's average capitation payments.

SSAP No. 84 defines risk-sharing agreements as contracts between health entities and providers with a risk-sharing element based upon utilization. The compensation payments for risk-sharing agreements are typically estimated monthly and settled annually. These agreements can result in receivables due from the providers if annual utilization is different than that used in estimating the monthly compensation. Consistent with pharmaceutical rebate receivables, although this asset is generally determined based upon estimates, it is allowed to be admitted to the extent it conforms to certain requirements of SSAP No. 84.

Despite these requirements, and the requirement that the collection of risk-sharing receivables be made quarterly, analysts should closely monitor the balance of this asset. Analysts should use the information from Note #28, along with other knowledge of the health entity's business, to assess whether the balance and the change in the balance from period to period appears reasonable. Refer to IV.B. Analysis of Notes to Financial Statements for guidance on reviewing Note #28.

- **Government Insured Plan Receivables**

Government plan receivables may be included in either uncollected premiums or under health care receivables. Analysts should determine their state's method of accounting. However, in some cases, the receivables are not specifically for premiums but arise from coordination of benefits with the government contract (Medicaid carve-out). Amounts receivable under government insured plans that qualify as accident and health contracts in accordance with SSAP No. 50–*Classifications and Definitions of Insurance or Managed Care Contracts,* are admitted assets. However, the collectability of these amounts must be periodically evaluated even though the 90-day past due rule does not apply. Any amounts deemed uncollectable must be written off and charged to income in the period the determination is made. See SSAP No. 84 for further discussion.

Amounts Receivable Relating to Uninsured Accident and Health Plans

SSAP No. 47–*Uninsured Plans* defines uninsured accident and health plans, including HMO administered plans, as plans for which a health entity, as an administrator, performs administrative services such as claims processing for an at risk third party. Accordingly, the administrator does not issue an insurance policy. Two of the more common types of uninsured accident and health plans include an Administrative Services Only (ASO) plan or an Administrative Services Contract (ASC) plan.

Under uninsured plans, there is no underwriting risk to the health entity. The plan bears all of the utilization risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. Because of this, accounting for income and disbursements resulting from such uninsured plans, or the uninsured components of a combination plan should not be reported as insurance premiums and claims. As discussed in

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SSAP No. 47, amounts received on behalf of uninsured plans or the uninsured portion of partially insured plans are not reported as premium income. Administrative fees for servicing the uninsured plans are deducted from general expenses. Conversely, income relating to the insured portion of any plan is reported as premium income. It should be noted that plans that include a capitated payment method are automatically considered an insured plan.

Although there is no underwriting risk on these types of plans, credit risk can still be an issue. Under these types of agreements, it is common for a receivable to be established for services performed by the health entity, and/or amounts due to the health entity for claims paid by the health entity on behalf of the uninsured plan. The credit risk varies on these types of plans because under an ASC plan, the health entity pays the claims directly from its own bank account and would seek reimbursement at a later date. In contrast, under an ASO plan, the claims are paid from a bank account owned and funded directly by the uninsured plan sponsor or are paid by the health entity but only after receiving funds to cover the amount paid. Combination plans may also be administered which contain elements of both an uninsured and an insured plan. If the funds held for disbursement under the uninsured plans are inadequate to meet disbursement needs, the insurer may advance funds to cover such disbursements.

As a result of such advances, the receivable should be recorded as an asset. Liabilities can also result from administering this type of business. This type of liability would result from funds of the uninsured plans being held by the health entity for making plan disbursements. Generally, the asset for the receivable and the liability for funds held should not be netted unless individual receivables and payments meet the requirements of SSAP No. 64–*Offsetting and Netting of Assets and Liabilities*.

Expense risk can also result from uninsured plans. This risk results primarily from the health entity incurring more expenses to administer the business than reimbursed from the uninsured plan. Analysts should use the information in Note #18, Uninsured Plans, to better assess the business risk to which the health entity is exposed under its uninsured plans. Refer to Section IV.B. Notes to Financial Statements, for guidance on reviewing Note #18.

D. Separate Accounts

Separate accounts are segregated pools of assets owned by a life/health insurer in which the investment experience is credited directly to the participating policies. Separate accounts are not a separate legal entity, but rather a segregated line of business where the assets and related investment gains and losses are insulated from general account creditors and liquidation claims. The insurer is not a trustee by reason of the separate accounts and state statutes provide that separate account assets may be invested and reinvested without regard to any requirements or limitations imposed upon an insurer by the investment statutes, which apply to insurers. Separate accounts were historically used for pension accounts. More recently they have been used to market unique investment options and guaranteed investment returns. The flexibility they offer policyholders has been the driving force behind their greatly expanded use. Separate accounts may be used to fund a variety of products including individual and group, fixed and variable, guaranteed and non-guaranteed, life insurance and annuities.

Accounting for separate account business involves both the general account of the insurer and the separate accounts. The Separate Accounts Annual Financial Statement is concerned primarily with the investment activities of the separate accounts and with the flow of funds from and to the general account. Only direct investment transactions (purchase, sale including profit and loss thereon, income, and direct expenses and taxes relative to specific investments) are recorded as direct transactions in the Separate Accounts Annual Financial Statement. All other transactions are reported as transfers between the general account of the insurer and the separate accounts statements. In general, the separate accounts do not maintain surplus since gain or loss from separate accounts is transferred to the general account each year.

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The following focuses primarily on the impact on the general account of separate accounts activities. With many of the separate accounts' products, the entire investment risk is absorbed by the policyholder. However, other types of separate accounts products include guarantees in the form of minimum death benefits, minimum interest rates and bailout surrender charge provisions. Any minimum guaranteed obligation must be recorded on the general account of the insurer since, by definition, the entire asset transferred to the separate accounts is at risk. The following is a brief summary of the types of separate accounts products that may create contingent liabilities to the general account:

NOTE: Refer to the branded risk assessments for additional guidance and considerations related to separate account risks in Operational Risk, Reserving Risk and Liquidity Risk.

Variable Annuities

These products may have implications for the general account by virtue of transfer rights, enhanced death benefits, and minimum interest rate guarantees. Excess reserves required by these provisions are normally carried in the general account of the insurer.

Modified Guaranteed Annuities

Modified Guaranteed Annuities were developed in the 1980s and are a hybrid between a book/adjusted carrying value deferred annuity and a variable annuity. This product provides interest rate guarantees for a period of time and is patterned after the group Guaranteed Interest Contract. If the policy is surrendered before maturity, then appropriate adjustments are made to the value. However, the insurer bears default risk and additional risk if the insurer's investment return does not match product guarantees.

Modified guaranteed annuities in general are not insulated or "walled off" from the general account. These liabilities are, in effect, guaranteed by the general account. The general account must fund any shortfalls in the separate account related to these products. Whether this product is insulated from the general account is determined by the product's contract wording. If not specifically addressed in the contract, certain states have taken the position that the product is not insulated. The lack of insulation would result in the assets and liabilities associated with the product being transferred to the general account in the event of liquidation.

Indexed Products

With an indexed product, an insurer guarantees that the portfolio will show returns, which will exceed a certain index by a specified number of basis points. An insurer generally requires a large commitment of deposits before issuing such a product, so that the portfolio can achieve the diversification necessary to support the product structure. The risk to the insurer is a mismatch risk between the index and the rate of return recognized. In addition, the product may also contain expense guarantees.

There are generally restrictions upon withdrawals for the accounts. Certain states have required excess reserves for these products based on the remaining guaranty period. However, there is not consistency within the industry as to whether excess reserves are required, how they are calculated, or where they are recorded.

Experience Rated Guaranteed Interest Contracts

These products are true group products, with three-party involvement. This is a fully guaranteed product from the plan participant's point of view. Interest rate guarantees are generally for interest credited to date. Future interest guarantees typically are 0%. Termination of the contract is generally at true fair value or paid out over time.

Fully Guaranteed Interest Contracts

These are traditional guaranteed interest contracts written in a separate account. Although many insurers carry non-par guaranteed interest contracts in the general account, insurers will write them in the separate account

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to better control duration matching. Assets and liabilities are generally valued at book, so reserve accounting and asset valuation is the same as for the general account. The product may or may not be insulated from the general account.

Funded, Experienced Rated Group Annuity

These products tend to be immediate annuities, where the plan sponsor participates in the earnings of a segregated investment portfolio. The plan sponsor provides a "margin" in order to participate in the preferred investment portfolio. Nearly all reserves are carried at fair value. If asset value falls below total liabilities plus a margin, then additional deposits are required, or a company has the right to invest the assets more conservatively to better hedge its risk. Reserves may be placed in either the general account or the separate account.

Synthetic Guaranteed Interest Contracts

This product creates an investment management vehicle for a benefit plan that does not require the plan to transfer ownership of plan assets. Therefore, the insurer selling these products provides investment management services but does not own the assets. The assets and liabilities from these products are not carried on the insurer's financial statements. These products were developed to provide an extra layer of insulation from general account liabilities. There are two types of synthetic guaranteed interest contracts: 1) participating and 2) non-participating. Non-participating products generally have a portfolio of high-quality assets that is not actively traded. The issuer (insurer) agrees to purchase plan assets at book value if needed to make plan benefit payments. If any plan assets associated with the product go into default, the insurer's purchase obligation is terminated to those securities. The insurer receives a fee for these services.

In participating products, plan assets are normally set aside in a separate custodial account and are actively managed, under agreed upon diversity and credit rating requirements. The portfolio is managed to provide for a return of principal plus a crediting rate. Generally, a floor is established which sets a minimum crediting rate. At the end of the contract term, the insurer is obligated to pay the plan the excess, if any, of the book value of the investment portfolio over its fair value (i.e., the insurer bears the risk of default). Current practices aimed at financial statement disclosure appear to include no disclosure, disclosure through footnotes, or disclosure through inclusion of liabilities on the Exhibit of Deposit-Type Contracts of the general account Annual Financial Statement as both a liability and a negative liability. Some insurers may carry excess reserves for the guaranty of performance, although current practices vary widely.

E. Risk Transfer Other Than Reinsurance (Health)

Risk to health entities comes primarily from underwriting risk, which is the risk that health care costs are higher than those anticipated in premium rate development. Health care costs can be higher than anticipated because of higher than forecasted cost per service or because of a higher level of utilization of those services. Any methodology that controls the cost or utilization of services decreases the risk of incorrectly estimating health care costs. Arrangements that control costs of services may not be as effective in reducing risk, if providers increase utilization to make up for lower costs. For example, controlling the cost of a day in the hospital by contracting for fixed per diems is not effective if lengths of stay increase. Contracting for reduced inpatient care cost or changing benefit designs to reduce the use of inpatient care is not effective if providers shift to outpatient facilities and increase the cost of outpatient care.

Health entities use many types of risk transfer arrangements with outside entities to help control costs. Risk can be transferred to:

- Reinsurers
- Groups
- Insured members

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- Providers/provider intermediaries

Risk can be retained by the employer, trade association or other groups using administrative services only (ASO) or administrative service contract (ASC) self-insurance arrangements. In both arrangements, the group bears the underwriting risk that claim payments will exceed a predetermined level, except for any risk that is reinsured through stop-loss contracts, while the health entity bears the business risk in administration. The difference between ASO and ASC arrangements is the amount of business risk that the health entity has if the group becomes insolvent. In ASO arrangements, the health entity is exposed to minimal business risk, but with ASC arrangements, one or more possible situations may result in the health entity being exposed to the business risk for claims, if the group does not pay the claims that it is contractually obligated to pay. First, identification cards given to the member are often indistinguishable from insured member cards. (This may also be the case with ASO arrangements, which would increase their business risk.) This can create an impression on the part of the provider or member that the health entity is responsible for the claims and result in litigation. Very few group members are aware or understand that their insurance is actually self-insured by their employer or association group and is not the responsibility of the health entity indicated on their insurance card. Second, in ASC arrangements where the health entity pays claims first and then bills the group or uses electronic funds transfer to be reimbursed for claims, they may have difficulty obtaining reimbursement if the group becomes insolvent. In addition, such risk can exist for both ASO and ASC contracts for claims in the course of settlement or claims incurred but not reported. Statutory accounting was changed under Codification to require premium income and claims expense for self-insured plans to be excluded from revenues and expenses, but rather to be included as a component of administrative expenses. SSAP No. 47, describes the accounting for ASO and ASC arrangements. ASO and ASC administrative expenses and ASC medical expenses are included in worksheet XR019 of the Risk-Based Capital (RBC) filing.

Minimum premium arrangements, which are hybrids between insured and self-insured plans, can be used to transfer claim cost risk to groups using an alternative funding mechanism. In these arrangements, a fund is established (e.g., a bank account) and used by the health entity for the purpose of paying claims, up to a pre-determined level (stop-loss threshold). These claims are self-insured, and the associated funding is excluded from premium revenue. In addition, the policyholder remits a minimum premium to the health entity to cover claims in excess of the stop-loss threshold. This portion of the policyholder payment is considered premium revenue to the health entity. Typically, there are two types of stop-loss provisions attached to this arrangement to control the claim cost risk for the policyholder. Individual specific stop-loss limits the risk of the policyholder to a pre-determined amount per covered individual or claim, (e.g., $50,000) and an aggregate stop-loss cover limits the risk of the policyholder to a pre-determined amount on an overall basis for all claims, (e.g., 120% of expected paid claims). The minimum premium remitted to the health entity covers claims in excess of the stop-loss threshold, both individual and aggregate, and for the administrative expenses of the policy. The amounts remitted in the deposit fund vary according to the pre-determined amounts in the individual and aggregate stop-loss provisions, and the benefit provisions of the underlying medical care plan. If claims experience is more favorable than expected, the policyholder may reduce its payments to the deposit fund. Unused amounts in the deposit fund at the end of the policy year revert to the policyholder.

An advantage of these arrangements to the policyholder is that they reduce the up-front cash flow in its first year of operation, as there is no reserve funding required for self-insured claims below the stop-loss threshold. Another advantage is that premium tax is usually not paid in the amounts paid into the deposit funds. At cancellation of this arrangement, the policy may call for the payment by the policyholder to the health entity of a supplemental premium for the handling of the claims incurred and not yet paid.

Another experience rating arrangement, which transfers some risk to the policyholder, is called the Retrospective Premium Arrangement. Under such arrangement, the health entity and policyholder agree to set premiums at a lower level than determined by the health entity, (e.g., 80% level, with a provision that an additional retrospective premium may be required, up to the 100% level, if claims experience is unfavorable). An individual stop-loss arrangement is typically included in these plans, to control the claim cost risk for the policy. These arrangements typically arise when there is some disagreement between the health entity and the

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policyholder on the magnitude of a premium rate increase. Agreement is reached on a lower level of premiums, with an arrangement for a potential retrospective premium if required. These arrangements also can incorporate a premium stabilization reserve where margins arising from favorable claims experience is deposited and which may be used to pay the additional retrospective premium when claims experience is unfavorable. A premium stabilization reserve reduces the health entity's risk of having to absorb experience deficits in addition to rate increases.

One advantage to the policyholder of these arrangements is that they reduce the up-front cash flow as premiums are remitted at a reduced level during the policy year. One disadvantage to the health entity is that it may be difficult to collect the retrospective premium, if required, at the end of the policy year, possibly leading to questions by the policyholder as to the size of the claim reserves established by the health entity. Once a retrospective premium is billed, any amounts due more than 90 days after the due date are treated as a non-admitted asset. At any time, if it is probable that the additional retrospective premium is uncollectable, it must be written-off against operations in the period such a determination is made. At termination, any fund remaining in the premium stabilization reserve is refunded to the policyholder. However, the health entity will normally hold the rate stabilization reserve for a one-year runoff period before refunding the balance.

A modification to the retrospective premium arrangement is where the full 100% premium is billed during the policy year, with margins arising from favorable claims experience being deposited in the premium stabilization reserve or remitted to the policyholder. Deficits arising from unfavorable claims experience may be recouped from available funds in the premium stabilization reserves. Unrecouped deficits are carried forward to the next policy year and may be recouped from future years' favorable claims experience. The health entity is not totally protected from unfavorable claims experience, as the policyholder may move the policy to another health entity, leaving the prior health entity with an unrecouped deficit. At termination, any fund remaining in the premium stabilization reserve is refunded to the policyholder after a one-year runoff period as described above.

Premium stabilization reserves are included in the reserve for rate credits or experience rating refunds on Underwriting and Investment Exhibit Part 2D - Aggregate Reserve for Accident and Health Contracts Only line 4, with a corresponding entry to premiums. Accounting guidance for retrospectively rated contracts with return of premium provisions can be found in SSAP No. 66–*Retrospectively Rated Contracts*.

Risk transfer to insured members is accomplished through the use of deductibles, coinsurance, and co-payments (copays), which transfers some of the risk of increased cost and utilization to members.

Although providers are more resistant to taking risk from health entities, there are still many types of arrangements found that transfer risk from health entities to providers. Capitation is the most common method of transferring risk. There are several types of arrangements that fall under the term capitation:

- Paid on a PMPM or percent of premium basis to a provider or provider group that covers only the services of that provider or group.
- Paid on a PMPM or percent of premium basis directly to a provider intermediary such as an Independent Practice Association (IPA) or provider group covering only the services of the providers that have a contract with the intermediary (participating providers or provider network) or provider group.
- Paid on a PMPM or percent of premium basis, covering the services of participating providers and the services of other providers (e.g., specialists and inpatient facilities).

Monthly capitations are paid for all members enrolled with the provider intermediary. Capitations can be deposited to a separate bank account that the provider intermediary then writes checks against to pay for provider services. Capitations can also be accounted for internally by the health entity, but not actually paid; rather a deduction is made from the internal account when claims are paid to providers contracting with the provider intermediary for enrolled member services.

Other arrangements include withholds, bonuses and special payment arrangements. Bonus and withhold arrangements can be structured to take the risk off the provider when there is a capitation arrangement.

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If capitation arrangements are significant, Analysts may consider getting more information on the structure of the capitation contract and if there are any associated bonuses and withholds. In the Annual Financial Statement, capitations are broken out in Exhibit 7 – Part 1- Summary of Transactions with Providers. Since intermediaries do not provide services directly, they may be more vulnerable to financial problems if the demand for medical services is higher than anticipated. Intermediaries may pass on some risk through capitating participating providers, but they may also pay some participating providers on a fee-for-service basis. If the total of the intermediary's incurred claims exceed the capitations that they receive from the health entity, the intermediary experiences financial losses. If this continues the intermediary may become insolvent, which can impact the ability of the health entity to maintain its network and ultimately to provide services to its members. Medical groups on the other hand provide more of the services directly and when the demand for services is more than anticipated, they can either work longer hours (called sweat equity) or delay services until their schedule allows.

Capitations have the effect of reducing the amount of unpaid claim liability as a portion of the incurred claims, since payments are made at the beginning of the month to cover services provided in the month.

Receivables from provider contracts are subject to the analysis and reporting requirements of SSAP No. 84. In the situation where the provider contract requires payments from, as well as, to the provider, the health entity should separate ultimate results into the liability entry and the receivable entry.

These amounts do not include the health entity's liability if a contracting provider becomes insolvent. Provision for the effect of provider insolvencies should be included in the claim liability and/or premium deficiency reserve as appropriate.

Special payment arrangements to provider groups can include fee schedules, discounts, and DRG payments to hospitals. See the Reserving Risk Assessment guidance for a discussion of how these arrangements affect risk transfer, liabilities, and reserves.

F. Other Provider Liabilities (Health)

Health entities can use many types of risk-sharing arrangements with a provider that transfers part of the financial risk to the provider. Although the type and form of these arrangements may differ, all will ultimately result in the settlement of the risk transfer arrangement. The most frequent arrangements are capitation arrangements where the provider is paid a per-member-per-month amount for providing specified medical services to the members that are enrolled with the provider. Other types of contracting arrangements may contain provisions for bonuses or withholds dependent on the provider meeting specific financial, utilization, and/or quality goals. Financial goals under these types of arrangements may include targets for loss ratios, total claims per-member-per-month, or average prescription drug costs per-member-per-month. Utilization or operational goals may include target hospital inpatient days per 1,000 members or goals for provision of a target number of preventative services per 1,000 members covered. Bonus payments and withhold payments are both dependent on performance over a period of time and are not based on any particular provider service.

Under bonus arrangements, bonuses are paid based on criteria defined in the provider contract. Under withhold arrangements, part of each payment, either fee-for-service or capitation, is retained until a specified point in time when a contractual formula determines the amount of the withholding that is to be paid to the provider. Bonus and withhold arrangements can be very complicated with separate pools being established for specific types of medical costs. For example, a pool can be established for prescription drug costs, another for inpatient days, and another for specialist referrals. Separate pools can be established for hospital services and for physician services.

If provider contract liabilities are percentage withholds from provider payments, they are included in Page 3 Line 1, claims unpaid, otherwise they are included in Page 3 Line 2, accrued medical incentive pool and bonus payments. The amounts included in Page 3 Line 1 are detailed in the Underwriting and Investment Exhibit - Part 2A Line 3, amounts withheld from paid claims and capitations. The current year's accrued medical incentive pool

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and bonus payments is also entered in the Underwriting and Investment Exhibit – Part 2 on Line 5, while last year's accrued medical incentive pool and bonus payments is entered on Line 10 of that exhibit. The liability is determined according to a formula contained in the provider contract describing the amount to be paid based on specific performance. For further accounting guidance, see SSAP No. 55–*Unpaid Claims, Losses, and Loss Adjustment Expenses.*

A provider contract liability should be established for all contracts that have outstanding amounts due. This includes estimated liabilities prior to the contract settlement date, as well as finalized liabilities that have not been paid as of the valuation date. For contracts prior to the settlement date, the actuary should have estimated the amount accrued based on the contract provisions and performance from the beginning of the contract period to the valuation date.

Methods used to estimate provider liabilities are discussed in detail in the NAIC *Health Reserve Guidance Manual*. The health entity can estimate the liability by reviewing each provider contract separately or by estimating groups of like contracts together. Historical information may be used as a basis for estimating the provider's liability using ratios of the provider liability to incurred claims or of the provider liability to member months. Because provider liabilities are based on claims experience, the lower the PMPM claims experience, the higher the provider liability will be. Consequently, in order to ensure that the estimated provider liability is appropriately conservative, the estimate of the unpaid claim liability used by the actuary in calculating the provider liability may contain fewer margins for adverse deviation than the estimate of the unpaid claim liability used in the financial statement. In any case, the actuary should have ensured that the unpaid claim liability and the provider liabilities, in total, make allowance for adverse circumstances.

Receivables from provider contracts are subject to the analysis and reporting requirements of SSAP No. 84. In the situation where the provider contract requires payments from, as well as, to the provider, the health entity should separate ultimate results into the liability entry and the receivable entry.

These amounts do not include the company's liability if a contracting provider becomes insolvent. Provision for the effect of provider insolvencies should be included in the claim liability and/or premium deficiency reserve as appropriate.

If the contract period has not ended as of the valuation date or if the settlement has not been paid, there will be expenses associated with the determination and payment of the settlement of the risk-sharing arrangement. A prorated share of this expense should be included on Page 3 Line 3, unpaid claims adjustment expenses.

When withholds and bonuses are paid, they are included in Underwriting and Investment Exhibit – Part 2 Line 2, paid medical incentive pools and bonuses, and are split between claims incurred during the year and claims incurred in prior years in Underwriting and Investment Exhibit – Part 2B Line 12, medical incentive pools, accruals and disbursements.

Withhold and bonus information is also included in the Risk-Based Capital (RBC) filing and is used in the determination of the managed care credit in the RBC calculation. Worksheets XR015 and XR016 contain claim payments subject to withholds, withholds and bonuses available, and withholds and bonuses paid. Some of the information used in the RBC filing corresponds to Exhibit 7 – Part 1, while other information is from company records. Since bonuses and withholds paid in conjunction with capitation arrangements are not itemized in Exhibit 7 or in the RBC filing, they do not provide a total breakout of bonuses and withholds paid.

G. Income Statement and Surplus, and Capital and Surplus Notes

Statutory accounting principles emphasize the balance sheet because statutory accounting is primarily directed toward the determination of an insurer's financial condition on a specific date. However, the income statement is also important and should be reviewed as a part of the financial analysis process. Income statement analysis primarily focuses on the operating performance of an insurer.

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a. **Property/Casualty**: The most common measure of an insurer's underwriting profitability for a property/casualty insurer is the combined ratio, which is a combination of the loss ratio, expense ratio, and the policyholder dividend ratio. The combined ratio is sometimes thought of as the amount of each dollar an insurer pays out for every dollar of premium received. For example, if an insurer has a combined ratio of 105%, it pays out roughly $1.05 in claims, expenses, and policyholder dividends for every dollar of premiums received. However, such an insurer may still be profitable because it will be earning investment income on the premium dollars held until claims and expenses are paid. The two-year overall operating ratio (P&C IRIS ratio #5) and the return on surplus are two measures of overall operating performance that include investment income.

b. **Life/A&H**: One of the most common measures of an insurer's overall profitability and operating performance for a life/health insurer is the IRIS ratio of net income to total income (including realized capital gains and losses). This ratio considers the six principal factors which affect the insurer's net gain: 1) mortality and morbidity experience; 2) adequacy of investment income; 3) commissions and expenses; 4) reinsurance transactions; 5) the relationship of statutory reserve requirements to prevailing interest and mortality rates; and 6) realized capital gains and losses. The return on capital and surplus, which considers net income as a percentage of capital and surplus, is another important measure of overall operating performance.

c. **Health**: One of the most common measures of a health entity's overall profitability and operating performance is its profit margin. This ratio considers the four principal factors which affect the health entity's net gain or loss 1) morbidity (claims) experience, 2) expense and commission structure, 3) investment income, and 4) realized capital gains or losses. The return on capital and surplus, which considers net income as a percentage of capital and surplus, is another important measure of overall operating performance.

   Measures such as the combined ratio, the medical loss ratio and administrative expense ratio provide analysts with more specific measures of the health entity's source of profits or losses. The health entity's management as well as external analysts generally use these more precise ratios. However, even these ratios are somewhat limited in their ability to target the sources of a health entity's profitability. There may be different loss or risk characteristics by product type, or even by region within the same product that the ratios do not reveal. The thresholds for medical loss ratio, the administrative expense ratio and investment yields, 85%, 15%, and between 2% and 6%, respectively, are based upon health entities that write only "comprehensive health products." Fluctuations in operating ratios are also important indicators of potential financial problems and concerns. For example, even if the health entity's medical loss ratio was considered good, an increase may indicate a loss of control in the health entity's underwriting or pricing standards. An increase in the administrative expense ratio may indicate escalating costs or an expense structure that no longer supports the health entity's premium volume.

   Health insurance is provided to consumers through various means and products. Some products provide very specific coverage (e.g., medical only, dental, vision and stop loss) while others provide much broader coverage (e.g., comprehensive, federal employees health benefit plan, Medicare and Medicaid). As previously mentioned, each of these products contains different loss and risk characteristics. Different mixes of these products can significantly impact the profitability of a health entity.

Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums written may be an indication of an insurer's entrance into new lines of business or sales territories that might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses. Significant increases in incurred loss ratios may indicate premium pricing errors or reserve strengthening due to prior reserve understatements, whereas significant decreases in incurred loss ratios may be indicative of current reserve redundancies.

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a. **Health**: Fluctuations in premium or enrollment for a health insurer may also indicate a reason for concern. Uncontrolled, excessive growth has been found to be one of the major causes of insolvency. If the growth is not accompanied by additional surplus, the capital and surplus may not be able to support the additional exposure. Growth is often times driven by a health entity's desire for greater market share. Many times, the health entity is able to gain that market share by lowering its prices or setting prices below the rest of the market. This desire for greater market share can lead to considerable underpricing. This underpricing can increase the amount of risk to the health entity for every dollar of premium written. Additionally, in many cases, the health entity may establish reserves as a percentage of premiums when it enters a new market, which can lead to additional risk. Therefore, if the product is underpriced, it's possible the reserves may be understated. As a result, growth by a health entity is often associated with underpricing and under reserving, which is a risky combination. In effect, the company may need to establish a greater reserve when unsure about its pricing.

In assessing the financial condition, considerable emphasis is placed on the adequacy of an insurer's capital and surplus. Surplus provides a cushion for policyholders against adverse underwriting results, catastrophe (P&C), reserve deficiency, insolvency of reinsurers, and fluctuations in the value of investments. In addition, surplus provides underwriting capacity and allows an insurer to expand its premium writings. The gross and net writings leverage ratios (P&C, A&H) measure the extent to which an insurer utilizes its underwriting capacity. High ratio results may indicate that an insurer is excessively leveraged and lacks sufficient surplus to finance the business currently being written.

Capital and Surplus Notes

The components of surplus can include common capital stock, preferred capital stock, gross paid-in and contributed surplus, surplus notes, unassigned funds (or retained earnings), and special surplus funds (usually established through an appropriation of unassigned funds). Each state has, by statute, established a minimum required amount of surplus for insurers. In some states, these minimum amounts are based on the lines of business written, while in other states the minimum amounts are based on the type of insurer. In addition, the RBC requirements must also be met.

Insurers may issue capital or surplus notes as a source of financing growth opportunities or to support current operations. Surplus notes (sometimes referred to as "surplus debentures" or "contribution certificates") have the characteristics of both debt and equity. Surplus notes resemble debt in that they are repayable with interest and sometimes, depending on the requirements of the domiciliary state insurance department, include maturity dates and/or repayment schedules. However, key provisions of the surplus notes make them tantamount to equity. These provisions include approval requirements as to form and content and the requirement that interest may be paid, and principal may be repaid only with the prior approval of the domiciliary state insurance department. SSAP No. 41–*Surplus Notes* requires that interest on surplus notes is to be reported as an expense and a liability only after payment has been approved. Accrued interest that has not been approved for payment should be reflected in the Notes to Financial Statements. Provided that the domiciliary state insurance department has approved the form and content of the surplus notes and has approval authority over the payment of interest and repayment of principal, surplus notes are considered to be surplus and not debt. The proceeds from the issuance of surplus notes must be in the form of cash, cash equivalents, or other assets having a readily determinable value satisfactory to the domiciliary state insurance department. Information regarding surplus notes must be reported in the Annual Financial Statement, Notes to Financial Statements #13.

Insurers may also issue capital notes, which are reported as a liability by the insurer, and are therefore treated as debt instruments (although in liquidation rank with surplus notes) and are subordinate to the claims of policyholders, claimants, and general creditors. Statutory accounting principles for issuers of surplus notes are included in SSAP No. 41, while principles for issuers of capital notes are provided in *SSAP No. 15—Debt and Holding Company Obligations*. Capital notes are included in the insurer's total adjusted capital for RBC calculations. Like surplus notes, capital notes are repayable with interest and include maturity dates and/or repayment schedules. However, payment of interest and repayment of principal generally do not require regulatory approval. When total adjusted capital falls below certain levels or if other adverse conditions exist,

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capital note payments may be required to be deferred. While deferred, any interest on the capital note should not be reported as an expense or the accrual as a liability, but instead should be reflected in the Annual Financial Statement, Notes to Financial Statements #11, similar to surplus note interest payments that have not been approved.

Capital and surplus notes may have the effect of enhancing surplus or providing funds only on a temporary basis. Capital and surplus notes may be issued to either an affiliated entity or a non-affiliated entity. The person or entity that holds the capital or surplus note may expect repayment on a scheduled basis and may exert pressure on the insurer to generate cash in order to be able to make the payments. When reviewing a request to issue a capital or surplus note to non-affiliated entities, analysts should be aware that non-affiliated entities, such as third-party banks, may require higher interest rates than an affiliated person/entity. As noted, pressure exerted by a third-party holder of the capital or surplus note on the insurer may make it more difficult for the state insurance regulator to disapprove an interest payment on the capital or surplus notes. Failure to make interest payments on third-party notes may impact credit ratings (i.e., AM Best).

As a result, analysts should be cautious when reviewing insurers that rely heavily on these notes. Capital and surplus notes are not inherently bad. They have provided regulators with flexibility in dealing with problem situations to attract capital to insurers whose surplus levels are deemed inadequate to support current operations. They provide a source of capital to mutual and other types of non-stock entities who do not have access to traditional equity markets and provide an alternative source of capital to stock reporting entities.

The primary aim of the analyst's review process is to ensure that surplus notes, as outlined in SSAP No. 41(3), are subject to strict control by the commissioner and contain the following provisions for classification as surplus rather than debt:

- Subordination to policyholders;
- Subordination to claimant and beneficiary claims;
- Subordination to all other classes of creditors other than surplus note holders; and
- Interest payments and principal payments require prior approval of the commissioner of the state of domicile.

State insurance departments may establish rules or guidance for when a state must complete its approval/disapproval for a capital or surplus note request. Timely review and processing of these requests is essential to ensure the insurer's financial stability and regulatory compliance. The review of a surplus note should be completed within [days set forth by the state's insurance department rules, e.g., 30 days]. However, it's essential to note that state laws supersede these general guidelines. Analysts should always refer to the specific requirements outlined by the relevant state insurance department when reviewing surplus notes for approval.

Review Procedures of an Insurer's Request to Issue Capital or Surplus Notes

1. Review the application to verify that all of the information required under the state's statutory rules or guidance have been provided (the following are examples that may differ from your states' rules).
    a. Identity of all parties to the transaction.
    b. The nature and purpose of the transaction, including a description of how the subordinated indebtedness relates to the future business plans of the insurer.
    c. A description of the consideration to be received by the insurer in exchange for the issuance of the subordinated indebtedness.
    d. A description of how the value of the consideration was determined.
    e. A statement as to whether any officers or directors of a party are pecuniarily interested in the transaction.
    f. A copy of the proposed written surplus note (or capital note) agreement.

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g. Request copies of any other side agreements with the holder of the note including any other documents prepared and distributed that describe the surplus note and its purpose, as it relates to non-affiliated notes.
h. Include a payment schedule for future principal and interest payments. Note that payment schedules are more common in non-affiliated surplus notes agreements.
i. A signed and notarized affidavit of an executive officer of the insurer that states: "The insurer is aware of the requirements of the insurance department regarding notices to the insurance department relating to the payment of interest or the repayment of principal corresponding to subordinated indebtedness and agrees to comply with such requirements. The insurer agrees that all agreements governing the terms of the surplus notes have been shared with the commissioner. The insurer agrees to issue the subordinated indebtedness and receive funding within a reasonable time after the date the order of the commissioner is entered approving the subordinated indebtedness, not to exceed (i) 30 days for affiliated notes and (ii) 90 days for unaffiliated notes; provided, that if the insurer fails to issue the subordinated indebtedness and receive funding within the applicable timeframe, the insurer shall not issue any capital notes or surplus notes that were previously approved until the insurer applies for and receives an updated approval from the commissioner.
j. The note includes the following terms:
    i. Surplus floor, if required by insurance department regulations. The purpose of a floor is to ensure that policyholders are protected against hazardous financial conditions that could develop if the floor is too low to provide for the maintenance of adequate capital and surplus.
    ii. Repayment. Provisions for repayment should be clearly set forth in the agreement.
    iii. Receivership. In the event of liquidation any payment of interest or repayment of principal under the agreement shall be in accordance with the department's Insurer Receivership Act. The written agreement should include specific language as required by the insurance department. For example:
        - "This surplus note is subject to the provisions of [insert state law], which binds the company and its successors and assigns. If action is taken against the company or its assets under the [insert state law], this surplus note shall be paid in accordance with the applicable [chapter or provision of the law]."
    iv. For a note with a sinking fund. If the subordinated indebtedness includes a provision for the payment or repayment only out of a sinking fund established by the insurer by setting aside a specified amount during a specified period, all payments must be made from the established sinking fund subject to the minimum surplus stated in the written agreement, and such amount accumulated and held in the sinking fund shall be a legal liability and financial statement liability of the insurer.
k. Either (i) the agreements governing the surplus notes and provided to the commissioner shall state, or (ii) the insurer shall represent to the commissioner, that such agreements provided to the commissioner, constitute the entire agreement between the parties with respect to the surplus notes issuance.

2. Assess the purpose and impact of the proposed transaction on the insurer.

3. Verify that the note complies with SSAP No. 41(4) which provides that proceeds received by the issuer must be in the form of cash or other admitted assets having readily determinable values and liquidity satisfactory to the commissioner.

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a. What asset is the insurer receiving in exchange for issuance of the note?
   - The preferred asset is cash.
   - If not cash, the asset must comply with the investment limitations prescribed by the state insurance department.
   - The purchaser of the note should not give a partnership as consideration to the insurer.
   - The Insurer cannot pledge stock in exchange for consideration as that would involve a change in control and require a Form A filing.

b. Assess the impact of non-cash assets on the mix of assets in the insurer's portfolio. Does the insurer maintain a high concentration in a class of assets that raises regulatory concerns?
c. Will the proceeds of the note increase investment risk? Consider diversification, asset quality and cash flow needs of the insurer.

4. Verify that the note complies with SSAP No. 41(5) which provides that (1) accrued interest may not be added to principal and (2) interest shall not accrue on unpaid interest.

5. Assess the interest rate on the note. Ask the insurer for evidence that the rate is a market rate if that information is not provided in the application.
   a. Note some states' laws cap interest rates on capital and surplus notes.
   b. Floating interest rates are not appropriate for capital and surplus notes.

6. If the insurer is applying for approval to issue a capital note or surplus note to:
   a. an affiliated insurer, verify that the holder has sufficient excess policyholder surplus available for transfer to the insurer. Verify whether the holder will be able to record the debenture as an admitted asset and understands the reporting requirements pursuant to SSAP No. 41 (paragraphs 9 to 13).
   b. a nonaffiliated insurer, verify whether the holder will be able to record the debenture as an admitted asset pursuant to SSAP No. 41 (9), (10) & (11). Consider whether the holder has sufficient excess policyholder surplus if the note is not admitted.
   c. If the insurer issues the notes to one or more investment banks or other initial purchasers in a capital markets transaction, request language in the note requiring approval of the commissioner before any payment of principal or interest can be made and specifying that the request for payment must be filed at least 30 days prior to the requested payment date [Notes: Refer to the state's requirement when a nonaffiliated investment pool is the holder, or when the insurer is a nonprofit legal services corporation, or any other unique situations defined in the state's requirements].
   d. its parent, request information about the source of the funds. It is not uncommon for the parent to borrow the money from a bank, and the parent's bank note will mirror the terms of the surplus note. Request a copy of the parent's note. If the parent is borrowing money from a bank to loan to the insurer, this is a red flag that the parent may be dependent on the insurer for the cash flow necessary to service the bank note. Ask the insurer about the parent's sources of revenue available to service the bank note. Review closely the insurer's ability to service this parent company debt. It may be necessary to request projections demonstrating the parent's debt service.
   e. other relationship (i.e., another person or entity not included in a-d above) It is important to understand the parties involved and the relationship between the parties and the insurer.

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7. Consider the insurer's current financial condition and operating trends (RBC ratio, net premium to surplus ratio, net income, or loss, increasing or decreasing surplus, increasing, or decreasing premium production).
    a. How much of the insurer's surplus is represented by the capital or surplus note?
        i. If the note is with an affiliate or parent, review the reasons why surplus is being requested in the form of a capital or surplus note rather than through a capital and surplus contribution.
        ii. Assess the insurer's ability to generate sufficient income to repay note, in particular in situations where the note is being issued to a non-affiliate.
        iii. Note that Reciprocal insurer's surplus is often 100% in the form of surplus notes.
    b. Does the insurer have any earned surplus or possibly an earned surplus deficit?
    c. Ensure the note does not include provisions that would pledge the insurance company's stock.
    d. Confer with the assigned financial analyst and/or your department supervisor if any of the financial information raises questions/concerns.

8. Verify the terms of any other capital or surplus notes currently outstanding.
    a. What is the surplus floor, if required by insurance department regulations, and payment date(s) for the other notes?
    b. Gain an understanding of the order in which the surplus notes will be paid off if there are more than one, and they contain special subordination language. Make certain that any older notes do not contain a lower surplus floor, if required by insurance department regulations, and payment dates that could trigger the insurer to pay out the surplus obtained from the new note. This does not preclude an insurer from using the proceeds of a new surplus note to pay off an existing surplus note that is maturing, if approved by the commissioner as part of the review of the surplus note and transaction.
    c. For multiple notes with the same floor and payment terms, understand if there is special subordination language in the agreement regarding order of payment on the notes. This does not require special subordination language be included in the surplus note.

9. Collaborate with the supervisor and other relevant department staff to discuss issues that could not be resolved during the review process and develop a possible course of action.

Review of Amendments of Capital and Surplus Notes

1. Review the amendment using the procedures above.

Review of Requests for Principal/Interest Payments on Capital and Surplus Notes

Each principal and interest payment request may be required to be reviewed and approved by the state insurance department in advance of the payment, under state law. Review your state's law to determine those situations when prior state insurance department approval is required. For example:

- The proposed payment does not conform to a payment schedule contained in the note agreement, or the note does not provide for a payment schedule.
- If the insurer is a county mutual, when making payments of principal or interest on a loan from a policyholder.
- If the insurer is a reciprocal or inter-insurance exchange, when making payments of principal or interest on money advanced from its attorney in fact.
- Payments on notes issued to investment pools.

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Consider the following when reviewing an application for approval to make a capital or surplus note payment:

1. Utilize similar considerations as with the review of dividend payment requests.

2. Consider the financial impact of the proposed payment and the insurer's overall financial condition in order to evaluate the adequacy of the insurer's policyholder surplus.
    - Consider risk-based capital, premiums to surplus ratio, trends in writings, profitability, and business plans.
    - Request a pro-forma financial statement that reflects the insurer's financial position after the payment is made.
    - Review the total consideration being paid through dividends along with the payment of the surplus note, to gain an understanding of the financial impact of the aggregate of payments being made to the holder of the note.
    - Will the company retain sufficient surplus after the payment to meet its floor requirement as stated in the note agreement?

3. Identify the source of funds to make the payment and the impact on the insurer's liquidity.

4. Review the request against the payment schedule that was provided to the regulator when the capital or surplus note was originally requested and approved.

H. Risk-Based Capital

An insurer's Risk-Based Capital (RBC) requirement is calculated by applying risk factors to various assets, credits, premiums, reserves, and off-balance sheet items, where the factor is higher for those items with greater underlying risk and lower for those items with lower underlying risk. The RBC ratio is defined as the ratio of Total Adjusted Capital divided by Authorized Control Level RBC. States that enact the *Risk-Based Capital for Insurers Model Act* (#312) and *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315) can take regulatory action based upon this ratio. Historically, minimal capital requirements were imposed on insurers by various state laws. Those minimums frequently were arbitrary, generally low, varied widely from state to state, and typically did not consider the risk profile of the insurer. Models #312 and #315 supplements the system of absolute minimums and considers the risk profile of each individual insurer.

The Model Acts require a comparison between Total Adjusted Capital and Authorized Control Level RBC. The Model Acts then defines several levels of RBC. The description of each level includes a brief summary of what happens if an insurer's Total Adjusted Capital is below that level. The various levels are related to one another by fixed percentages as follows:

Action Levels Based on RBC Ratio:	
> 200%	No Action Level
≥ 150 to ≤ 200%	Company Action Level
≥ 100 to < 150%	Regulatory Action Level
≥ 70 to < 100%	Authorized Control Level
< 70%	Mandatory Control Level
Company Action Level based on Trend Test:	
> 200 to < 300% and a Combined Ratio of > 120%	P&C Trend Test

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> 200% to < 250% (or 300%)	Life/A&H Trend Test Level
> 200 to < 300% and a Combined Ratio of > 105%	Health Trend Test

Most insurers are required to file an RBC report. The report shows the calculation of the Total Adjusted Capital and the calculation of the RBC levels. An insurer whose Total Adjusted Capital is greater than 200% of the Authorized Control Level is not within an action level. Other than filing the RBC report, no further action is required by the insurer. An insurer may trigger a Company Action Level event if the RBC Trend Test is triggered and the domiciliary state has adopted the trend test. An insurer that falls within or below the Company Action Level is required to file an RBC plan with the domiciliary state. The plan must include proposals for corrective steps by the insurer. Models #312 and #315 provide that the plan is confidential. If an insurer's Total Adjusted Capital is within the Regulatory Action Level, the insurance commissioner must perform an examination, as deemed necessary, of the company and issue an order specifying the corrective steps to be taken by the insurer. If an insurer's Total Adjusted Capital is within the Authorized Control Level, the commissioner may seize the company if deemed to be in the best interests of the policyholders and creditors of the insurer and of the public. If an insurer's Total Adjusted Capital is within the Mandatory Control Level, the commissioner must seize the company. However, that step may be forgone if there is a reasonable expectation that the circumstances causing the company to be within that level will be eliminated within 90 days.

Property & Casualty

The components of the Authorized Control Level are factored to apply the level of risk. There are eight major categories of risk including business risk as detailed below:

Asset Risk - Subsidiary Insurance Companies:

This risk focuses on the default of certain affiliated investments. This represents the RBC requirement of the downstream insurance subsidiaries owned by the insurer. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the carrying value. There are several categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items (e.g., non-controlled assets, guarantees for affiliates, contingent liabilities, etc.) are included in this risk component,

Asset Risk - Fixed Income:

This risk focuses on the default of debt assets. Fixed income assets include bonds, mortgages, short-term investments, etc. For property/casualty insurers, the risk associated with fixed income assets and equity assets is not correlated, so there are two separate components of risk. Each category of assets is assigned a risk factor that increases with the perceived risk (quality) of the asset. For example, high-quality bond investments are assigned a low factor, and non-investment grade bonds are assigned a high factor. An asset concentration factor also exists to reflect the additional risk of high concentrations in single exposures represented, for example, by an issuer of a bond or a holder of a mortgage.

Asset Risk – Equity:

This risk focuses on the loss in fair value for equity assets. Equity assets include common and preferred stock, real estate, long-term assets, etc. Each category of assets is assigned a risk factor that increases with the perceived risk (quality) of the asset.

Asset Risk - Credit Risk:

Credit risk attempts to measure the risk of defaults by agents, reinsurers, and other creditors. Ceded reinsurance balances, including recoverable from paid losses, case and incurred but not reported losses, and unearned

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premiums, are all assigned a risk factor. Some ceded reinsurance balances, such as recoverable from affiliates and from mandatory pools and associations, are exempt.

Underwriting Risk - Reserves and Premiums:

There are two components to underwriting risk: reserve risk and premium risk.

Reserve risk attempts to measure the risk of adverse development in excess of expected investment income from loss reserves. Because reserves for the various types of business possess different frequency and severity characteristics, there are separate factors for each major line of business. The loss reserve calculation depends significantly on the development of overall industry loss reserves modified for the insurer's actual experience. The resulting insurer's loss reserve factor is adjusted for expected investment income and applied to its unpaid loss and LAE reserves.

Premium or pricing risk attempts to measure the risk of inadequate rates on business to be written over the coming year (premiums charged are not sufficient to pay future losses). Medium to long-tail lines of coverage are generally more volatile and, therefore, carry higher risk factors than short-tail lines. Similar to the loss reserve component, the pricing risk calculation depends significantly on the industry's loss experience as modified for an insurer's experience. The resulting company loss ratio is then adjusted for expected investment income and the insurer's overall expense ratio on a line of business basis. The factor is applied to the previous year's written premium. Thus, the formula establishes a minimum capital standard that requires for the industry as a whole to have sufficient capital to survive a repeat of historically poor underwriting experience. The factors for reserves and premiums are modified to increase the RBC required for lines with relatively favorable historical experience and lower the RBC required for lines with relatively adverse historical experience. This recognizes that particularly favorable or unfavorable historical experience will not necessarily repeat itself in the future.

Business Risk:

Business risk represents other potential risks that are not effectively covered by the previous five categories.

Business risk also includes administrative expense risk which is associated with the fluctuation of administrative expenses relative to the premium needed to pay those expenses; and guaranty fund assessment risk for property insurers who write direct earned premium in any state that is subject to guaranty fund assessments.

RCAT – Catastrophe Risk:

The catastrophe risk is for earthquake and hurricane risks in certain prone areas of the U.S.

Life/A&H, Fraternal

The components of the Authorized Control Level are factored to apply the level of risk. There are nine major categories of risk including business risk as detailed below:

Asset Risk – Affiliates:

This is the risk of assets' default for certain affiliated investments. This represents the RBC requirement of the downstream insurance subsidiaries owned by the insurer. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the carrying value. There are fourteen categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items (e.g., non-controlled assets, guarantees for affiliates, contingent liabilities, etc.) are included in this risk component, such as non-controlled assets, guarantees for affiliates, contingent liabilities, etc.

Asset Risk – Other:

Asset risk attempts to measure the risk that an insurer's assets will default or will decline in fair value. Each category of assets is assigned a risk requirement factor that increases with the perceived risk level of the asset.

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For example, high quality bond investments are assigned a low factor and noninvestment-grade bonds are assigned a high factor. Similar factors are assigned to other asset categories.

Insurance Risk:

Insurance risk represents the risk associated with unfavorable and/or improper assumptions used by an insurer in the mortality, morbidity, persistency and investment income components of insurance underwriting. The risk factors target the net amount of insurance at risk, net of reinsurance. The higher the level of insurance in-force, the lower the relative factor. Health insurance premiums and reserves are also targeted in the insurance risk factor.

Interest Rate Risk:

Interest rate risk represents the risk that may arise under changing interest rate environments associated with asset and liability mismatches. This area especially impacts annuity writers. Annuity products that are not subject to discretionary withdrawal or are subject to discretionary withdrawal with a market value adjustment, are assigned a lower risk factor. Annuity products subject to discretionary withdrawal with nominal surrender charges receive a higher risk factor. Thus, those insurers that have written large volumes of high yielding annuities, and invested in high-risk assets to earn a spread, are required by both the asset risk and interest rate risk formula to maintain higher capital levels to reflect the increased risk.

Market Risk:

Market risk addresses risk for variable annuities and similar products.

Health Credit Risk:

Health credit risk is the risk that health benefits prepaid to providers become the obligation of the health insurer once again.

Business Risk:

Business risk represents other potential risks that are not effectively covered by the previous six categories. General business risk is based on premium income, annuity considerations and separate account liabilities.

Business risk also includes administrative expense risk which is associated with the fluctuation of administrative expenses relative to the premium needed to pay those expenses; and guaranty fund assessment risk for life insurers who write direct earned premium in any state that is subject to guaranty fund assessments.

Growth Operational Risk:

This is based on the increase in gross direct premium (direct + assumed) from the prior year to the current year.

Health

The components of the Authorized Control level are factored to apply the level of risk. There are five major categories as detailed below.

Asset Risk-Affiliates:

This is the risk of default for certain affiliated investments. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the subsidiary's statutory surplus, multiplied in either case by the percentage of the subsidiary owned by the health entity. There are 10 categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items (e.g., non-controlled assets, guarantees for affiliates, and contingent liabilities, etc.) are included in this risk component.

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Generally, HMOs have a low affiliated asset risk of less than 5% of the total RBC (before covariance); however, more complex health organizations, such as HMDIs, will carry a higher affiliated asset risk of between 14% and 20% of RBC (before covariance).

Asset Risk-Other:

Asset risk attempts to measure the risk that a health entity's assets will default or will decline in fair value. Each category of assets is assigned a factor that increases with the perceived riskiness of the asset. For example, high quality bond investments are assigned a low factor and non-investment grade bonds are assigned a high factor. Similar factors are assigned to other asset categories. An asset concentration factor adds RBC for holdings of a single issuer that represent a substantial proportion of the health entity's assets.

The Asset Risk – Other component of RBC is usually low for HMOs, between 5% and 10% (before covariance), while HMDIs are generally higher, between 20% and 24% (before covariance). The difference between HMOs and HMDIs is reflected primarily in unaffiliated common stock with less than 2% for HMOs and up to 10% for many HMDIs. Fixed income and property and equipment can account for up to 4% of RBC for HMOs and HMDIs.

Underwriting Risk:

Underwriting risk represents the risk associated with the unexpected fluctuation of incurred claims, typically resulting from variations in such factors as mortality, morbidity, and persistency. The risk factors are applied to the previous year's incurred claims or earned premiums for different categories of health insurance.

The factors are smaller for large volumes of business, because less fluctuation is expected than for small volumes. Similarly, the factors are reduced by a credit for managed care arrangements, which generally reduces the fluctuation of incurred claims relative to fee-for-service arrangements. Note: The factors are larger for coverage that can fluctuate more in claim experience, such as comprehensive medical, which can have individual claims of $1 million or more, compared to the smaller factors for less volatile coverage, such as dental.

The underwriting risk calculation does not directly reflect the risk of underpricing or other poor management decisions by the health entity, although these risks were implicitly reflected in the studies of needed capital on which the formula is based, to the extent they existed in the general population of health entities.

A minimum RBC requirement is applied for each category for small companies, equal to the dollar amount of two unusually large claims, which are assumed to be no less than $750,000 each. For companies that have purchased stop-loss reinsurance and are liable for less than $750,000 per claim, the minimum requirement is reduced to reflect their lower liability.

As previously mentioned, net underwriting risk accounts for the largest percentage of RBC for both organization types. HMOs typically have a higher percentage of RBC in net underwriting risk, between 70% and 75% (before covariance), while HMDIs have less net underwriting risk, but still have between 45% and 55% of RBC (before covariance) in net underwriting risk.

Credit Risk:

Health credit risk is the risk that health benefits (or other receivables) that are due from health care providers or other creditors will become an obligation of the health entity as a result of a default by the providers or other creditors.

Health organizations typically have low credit risk, less than 7% of RBC (before covariance) for HMOs and less than 4% of RBC (before covariance) for HMDIs. The higher credit risk on HMOs tends to be driven by the risk with intermediaries.

Business Risk:

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Business risk includes the risk of loss on the health entity's non-insurance business such as Administrative Services Only (ASO) and Administrative Service Contract (ASC) plans and agreements, and the risk associated with growth in the RBC that exceeds growth levels of the health entity's premiums.

Business risk also includes administrative expense risk which is associated with the fluctuation of administrative expenses relative to the premium needed to pay those expenses; and guaranty fund assessment risk for health entities who write direct earned premium in any state that is subject to guaranty fund assessments.

The business risk component of RBC is generally low for health organizations, between 7% and 13% (before covariance). HMOs typically have 7% or less in administrative expenses base and 5% or less in excessive growth risk. Business risk for HMDIs is distributed somewhat differently, with 4% or less in administrative expenses base and 6% or less in non-underwritten and limited risk business.

I. Transactions with Affiliates

SSAP No. 25 - *Affiliates and Other Related Parties* defines an affiliate as an entity that is within the holding company system or a party that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. According to SSAP No. 25, control is defined as possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person or entity, whether through the a) ownership of voting securities, b) by contract other than a commercial contract for goods or non-management services, c) by contract for goods or non-management services where the volume of activity results in a reliance relationship, d) by common management, or e) otherwise. Control is presumed to exist when an entity or person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities. An analyst may also refer to the NAIC *Insurance Holding Company System Regulatory Act* for additional guidance.

Transactions between affiliates and other companies within the same holding company system shall be fair and reasonable. The accounting for assets transferred between affiliates is generally determined by an analysis of the economic substance of the transaction. An economic transaction is an arm's length transaction that results in the transfer of risks and rewards of ownership and represents a consummated act. An arm's length transaction is defined as one in which a willing buyer and seller, each being reasonably aware of all relevant facts and neither under compulsion to buy, sell or loan, are willing to participate. Such a transaction must represent a bonafide business purpose demonstrable in measurable terms, such as the creation of a tax benefit, an improvement in cash flow position, etc. A transaction that results in the mere inflation of surplus without any other demonstrable and measurable improvement is not an economic transaction.

Determining that the risks and rewards of ownership have been transferred to the buyer requires an examination of the underlying facts and circumstances. The following circumstances may raise questions about the transfer of risks:

a. A continuing involvement by the seller in the transaction or in the assets transferred, such as through the exercise of managerial authority to a degree usually associated with the ownership, perhaps in the form of a remarketing agreement or a commitment to operate the property.

b. Absence of significant financial investment by the buyer in the asset transferred as evidenced, for example, by a token down payment or by a concurrent loan to the buyer.

c. Repayment of debt that constitutes the principal consideration in the transaction dependent on the generation of sufficient funds from the asset transferred.

d. Limitations or restrictions on the purchaser's use of the asset transferred or on the profits from it.

e. Retention of effective control of the asset by the seller.

Security swaps of similar issues between or among affiliated companies are considered non-economic transactions. Swaps of dissimilar issues accompanied by exchanges of liabilities between or among affiliates are

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considered non-economic transactions. The appearance of permanence is also an important criterion in establishing the economic substance of a transaction. If subsequent events or transactions reverse the effect of an earlier transaction, the question is raised as to whether economic substance existed in the case of the original transaction. In order for a transaction to have economic substance and thus warrant revenue (loss) recognition, it must appear unlikely to be reversed.

A bonafide business purpose would exist, for example, if an asset were transferred in order to create a specific advantage or benefit. The advantage or benefit must be to the benefit of the insurer. A bonafide business purpose would not exist if the transaction was initiated for the purpose of inflating (deflating) a particular insurer's financial statement, including effects on the balance sheet or income statement.

When accounting for a specific transaction with affiliates, the following valuation methods should be used, according to SSAP No. 25:

a. Economic-based transactions between affiliates should be recorded at prevailing fair values at the date of the transaction.

b. Non-economic-based transaction between affiliated insurers should be recorded at the lower of existing book/adjusted carrying values or prevailing fair values at the date of the transaction.

c. Non-economic-based transaction between an insurer and an entity that has no significant ongoing operations other than to hold assets that are primarily for the direct or indirect benefit or use of the insurer or its affiliates should be recorded at the prevailing fair value at the date of the transaction. However, to the extent that the transaction results in a gain, that gain should be deferred until such time as permanence can be verified.

d. Transactions that are designed to avoid statutory accounting practices shall be included as if the insurer continued to own the assets or to be obligated for a liability directly, instead of through a subsidiary.

Assets may be valued on a different basis if held by a life insurer versus a property/casualty insurer. Therefore, the regulator must take this into consideration when using the general guidelines. In the absence of specific guidelines or where doubt exists as to the propriety of a special accounting method, the domiciliary state should be consulted.

Health Entities:

Affiliated relationships that are unique to health entities include not-for-profit corporations (e.g. hospitals) and other providers of medical care. Not-for-profit health entities are membership corporations that can be affiliated with other entities via common management (members or boards of directors) with other business corporations or not-for-profit corporations. Entities related in this way are often deemed to be affiliates. Further, reliance on a particular provider or provider intermediary to provide medical services to members can create an affiliate relationship pursuant to SSAP No. 25. Relationships such as the above can have a material impact on the way a health entity operates. In a corporate structure that includes a hospital, the health entity may exist for the primary purpose of providing a health care delivery system to a community or region. As a result, the operations and financial condition of the health entity may be secondary to other missions of the corporate structure. Also, providers that are affiliated with a health entity may be used by the health entity to mask poor underwriting results of the health entity and/or manipulate Risk-Based Capital (RBC) results. Continual losses of a provider affiliate may be the result of the health entity transferring those losses to the affiliate. Such losses may ultimately impact the health entity. RBC levels of the health entity may not reflect the true nature of the underwriting risk being borne. Conversely, where the provider affiliate is periodically transferring capital to the health entity in order to keep the health entity solvent or to keep from triggering RBC events, the provider may not be able to continue making sufficient contributions. This may result in the health entity becoming financially distressed. The continuing obligations of a health entity, as in the case where capitated or other risk transfer payments are made to an affiliated provider or intermediary, but the health entity retains the ultimate obligation to provide or pay for medical services, may raise questions about the transfer of risks.

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Compared to commercial accident and health insurers, some states require health entities, particularly Health Maintenance Organizations (HMOs) and not-for-profit health plans (HMDI or Blue Cross Blue Shield type plans) to be licensed or otherwise authorized to operate in a single state. HMOs can operate regionally or even nationally via a holding company system with an ultimate parent controlling multiple single state affiliated HMOs. In these instances, there are generally administrative services provided by the parent and medical services provided by the affiliated HMOs within a geographic region. Blue Cross Blue Shield Plans may also operate in multiple states via a holding company system. Some services such as administrative services, investment management, and actuarial support may be centralized, while other services, such as marketing, may be decentralized. It is essential for analysts to be satisfied that the identity of, and asset control by, the individual health entities are maintained. Since much of the overall financial strength can be concentrated at the holding company level rather than remaining in the health entity, understanding the consolidated financial condition of the holding company system is important.

J. Insurers in Run-Off

Run-off may be either a voluntary or state mandated course of action where the insurer ceases writing new policies on a portion of business, or all business written. A company in run-off should prepare a run-off plan outlining how it will manage its resources in this stage of its operations. During run-off, the insurer typically continues collecting premiums on mandatory policies for a statutorily mandated period and through policy expiration dates. The degree and timing of the reduction in premiums should be closely monitored through the projections provided within the run-off plan. The specific content of the run-off plan may vary depending upon the line and nature of business in run-off and the financial condition of the insurer; however, at minimum, the plan should include the size of the operations during run-off, employee retention plans, consideration of key decision points (such as when employees may be terminated, whether loss portfolio transfers may occur, or whether companies be merged or sold), and key performance indicators and metrics for the run-off (e.g., cashflow projections and Asset Liability Management plans). The run-off of claims becomes the focus of attention until the last dollar of exposure is paid. The risk exposures for insurers in run-off are likely to be different than that of an insurer writing new business; therefore, it may be necessary for an analyst to narrow the focus of the annual analysis and ongoing oversight of the insurer. Insurers that are no longer actively writing new business but continue to service policies and run-off long term claim liabilities often require customized solvency monitoring procedures and considerations. In addition to analysis outlined in the branded risk assessments.

Scope: Please note that the following guidance pertains to *solvent* run-off insurers, as the Handbook guidance is not applicable to those companies in receivership[1]. In particular, the below guidance most directly applies to insurers whose entire company is in run-off. Some elements of the guidance may be applicable in other run-off situations (e.g., one block of business is in run-off), and the examiner/analyst should use judgment in determining which elements may be relevant and in applying them to the risk-focused process.

The focus of the analysis of a run-off insurer may include, but not be limited to, the following:

Run-Off Plan (ST, OP)

- Analysts should obtain a copy of the run-off plan at the beginning of the run-off process and determine whether the plan is reasonable. The evaluation may include:
    - Consider the overall planning process and related assumptions built into the run-off projections.

[1] For further guidance on run-off of insurers deemed to be financially troubled, refer to the NAIC *Troubled Insurance Company Handbook* (regulator only publication). For further guidance on insurers in receivership, refer to the NAIC *Receiver's Handbook for Insurance Company Insolvencies*.

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- Evaluate the effectiveness of the insurer's run-off plan by tracking the company's progress against its plan. Analyze and document any variances in projected exposures, claims counts, and cash flow needs.
- Review the plan to ensure it covers size of operations during the run-off, employee retention plans, consideration of key decision points, and key performance indicators and metrics for the run-off, including cashflow projections and Asset Liability Management plans.
- Assess the management team and its retention of staff to determine if they possess the expertise to achieve a successful run-off.
- Gain an understanding of the insurer's record-keeping processes, with special attention paid to claims records and data sources, including that the data is in a usable format and that the insurer has the ability to transfer claims data to guaranty funds in the event of receivership, as needed in a timely manner.[2]
- Gain an understanding of the insurer's use of service providers and third-party administrators, including plans for continuity of services as operations shrink over time.
- Consider expense reduction, reinsurance, plans for collection of outstanding premium and reinsurance recoverables, potential recovery of statutory deposits, policy buy-back, novation, and claim settlements.
- The insurer's investment portfolio should reflect a conservative strategy to preserve invested assets to meet runoff obligations. Any aggressive strategies may require analysts to discuss the insurer's investment philosophy to ensure that the matching of assets and liabilities are maximized given available capital.

Corporate Governance and Operations (OP, ST)

- Employee Retention: Insurers in run-off are faced with unique challenges in maintaining effective oversight and staffing in circumstances of decreasing resources. Some areas of corporate governance that may be more critical for an insurer in run-off include employee compensation and retention, succession planning, and adequate oversight of critical functions by the Board of Directors and senior management. Evaluating the suitability of key management becomes of increased importance in an environment of high turnover and changing responsibilities. Employee retention may be more difficult for a run-off insurer to manage, it is important to ensure that the company maintains qualified officers with sufficient knowledge and experience throughout the course of the run-off.
  - Closely monitor employee turnover and request additional reporting on any changes in senior officers throughout the run-off period.
  - An analyst may want to consider the need for an insurer in run-off to retain essential IT staff.

Capital and Liquidity Management (LQ, ST, OP)

- The ability to manage capital and liquidity risk can be of heightened importance to run-off insurers given limited resources and flexibility. An objective of an insurer in run-off is to manage its assets and liabilities and maintain sufficient cash flow to ensure claim payments are met. Ideally, the insurer will reduce liabilities over time while ensuring its balance sheet maintains liquid assets to pay claims. An insurer in run-off would generally be expected to maintain a conservative strategy in order to preserve the ability of invested assets to meet run-off obligations. An aggressive strategy may warrant additional scrutiny.
  - To assess liquidity and surplus adequacy, evaluate the insurer's liquidity ratio and surplus to asset ratio.

[2] For further guidance on data transfer formats, such as Uniform Data Standards (UDS) for property and casualty insurers in receivership, refer to the NAIC *Receiver's Handbook for Insurance Company Insolvencies*.

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- Document any material fluctuations in the liquidity and surplus to asset ratio and apply stress testing to assess the capital needs of the insurer.
- Consider the allocation of long v. short tail lines of business in run-off to gain a sense of the length of tail to assess future cash flow needs.
- Monitor investment income in relation to operating expenses, using pro forma projections and reconciling differences. If operating expenses exceed investment income, the resulting losses could quickly erode policyholder surplus and create liquidity issues.
- Inquire of the insurer:
  - Information regarding the insurer's analysis performed to determine future cash flow needs and stress testing to assess its capital needs.
  - Request pro forma projections.

- **Loss and Loss Adjustment Expense (LAE) Reserves** (RV, ST). Loss reserves are the largest liability reported by an insurer and one of the most critical pieces of data in assessing an insurer that has entered run-off. Many run-off insurers are thinly capitalized. Given the materiality of this liability, a slight variance in reserves can have a significant impact on the insurer's ability to continue as a going concern. As a result, there is increased importance placed on highly accurate reserve estimations as well as close monitoring of loss reserves.
  - For property/casualty (P/C) insurers, much of the analytical work is done by a review of Schedule P. Loss reserve accuracy can be assessed by analyzing reserve development by line of business and accident year. In addition, it's critical to review claims counts and assess the trending and severity by reviewing this data within Schedule P.
  - Life insurers at times enter run-off, however, more frequently a block of business will enter run-off. Typically, with regard to Life run-off blocks, another life insurer will manage that run-off while managing other active blocks of business, closely monitor asset adequacy.
  - Given the importance of reserve estimations, consider conducting independent reserve estimations and reviews more frequently or calling a targeted exam before the next full scope exam would be scheduled to have the examiner conduct independent reserve estimations.

- **Legal Risk** (LG) – Legal risks have the potential to be more significant to run-off insurers given their limited ability to adjust pricing or take other actions to address legislative changes, changes in case law, or litigation activity with the ability to significantly impact loss reserves. Therefore, it may be appropriate to:
  - Require regular legal risk update reports.
  - Involve those with legal knowledge and expertise in monitoring the company.
  - Monitor the impact of legal risks more closely on run-off companies.

- **Reinsurance Risks** (ST & CR) – Run-off insurers can benefit from carefully monitoring and applying reinsurance coverage in place to ensure that covered losses are identified and collected. In addition, reinsurance recoverable amounts and the credit risk associated with reinsurance can often be material to the solvency position of run-off insurers. Therefore, regulators should closely monitor insurer operations in this area.

- **Regulatory and Stakeholder Communications -** As the run-off plan proceeds and block of business shrinks, the domiciliary regulator should establish a plan to effectively and timely communicate its analysis of the run-off insurer.

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- Identify key stakeholders in the run-off process, including other state regulators and receivership/guaranty fund contacts[3].
- Ensure that sufficient confidentiality measures are in place to govern and protect communications with other stakeholders.
- Develop a plan to communicate appropriate information in a timely and effective manner throughout the course of the run-off.

Insurance Business Transfers (IBT's) and Corporate Divisions (CD's)

Over the past few years, states have begun enacting statutes which provide opportunities for solvent insurers considering run-off of certain lines or their entire book of business to restructure their run-off with finality. These processes can be broken down into two categories generally referred to as insurance business transfer ("IBT") and corporate division ("CD").

An insurance business transfer (IBT) represents a transaction designed to transfer existing insurance obligations of one insurer (transferring insurer) to a second insurer (assuming insurer) without policyholder consent, subject to approval regulatory approval and court approval. While policyholder consent is not required, notice to policyholders, key stakeholders and the general public is required, and concerns regarding the transaction will be considered in the regulatory and/or court approval process. Following an IBT, the assuming insurer becomes directly liable to policyholders and the transferring insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the transferring insurer.

A corporate division (CD) is a division of one dividing insurer into two or more resulting insurers. The dividing insurer's assets and liabilities are allocated between or among the resulting insurers without requiring affirmative policyholder consent. Following a CD, the resulting insurer(s) becomes directly liable to policyholders and the dividing insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the dividing insurer.

Refer to the work of the Restructuring Mechanisms (E) Working Group, including the draft "Restructuring Mechanisms White Paper" and the draft regulatory "Best Practices Procedures for IBT/Corporate Divisions" currently proposed, for additional information specific to IBTs and CDs that may warrant consideration in the analysis and solvency oversight of these entities.

K. TPAs, MGAs, and IPAs

The NAIC *Managing General Agents Act* (#225) (MGA Act) defines an MGA as any person who (1) manages all or part of the insurance business of an insurer (including the management of a separate division, department, or underwriting office), and (2) acts as an agent for such insurer who, with or without the authority, produces directly or indirectly and underwrites an amount of gross direct written premiums equal to or more than 5% of the insurer's surplus in any one quarter or year and either adjusts or pays claims or negotiates reinsurance on behalf of the insurer. However, the MGA Act exempts certain persons from being considered MGAs, including employees of the insurer, underwriting managers under common control with the insurer whose compensation is not based on the volume of premiums written, and attorneys-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney. MGAs produce or solicit business for insurers and can also provide one or more of the following services: underwriting, premium collection, enrollment changes, claims adjustment, claims payment and reinsurance negotiation. Although this

[3] The optional memorandum of understanding with P/C guaranty funds template is available on the NAIC website at: https://content.naic.org/sites/default/files/committee_related_documents/2022_PreLiquidation_PC_MOU.docx

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may help to gain critical mass, it can also lead to rapid growth and becoming over leveraged. A written contract should be executed with each MGA and should set forth the specific responsibilities of each party.

The NAIC *Registration and Regulation of Third-Party Administrators* (#1090) (TPA Statute) defines a TPA as any person who, directly or indirectly, solicits or effects coverage of; underwrites; collects charges, collateral or premiums from; or adjusts or settles claims in connection with life or health insurance coverage, annuities, employee benefit stop-loss, or workers' compensation insurance. However, the TPA Statute exempts certain persons from being considered TPAs including, among others, insurers (or health entities), licensed agents whose activities are limited exclusively to the sale of insurance and licensed adjusters whose activities are limited to the adjustment of claims and MGAs. TPAs can serve the same function as MGAs as well, but are more typically used in the processing or preauthorization of claims, or the administration of particular types of business. For example, for health entities this includes benefits for prescription drugs (pharmacy benefit managers), dental, mental health and chiropractic service for health entities that underwrite comprehensive medical coverage. In these cases, it is critical that the insurer is able to obtain timely and accurate data from the TPA in order to adjust its reserving and pricing assumptions accordingly. It should be noted that TPAs might contribute to net income of the insurer via reduced claims expenses (e.g., pharmaceutical rebates from manufacturers).

TPAs are also often used to administer uninsured business (ASO/ASC) that is solicited by a health entity when such entity is either precluded by statute or regulation from acting as a TPA, or where it desires to separate this function from its insurance operations. In these cases, the TPA is often affiliated with the health entity. A health entity may also provide stop loss insurance to groups administered by TPAs. Individual Practice Associations (IPAs), which include other provider-based organizations, can act like TPAs but also add the element of risk transfer.

Managing general agents (MGAs) and third-party administrators (TPAs) produce or solicit business for an insurer and also provide one or more of the following services: underwriting, premium collection, claims adjustment, claims payment, and reinsurance negotiation. In addition, IPAs or other provider-based organizations are utilized by health entities to perform similar services, and also can add the element of risk transfer. Insurers are required to have written contracts with MGAs, TPAs and IPAs that set forth the specific responsibilities of each party. MGAs, TPAs and IPAs have been used by insurers to increase the volume of business written without having to expand internal staffing and to facilitate entry into new lines of business or geographical locations. However, the more authority delegated to MGAs, TPAs and IPAs, the greater the opportunity for abuse. If the insurer relinquishes too much control, management may not be able to effectively guide and monitor the insurer's operations. MGAs and TPAs may have priorities or needs that conflict with those of the insurer. For example, there is an inherent conflict for MGAs, TPAs and IPAs between writing quality business and being compensated by commissions based on the volume of business written. When MGAs, TPAs and IPAs are compensated based on the volume of business written, their incentive is to write as much business as possible, which may compromise underwriting controls. TPAs are also often compensated on the basis of claim volume processed, which may lead to lack of adherence to claims adjudication rules and procedures. Alternatively, when TPAs or IPAs preauthorize or process claims, they can cause problems for insurers that must meet regulatory requirements for claims processing. Also, if customer service is delegated to the MGA or TPA as part of the claims payment process, the insurer retains the responsibility if regulatory requirements are not met. In some cases, these problems can result in sizable penalties imposed on the insurer. Furthermore, TPAs, IPAs and MGAs can be responsible for establishing reserves for unpaid claims, or for providing paid claims data that is used by the insurer in estimating reserves for unpaid claims. Note, in some states, IPAs need to be licensed as TPAs or claims adjusters to perform certain functions in a state.

These types of conflicts have played a significant part in the failure of several insurers. The more authority that is delegated to TPAs, IPAs and MGAs, the greater the potential impact of mismanagement making it more important for the insurer to provide active ongoing oversight into the MGAs or TPAs operations. It is important that the insurer actively supervise, control, and monitor the performance of MGAs and TPAs on an ongoing basis to help avoid these conflicts.

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To effectively monitor MGAs, TPAs and IPAs, insurers should obtain and review the MGAs', TPAs' and IPAs' annual independent financial examinations and financial reports. In addition, the NAIC model acts regarding MGAs, TPAs and IPAs require insurers to periodically perform on-site reviews of the underwriting and claims processing operations of each MGAs, TPAs and IPAs utilized. If an MGA establishes loss reserves, the insurer must also obtain the opinion of an actuary regarding the adequacy of loss reserves established on the business produced by the MGA.

L. Reinsurance

Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the insurer transfers or cedes to the reinsurer all or part of the financial risk of loss for claims incurred under insurance policies sold to the policyholder. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding company for all or part of the loss that the ceding company may sustain from claims. Reinsurers may, in turn, transfer or retrocede some of the risk assumed under reinsurance contracts. This form of reinsurance is known as retrocession, and the reinsurer of reinsurance is known as the retrocessionaire. Retrocessions are simply reinsurance for reinsurers.

Property & Casualty

One of the basic functions of reinsurance is to spread the risk of loss throughout the property/casualty industry and increase the amount of coverage insurers can provide. Through reinsurance, an insurer can share its risk with another insurer or insurers and limit its losses on claims incurred under policies written. An insurance company generally limits the amount of coverage it is willing to underwrite relative to its surplus. Through reinsurance, an insurer can reduce its loss reserves by the amount of risk transferred to the reinsurer and, as a result, increase its capacity to write more business.

Reinsurance does not modify in any way the obligation of the primary insurer to pay policyholder claims. Only after loss claims have been paid can the primary company seek reimbursement from a reinsurer for its share of paid losses. Generally, a reinsurer has no direct relationship or responsibility to policyholders.

Insurers operating in the U.S. may obtain reinsurance from insurance companies that specialize in assuming reinsurance, referred to as professional reinsurers, reinsurance departments of primary insurers, and alien reinsurers (i.e., a reinsurer domiciled in another country). Generally, any primary insurer may assume reinsurance for those lines of business in which it is licensed. Reinsurance is also available from pools, which are groups of insurers organized to jointly underwrite reinsurance. According to the booklet *Offshore Reinsurance in the U.S. Market: 2013 Data*, which was produced by the Reinsurance Association of America (RAA), total U.S. premiums ceded to offshore insurers in 2013, affiliated and unaffiliated, totaled $65.7 billion, and net recoverables totaled $111.2 billion.

The basic objective of reinsurance is to spread the risk of loss. Through reinsurance, an insurer can limit its losses under policies issued, as the reinsurer assumes the obligation to indemnify the insurer. There are four primary reasons why an insurer enters into reinsurance transactions:

- Increase Underwriting Capacity

  Reinsurance increases an insurer's capacity to write greater amounts of policy coverage than it could cover on its own. Some risks (e.g., commercial risks) would be too large for any company to insure alone. Prudent management and certain insurance regulations demand limits on any one potential loss proportionate to the size of the insurer's surplus. By transferring risks in excess of this prudent retention, an insurer can write policies with greater amounts of coverage without having to bear the full impact of potential losses under such policies. This function is crucial for small and medium size insurers to compete with larger insurers in meeting policyholders' coverage needs.

- Stabilize Underwriting Results

Reinsurance can serve to stabilize an insurer's overall underwriting results by allowing an insurer to pass along losses to reinsurers that occurred during bad years in exchange for sharing profits that occurred during good years. Like other businesses, an insurance company tries to avoid wide fluctuations in profits and losses from year to year. As discussed above, an insurer limits exposure to an individual risk by retaining a portion of the original risk and reinsuring the balance. To some extent, an insurer may also limit aggregate losses sustained over a specific period, such as a year, by reinsuring losses in excess of a predetermined cap.

Reinsurance also stabilizes underwriting results by reducing the possible impact of any one line of business or geographic area on overall results. To adjust its mix of business or geographic spread of risk, an insurer may reinsure certain (e.g., more hazardous or unprofitable) lines of business or policies concentrated in a particular geographic region. Also, insurers may rely on reinsurers for underwriting assistance when entering new lines of business.

- Protect Against Catastrophic Losses

  Reinsurance protects insurers against large aggregate losses due to natural or man-made catastrophes, such as hurricanes or riots. While individual losses may be small, an insurer may not be able to absorb the accumulation of multiple losses due to a single event or occurrence. Protecting against catastrophic losses is related to stabilizing underwriting results because catastrophes are major causes of loss instability.

- Increase Financial Strength

  Reinsurance provides a form of financing for insurance companies. Generally, an insurance company limits the amount of insurance it is willing to underwrite relative to its surplus. Upon issuing a policy, an insurer must recognize the unearned portion of premiums as a liability. However, the insurer must also pay its expenses at the beginning of the policy. Since premium income is deferred over the policy period and expenses are charged-off immediately, an insurer's surplus shrinks, thus reducing its capital base to finance new growth. Reinsurance can relieve the impact of this accounting allocation. When reinsuring its policies, an insurer transfers a portion of its unearned premiums to the reinsurer and receives a ceding commission from the reinsurer. As a result, the ceding company's surplus rises by an amount equal to the ceding commission. This function of reinsurance is referred to as surplus aid.

Life/A&H, Fraternal

Reinsurance commonly is undertaken in ordinary life insurance (with accompanying disability and accidental death benefits), in credit insurance, in individual health insurance, in annuities, and in group insurance in its various forms. In most ways, reinsurance is in the same position as direct insurance, with several exceptions. There is no direct relationship between the reinsurer and the ceding company's policyholder. In the event of the ceding insurer's insolvency, the policyholder or beneficiary under a contract that is reinsured has the same status as a policyholder or beneficiary with a policy that was not reinsured. Insurers may be required to file copies and receive approval of reinsurance treaties. An insurer may not need to be licensed in a state in order to act as a reinsurer of a domestic insurer. The domestic insurer may not receive full reinsurance credit on business ceded to such reinsurers. Some states require that, to be "authorized," a reinsurer must meet certain criteria, but these may not be the same as those demanded of companies doing direct business in the state. Reinsurance premiums usually are not subject to premium taxes. Frequently, the reinsurer reimburses the ceding insurer for the premium taxes paid on that portion of the direct premium equal to the reinsurance premiums.

In formulating its rules for accepting applications for insurance, an insurer must decide upon three areas of action: retaining, reinsuring or declining the risks presented. Insurers of various sizes have different capacities to write insurance on a single life. An insurer must determine the maximum exposure it is able to accept and retain as its own insurance business. Having made this determination, the insurer must then decide what to do with any risks that exceed the maximum amount it is willing to retain. It has two choices: 1) accept the additional risk and reinsure it or 2) decline the extra risk. Once an insurer has decided to reinsure amounts in excess of its desired retention, it may proceed on one of several basic modes.

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- Coinsurance

  Under this mode, the excess face amount is reinsured on the same plan as that of the original policy. The direct writer and the reinsurer share in the risk in the same manner. The ceding insurer pays the reinsurer a proportional part of the premiums collected from the insured. In return, the reinsurer reimburses the ceding insurer for the proportional part of the death claim payments and other benefits provided by the policy, including nonforfeiture values, policy dividends, commissions, premium taxes, and other direct expense agreed to in the contract. The reinsurer must also establish the required reserves for the portion of the policy it has assumed. In coinsurance of participating policies, the reinsurer reimburses the ceding insurer for its portion of the dividends paid to the policyholder. In determining its schedule of dividends, the ceding insurer takes into account the experience on the business as written and the reinsurer generally is required to accept or match this schedule. Coinsurance is also used for nonparticipating policies, particularly in situations where a severe strain is on the direct writing insurer's surplus in the first policy year. For example, the premium received by the direct writer during the first policy year usually is insufficient to pay the high first-year commissions and other costs of issue, to establish the initial reserve, and to avoid a surplus loss. In such an example, coinsurance relieves some of the surplus strain of adding large amounts of new insurance and commissions, and expense allowances on the reinsurance provide direct surplus relief to the ceding insurer.

- Modified Coinsurance

  A number of companies reinsure on the "modified coinsurance" mode, which is a variation of coinsurance whereby the reserves for the original policies may be maintained by the ceding insurer instead of the reinsurer. Under modified coinsurance, the assuming company transfers to the ceding insurer, usually on an annual basis as of Dec. 31, the increase in the mean reserve on the reinsured portion. From this is deducted interest at a rate stated in the reinsurance contract on the prior year's total mean reserves. The resulting net transfer is called the modified coinsurance reserve adjustment. The modified coinsurance agreement may provide surplus relief through reinsurance commissions and allowances. In some cases, a policy may be reinsured partially on a coinsurance mode and partially on a modified coinsurance mode.

- Yearly Renewable Term (YRT)

  Under this mode of reinsurance, the primary insurer transfers the net amount at risk to the reinsurer and pays a one-year term premium. The "net amount at risk," as defined in the treaty, is usually the amount of insurance provided by the policy in excess of the reserve on it. In certain term insurance, reserves generally are disregarded. The ceding insurer's liability is the reserve held in the event of death and the cash value held in the event of withdrawal.

- Other

  Other forms of reinsurance are also available, such as catastrophe and stop loss coverage. The terms of such reinsurance vary considerably, so no general rules can be made.

Health

Although reinsurance is not uncommon among health entities, its use is generally more limited compared to traditional life/health and property/casualty insurers. Approximately 40% of health entities have no ceded reinsurance premiums. Health entities that are not licensed as insurers are often not authorized to assume reinsurance. More than 95% of health entities have no assumed reinsurance premiums.

Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the primary health entity transfers or "cedes" to another insurer (the reinsurer) all or part of the financial risk of loss for claims incurred under insurance policies sold to the policyholder or subscriber. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding company for all or part of the claims that the ceding company may sustain.

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One of the basic functions of reinsurance is to spread the risk of loss and increase the amount of coverage health entities can provide. Through reinsurance, a health entity can share its risk with another insurer or insurers and limit its claims incurred under policies written. An insurance company generally limits the amount of coverage it is willing to underwrite relative to its surplus. Through reinsurance, a health entity can reduce its incurred claims by the amount of risk transferred to the reinsurer and, as a result, increase its capacity to write more business.

Health entities operating in the United States may obtain reinsurance from insurance companies that specialize in assuming reinsurance, referred to as professional reinsurers; reinsurance departments of primary insurers; and alien reinsurers (i.e., a reinsurer domiciled in another country). Generally, any health entity licensed to write accident and health insurance may assume reinsurance for that line of business unless prohibited by Statute or Regulation. Reinsurance is also available from pools, which are groups of insurers organized to jointly underwrite reinsurance. Although voluntary and intercompany pooling is somewhat uncommon among health entities, involuntary pools are used by many states to provide coverage to individuals or small groups in order to mitigate the risk of anti-selection or high-cost claims. See SSAP No. 63–*Underwriting Pools*, for further discussion.

Reinsurance does not modify in any way the obligation of the primary health entity to pay policyholder or subscriber claims. Only after claims have been paid can the primary health entity seek reimbursement from a reinsurer for its share of paid claims. Generally, a reinsurer has no direct relationship or responsibility to policyholders. In the event of the ceding company's insolvency, the policyholder or beneficiary under a contract that is reinsured has the same status as a policyholder or beneficiary with a policy that was not reinsured. Health entities may be required to file copies and receive approval of reinsurance treaties. A company may not need to be licensed in a state in order to act as a reinsurer of a domestic health entity. The domestic company may not receive full reinsurance credit on business ceded to such reinsurers. Some states require that, to be "authorized," a reinsurer must meet certain criteria, but these may not be the same as those demanded of companies doing direct business in the state. An analyst should review their state's criteria for licensing of reinsurers and approval of reinsurance treaties or any special exceptions the state has made specific to the health entity. Reinsurance premiums usually are not subject to premium taxes. Frequently, the reinsurer reimburses the ceding company for the premium taxes paid on that portion of the direct premium equal to the reinsurance premiums.

Health entities of various sizes have different capacities to write insurance. A health entity must determine the maximum exposure it is able to accept and retain as its own insurance business. Having made this determination, the health entity must then decide what to do with any risks that exceed the maximum amount it is willing to retain. It has two choices - accept the additional risk and reinsure it, or decline the extra risk.

The two most commonly used types of reinsurance for health entities are excess-of-loss (also referred to as stop-loss) and coinsurance. Excess-of-loss is the most common type of reinsurance arrangement used by managed care health entities. HMDIs also use excess-of-loss coverage and are more likely than other health entities to use coinsurance.

Excess-of-loss

Many managed care health entities use excess-of-loss coverage to provide for day-to-day operations. Other types of companies may use this type of coverage to provide catastrophe coverage. Excess-of-loss reinsurance is often referred to as non-proportional reinsurance or stop-loss reinsurance. Health entity's reinsurance contracts generally operate on a per risk excess-of-loss basis with an aggregate limit per year on each risk and aggregate limit on the life of the member covered. Generally, the excess-of-loss reinsurance agreement reimburses an agreed upon percentage of claims once the ceding company reaches its retention for claims. Excess-of-loss reinsurance may reimburse on the basis of an individual claim or accumulation of claims for a particular member, occurrence or accident, or an aggregate. On a per claim basis, the ceding company recovers claims in excess of a retention that applies to each claim or series of claims for a given member. On an occurrence or accident basis, the company recovers claims in excess of a retention applied to each occurrence or accident resulting in multiple claims, regardless of the number of members involved. The aggregate basis allows the

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ceding company to recover claims that in the aggregate exceed retention, usually a flat amount for aggregate excess covers and a percentage of net premiums for stop-loss covers. The terms of excess-of-loss reinsurance vary considerably, so no general rules can be made.

Excess-of-loss reinsurance pays benefits to the ceding company after a claim(s) has exceeded a predetermined amount, often referred to as a deductible or retention. This predetermined amount can be either a specific dollar amount or some other amount such as a percentage. An example of a specific dollar amount would be where a contract states that if an individual claim exceeds $100,000, the reinsurance contract becomes effective and the reinsurer will reimburse the ceding company for the amount or part of the amount exceeding the established retention. Contracts that use a percentage to establish retention might state that a reinsurer shall reimburse the ceding company when a financial ratio, such as the loss ratio, exceeds a certain percentage.

Excess-of-loss premiums are typically based upon the number of members reinsured and generally paid on a per member per month basis. Unlike many other types of reinsurance, in this contract, there is no proportional relationship to the original premiums and claim. Generally, the contract reimburses an agreed upon percentage of claims in excess of the ceding company's retention. Often times the retention amounts, or the reimbursement amounts vary for in-network claims, vs. out-of-network claims or for hospital claims vs. physician claims. Hospital excess-of-loss coverage is the most common excess-of-loss coverage for managed care health entities.

Catastrophe reinsurance is also non-proportional reinsurance. Under this type of reinsurance the ceding company receives payment from the reinsurer when the ceding company's total net retained claims that result from a single accidental event exceed the ceding company's retention or a specified loss ratio.

Coinsurance

Under this mode, the direct writer and the reinsurer share in the risk of claims and expenses on a proportionate basis. The ceding company pays the reinsurer a proportional part of the premiums collected from the insured. In return, the reinsurer reimburses the ceding company for the proportional part of the claim payment and other benefits provided by the policy. The reinsurer may also reimburse the ceding company for its commissions and out-of-pocket expenses incurred in writing the business. This is referred to as an expense allowance.

The reinsurer must also establish the required reserves for the portion of the policy it has assumed. Coinsurance and most excess-of-loss reinsurance contracts are automatic. An automatic contract covers risks meeting the contract criteria at the set premium without specific review of individual claims by the reinsurer. Some coinsurance contracts may be facultative. A facultative contract requires the ceding company to submit the underwriting file on each individual application to the reinsurer for review. Then the reinsurer individually accepts or declines to participate in the reinsurance of that individual. Facultative reinsurance is rarely encountered in the health market.

The basic objective of reinsurance is to spread the risk of loss. Through reinsurance, a health entity can limit its claims under policies issued, as the reinsurer assumes the obligation to indemnify the health entity. There are four primary reasons why a health entity enters into reinsurance transactions.

Stabilize Underwriting Results

Reinsurance can serve to stabilize a health entity's overall underwriting results by allowing a health entity to pass along claims to reinsurers in bad years in exchange for sharing profits in good years. Like other businesses, health entities try to avoid wide fluctuations in profits and losses from year to year. As discussed above, a health entity limits exposure to an individual risk by retaining a portion of the original risk and reinsuring the balance. To some extent, a health entity may also limit aggregate claims sustained over a specific period, such as a year, by reinsuring claims in excess of a predetermined cap.

Increase Underwriting Capacity

Reinsurance increases a health entity's capacity to write greater amounts of policy coverage than it could cover on its own. Some risks may be too large for any health entity to insure alone. Prudent management and certain insurance regulations demand limits on any one potential claim proportionate to the size of the health entity's

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surplus. For example, a health entity may issue a policy to its members with a maximum annual coverage of up to $1,000,000 per year with a lifetime limit of $2,000,000. The health entity's retention on any one risk is based upon the total surplus, the number of members covered and how long the company has written this business. By transferring risks in excess of this prudent retention, a health entity can write policies with greater amounts of coverage without having to bear the full impact of potential claims under such policies. This function is crucial for small and medium size health entities to compete with larger health entities in meeting policyholders'/subscribers' coverage needs.

Support Point of Service Operations

The use of reinsurance to stabilize underwriting results and increase underwriting capacity is common to all types of insurance. However, one purpose of reinsurance that is specific to health entities is driven by how a particular health entity provides a point of service product. Depending upon state preferences, a health entity may provide a point of service type of product by providing the coverage through the health entity, but only if parts of the coverage are pick up or reinsured by an indemnity company.

Provide Continuation of Coverage and Benefits in the Event of Insolvency

Most health contracts have termination language that allows for automatic termination in the event of insolvency or cessation of operations. This feature is a critical distinction among health contracts since the health entity is presumed to be acting as the primary mechanism to deliver care to its subscribers. In the event of insolvency, a continuation of the benefits clause within the reinsurance agreement will require the reinsurer to be liable for all claims incurred from the date of insolvency for a specified period of time. In addition, continuation of benefits clauses typically require that the reinsurer pay claims from the date of insolvency through the earlier of the date of discharge for a member who is confined to an impatient facility, or the date the member becomes eligible for health coverage under another plan. Continuation of benefits clauses may also contain other limitations as well. The coverage may also provide that the reinsurance company continues benefits for any member for medical services incurred for a service date subsequent to the date of insolvency provided that premium for the members are current. Historically, continuation of benefits clauses has not contained maximum limits. However, more recently, reinsurers have attempted to insert dollar limits to avoid large exposure under the provision resulting from the insolvency of a large health entity.

M. Audited Financial Report

The Annual Financial Statement filed by an insurer is the primary source of the financial information used by a financial analyst during the analysis process. Therefore, it is important that the financial information included in the Annual Financial Statement be accurate if the analysis process is to be beneficial in monitoring the financial solvency of the insurer. However, most state insurance departments perform financial condition examinations of its domestic insurers to verify the accuracy of the financial information reported in the Annual Financial Statement only once every three to five years. The Audited Financial Report can provide comfort to analysts regarding the accuracy of the financial information in the Annual Financial Statement.

Per the NAIC *Annual Financial Reporting Model Regulation* (#205), insurers are required to file an audited statutory financial report by June 1 of each year, which includes an opinion by an independent certified public accountant or accounting firm (hereinafter referred to as CPA) regarding the audited financial statements. For guidance regarding this model, see Appendix G of the NAIC's *Accounting Practices and Procedures Manual*. The independent CPA's opinion may be an unmodified or a modified opinion; however, there are three types of modified opinions: qualified, adverse and disclaimer of opinion. The decision regarding which type of modified opinion is appropriate depends upon the nature of the matter giving rise to the modification and the auditor's professional judgment about the pervasiveness of the effects (or possible effects) of the matter on the financial statements. If the Audited Financial Report differs from the Annual Financial Statement, reconciliation is required, along with a description of the difference(s) in the Notes to Financial Statements in the Audited Financial Report.

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The text of the Audited Financial Report should be reviewed carefully. Although an independent CPA's opinion on an insurer's financial statements might, at first glance, appear to be a standard unmodified opinion, additional explanatory language included in the opinion may flag a potential problem. For example, the CPA might issue an unmodified opinion on the financial statements while also including additional language in the auditor's report emphasizing uncertainties, such as contingencies concerning future events that could impact the insurer's financial position or substantial doubt regarding the insurer's ability to continue as a going concern. In addition, the notes to the audited financial statements should be thoroughly reviewed, especially for information concerning investments, reserves, reinsurance, affiliated transactions, contingent liabilities, and if applicable, the amount and nature of differences between the Audited Financial Report and the Annual Financial Statement that was filed by the insurer.

In addition to and for filing with the Audited Financial Report, the independent CPA is required to prepare a Letter of Qualifications each year. The letter includes a statement regarding the CPA's awareness of the domiciliary commissioner's reliance on the Audited Financial Report and opinion thereon in the monitoring and regulation of the financial position of the insurer. The Annual Financial Reporting Model Regulation requires that the lead audit partner not serve in that capacity for more than five consecutive years and may not rejoin in that capacity of a period for more than five consecutive years. The auditor may not provide various non-audit services that, if performed, would impair the auditor's independence in relation to that company. Insurers with less than $100 million in direct and assumed premium may request a waiver from this requirement based on financial or organizational hardship. Partners and senior managers of the audit committee may not serve as a member of the board of directors, or as president, chief executive officer, controller, chief financial officer, or some other similar position of the insurer if employed by the independent public accounting firm that audited the firm during a one-year period preceding the most current statutory opinion. The letter further states that the CPA will agree to make all work papers prepared during the audit available for review by the domiciliary state insurance department examiners.

If the insurer is an SEC registrant, or significant deficiencies in an insurer's internal control structure are noted during the audit, the independent CPA is required to prepare a report that describes the deficiencies. This report, along with a description of the improvements made or proposed by the insurer to correct the deficiencies noted, must be filed with the domiciliary state insurance department. Insurance company management is required to file an assessment of internal controls over financial reporting with the state insurance department. This report should include a statement by management explaining whether these controls are effective in providing reasonable assurance that the statutory financial statements and disclosure of any unremediated material weaknesses in internal control over financial reporting is reliable. No CPA opinion is required of management's assessment.

The independent CPA is required to notify an insured's board of directors or its audit committee within five business days of any determination that the insurer has materially misstated its financial condition as reported to the domiciliary state insurance department or that the insurer does not meet the minimum surplus/capital and surplus (based on business type) requirement of the domiciliary state. Once notified, the insurer is required to send a copy of the notice to the domiciliary state insurance department within the next five business days. If the CPA does not receive evidence that the insurer has sent a copy to the domiciliary state insurance department, the CPA must then forward a copy of the notice directly to the insurance department within five business days.

The insurer is required to notify the domiciliary state insurance department within five business days when the insurer's independent CPA is dismissed or resigns. The insurer is also required to furnish a separate letter within 10 business days of the previous notification stating whether, in the 24 months preceding such event, there were any disagreements with the former independent CPA on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, and which disagreements, if not resolved to the satisfaction of the former independent CPA, would have caused the CPA to make reference to the disagreement in connection with the opinion. In addition, the insurer is further required to furnish a letter from the former

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independent CPA stating whether the independent CPA agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which there is disagreement.

The Audited Financial Report Worksheet is designed to assist analysts in reviewing the Audited Financial Report and assist in identifying significant information and explanatory language regarding the insurer, which has been emphasized by the independent CPA. Additionally, a review of the independent CPA's Letter of Qualifications and, if applicable, the report of significant deficiencies in the insurer's internal control structure is included within the legal risk assessment.

N. Management's Discussion & Analysis

The Management's Discussion and Analysis (MD&A) is a material historical and prospective textual disclosure enabling regulators to assess the financial condition and results of operations of the reporting entity. The MD&A is intended to give analysts an opportunity to look at the reporting entity through the eyes of management by providing both a short and long-term analysis of the business of the reporting entity. The information provided pursuant to this MD&A need only include that which is available to the insurer without undue effort or expense and that which does not clearly appear in the insurer's Annual Financial Statement.

Generally, the MD&A shall cover the two-year period covered by the Annual Financial Statement and shall use year-to-year comparisons or any other formats that, in the insurer's judgment, will enhance analysts' understanding. However, where trend information is relevant, reference to the Annual Financial Statement, Five-Year Historical Data pages in the Annual Financial Statement may be necessary.

The MD&A shall focus specifically on material events and uncertainties known to management that would cause reported financial information not to be necessarily indicative of future operating results or of future financial conditions. This would include descriptions and amounts of matters that would have an impact on future operations and have not had an impact in the past and matters that have had an impact on reported operations and are not expected to have an impact upon future operations.

O. Management Considerations

Although many insurers have boards of directors, some insurers may have other forms of governing bodies that perform similar roles as a board of directors. In this handbook, any reference to the board of directors refers to the governing body of the insurer.

In order to get a complete picture of insurance operations, it is important to understand who is driving operations within the business enterprise (e.g., chairman of the board, board of directors, president or chief executive officer, operations vice presidents, etc.). Management not only performs the primary role in daily decisions related to operations, but also makes decisions related to the overall mission of the company. However, another factor can be the board of directors' role in this decision-making process. Once analysts determine the players in the decision process, it is necessary to understand management's philosophies as well as the overall process in initiating a business decision. It is also important to assess management or board of directors' changes and determine if the changes appear to indicate a shift in management philosophy or whether management has made any changes in its business plan.

Assessment of management and the board of directors might include:

- Face-to-face interviews
- Review of biographical affidavits
- Review of board of directors' meeting minutes
- Review of Insurer Profile Summary

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- Review of examination work papers
- Review of supplemental reports (e.g., S&P and A.M. Best)

Corporate Governance

Corporate governance can be defined as a framework of rules and practices by which a board of directors ensures accountability, fairness, and transparency in an insurer's relationship with its stakeholders. It is important that a fully functional, well-qualified, and independent board of directors be established to ensure that corporate governance principles are effectively implemented. Corporate governance is viewed as a company responsibility defined by corporate law, which may be defined by state law. However, as a result of changes in the economic environment and the move toward principle-based regulation, it may be necessary for a greater regulatory focus on corporate governance.

Components of effective corporate governance programs include:

- Adequate competency (industry experience, knowledge, skills) of members of the board of directors;
- Independent and adequate involvement of the board of directors;
- Multiple, informal channels of communication between board of directors, management, and internal and external auditors to create a culture of openness;
- A code of conduct established in cooperation between the board of directors and management, which is reviewed for compliance and is formally approved by senior management;
- Identification and fulfillment of sound strategic and financial objectives, giving adequate attention to risks;
- Support from relevant business planning and proactive resource allocation;
- Support by reliable risk-management processes across business, operations, and control functions;
- Reinforcement of corporate adherence to sound principles of conduct and segregation of authorities;
- Independence in assessment of programs and assurance as to its reliability;
- Objective and independent reporting of findings to the board of directors or appropriate committees thereof;
- Adoption of federal Sarbanes-Oxley Act provisions, whether or not mandated, including, but not limited to, auditor independence and whistle-blower provisions; and
- Board oversight and approval of executive compensation and performance evaluations.

The board of directors should:

- Be composed of a sufficient number of knowledgeable, independent, and active members to properly fulfill its governance and oversight responsibilities.
- Be governed by formal bylaws and charters and to ensure that duties and responsibilities are effectively documented and communicated.
- Possess the appropriate professional qualifications, knowledge, and experience to ensure sound and prudent management.
- Be guided by the basic principles of duty of care and loyalty.

Many insurers, based on premium volume and public company status among other factors, are required to comply with the NAIC *Annual Financial Reporting Model Regulation* (#205), the federal Sarbanes-Oxley Act of 2002, and various other corporate governance standards that require a certain amount of board oversight and risk management.

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Risk Management

Broadly defined, risk management can be defined as a process implemented by a company's board of directors and management that is applied through strategy setting throughout the enterprise. It is designed to identify potential events that may affect the company's ability to manage risk within its risk appetite. It is also intended to provide reasonable assurance regarding the achievement of the company's objectives. An insurer's risk management function should limit the risks acceptable to the group to ensure continued operations following an extreme loss event. It is important to note that the risk management principles and processes may be applied at a legal entity level or at the group level, depending on the organizational structure. Risk management should be applied at every level within the group, including an entity-level view of risk.

Risk management should be composed of (1) setting objectives; (2) identifying significant risks and events affecting the group's objectives; (3) assessing risk, the group environment, the group's response to risks, control policies and procedures, information, and communication; and (4) monitoring of ongoing activities.

An effective risk management function is essential in providing effective corporate governance over financial solvency. Under the risk-focused surveillance approach, analysts and examiners must consider and evaluate the insurer's corporate governance and established risk management processes. By understanding the corporate governance structure and by assessing the risk management processes and the "tone at the top," analysts will obtain information on the quality of guidance and oversight provided by the board of directors and the effectiveness of management.

It is critical for both analysts and examiners to understand and leverage the company's risk management program; that is how the company identifies, controls, monitors, evaluates, and responds to its risks. The discipline and structure of risk management programs vary dramatically from company to company. "Best practices" are emerging for risk management programs and more companies are appointing chief risk managers whose responsibilities go well beyond the traditional risk management function (i.e. the buying of insurance or reinsurance). The most commonly accepted standards relating to internal controls are the Committee of Sponsoring Organization's (COSO) Integrated Framework of Internal Control and the IT Governance Institute's Control Objectives for Information and Related Technology (COBIT). As these standards are widely accepted by many companies, it may be useful for analysts to become familiar with the concepts included in the COSO Integrated Framework of Internal Control and the COSO Enterprise Risk Management Integrated Framework, as well as other COBIT tools, to utilize as sources when identifying and assessing an insurer's risk mitigation strategies/controls. Although companies are not required to utilize the COSO or COBIT standards, the key components within these standards are likely to be incorporated.

Following are five basic elements that contribute to a sound risk management environment:

- Active board and senior management oversight
- Adequate risk identification, monitoring and management processes
- Adequate and clear policies, authorization limits and procedures
- Comprehensive and effective internal controls
- Processes to ensure compliance with laws and regulations

Regardless of the complexity of an entity, certain aspects of a risk control environment facilitate effective oversight of inherent business risks, which include the following:

- Processes that accurately monitor compliance with internal policies and limits on a timely basis
- Effective management oversight and internal controls of day-to-day business activities, including cohesive, effective internal communication mechanisms and appropriate lines of reporting
- Sufficient independence between the risk control functions and the business line functions, so that the adequate segregation of duties and the avoidance of conflicts of interest are ensured

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- An effective internal audit function (or effective external audit program for operations) that comprehensively identifies and assesses key areas of risk

Sources of Risk Management Information:

- Descriptions of the internal auditor's role in development of the entity's risk management methodology and in risk monitoring and control
- Recent external and internal auditor reports and management responses
- Summary of the company's overall risk profile, including significant areas of regulatory concern. *(Review the Insurer Profile Summary)*
- Recent risk-management reports detailing pricing/underwriting, market, credit, liquidity and reserving risk exposures (including those identified as Enterprise Risk Management reports) and other key management reports
- Assessments of the presence and effectiveness of internal control measures across primary business lines; and current year-to-date and prior-year comparisons of financial results to plan*. (This could include assessments made by the company, i.e., internal audit reports, or by the examiner as a result of prior-year examinations)*

Communication and Coordination

In performing an analysis of management considerations, analysts should utilize the risk-focused surveillance examination work that has been most recently completed related to these risk areas. Where applicable, analysts should follow-up on the work performed by the examiners.

In an insurance holding company system, the domestic insurer may share common management and/or a common board of directors with other insurers within the group. Similarly, depending on the nature of the risk, multiple insurers within an insurance holding company system may experience similar risks or be impacted similarly by events or management decisions. For example,

- A board of directors' decision to alter strategic business plans for the group may have similar operational changes to multiple insurers within the group.
- A management decision to implement new IT claim handling systems utilized by multiple affiliated insurers that results in improper claims payments may result in market conduct violations or have a financial impact for more than one insurer within the group.
- Insurers that share common financial reporting staff may experience similar accounting errors that could have a financial impact on more than one insurer within the group.
- News reports about the parent company may result in reputational risk that has a negative impact on multiple insurers' ratings or writings.

The department should utilize the lead state to communicate and coordinate any material analysis findings regarding management and corporate governance risks with other interested regulators.

P. References

Publications

- *Accounting Practices and Procedures Manual*, NAIC
- *Annual Statement Instructions*, NAIC
- *Financial Condition Examiners Handbook*, NAIC

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- *Health Reserve Guidance Manual,* NAIC
- *Market Regulation Handbook,* NAIC
- *Own Risk Solvency Assessment Guidance Manual*, NAIC
- *Purposes and Procedures Manual of the NAIC Investment Analysis Office*, NAIC
- *Troubled Insurance Company Handbook*, NAIC

Model Laws

- *Actuarial Opinion and Memorandum Regulation (#822), NAIC*
- *Annual Financial Reporting Model Regulation (#205), NAIC*
- *Corporate Governance Annual Disclosure Model Act (#305), NAIC*
- *Corporate Governance Annual Disclosure Model Regulation (#306), NAIC*
- *Credit for Reinsurance Model Act, (#785), NAIC*
- *Credit for Reinsurance Model Regulation (#786), NAIC*
- *Disclosure of Material Transactions Model Act (#285), NAIC*
- *Health Insurance Reserves Model Regulation (#10), NAIC*
- *Insurance Holding Company System Regulatory Act (#440), NAIC*
- *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450), NAIC*
- *Investments in Medium Grade and Lower Grade Obligations Model Regulations (#340), NAIC*
- *Investment of Insurers Model Act (Defined Limits Version) (#280), NAIC*
- *Life and Health Reinsurance Agreements Model Regulation (#791), NAIC*
- *Managing General Agents Model Act (#225), NAIC*
- *Model Law on Examinations (#390), NAIC*
- *Model Regulation to Define Standards and Commissioners Authority for Companies Deemed to be in Hazardous Financial Condition (#385), NAIC*
- *Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2010 and 2013 per Section 2718(b) of the Public Health Service Act (#190), NAIC*
- *Reinsurance Intermediary Model Act (#790), NAIC*
- *Risk-Based Capital (RBC) for Health Organizations Model Act, (#315), NAIC*
- *Risk-Based Capital for Insurers Model Act (#312), NAIC*
- *Risk Management and Own Risk and Solvency Assessment Model Act (#505), NAIC*
- *Registration and Regulation of Third-Party Administrators (#1090), NAIC*

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Note 1 – Summary of Significant Accounting Policies and Going Concern

This Note is required as a result of *Statement of Statutory Accounting Principles (SSAP) No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures* and focuses on:

- The insurer's accounting policies compared to the NAIC *Accounting Practices and Procedure Manual* (AP&P Manual).
- The insurer's compliance with the *Annual Statement Instructions,* the AP&P Manual and the insurer's use of estimates.
- Disclosure of all accounting policies that materially affect the assets, liabilities, capital and surplus, or results of operations.
- Going concern disclosures.

Section, Part		*Risks*
A, 1	The first part of Section (A) addresses accounting policies that differ from the AP&P Manual. The analyst should use this information to determine if an insurer's financial position would be different if all the accounting rules of the NAIC were followed. The disclosure requires reporting on permitted practices that have been allowed by the state of domicile, as well as prescribed differences. Prescribed differences represent differences in the accounting methods that the state requires for all of its companies and the accounting methods of the AP&P Manual. This disclosure primarily assists regulators in reviewing the financial statements of foreign (non-domestic) companies because permitted and prescribed practices are approved by the domestic state and should already be known to the analyst. The analyst should consider the dollar amount of differences that exist in this disclosure in determining the priority given to an insurer. The analyst should gain an understanding of the differences if the insurer's capital and surplus is reduced by, for example, 5% or greater, as a result of applying the NAIC methods to illustrate the magnitude of the impact on the insurer's financial position.	LG, OP, ST
A, 2	The analyst should use the information to gain an understanding of any unusual transaction(s) for which the NAIC has not developed any standard accounting rules and which are not discussed in the AP&P Manual. Generally speaking, the AP&P Manual contains accounting guidance for most transactions common to insurers. However, transactions that are unusual within the industry are not documented within the manual. The materiality of the transaction on the financial statements should be considered, but the analyst should examine the accounting to determine if it is consistent with the NAIC statutory concepts of conservatism, consistency, and recognition. These concepts are discussed in the Preamble of the AP&P Manual. The analyst should determine if risk-based capital (RBC) would have triggered a regulatory event had the permitted practice not been used. By reviewing these issues, the analyst can determine if additional information is needed from the insurer and its state of domicile.	LG, OP, ST
B	The *Annual Statement Instructions* are required to be followed by most insurance departments, and generally, there are very few companies that disclose any differences in this section. Because of this, the analyst should carefully review any items that the insurer has disclosed in this section in order to more clearly understand the accounting principles used by the insurer.	LG
C	Insurers are generally required to follow the AP&P Manual for invested assets. Any differences in accounting principles used must be disclosed by an insurer on an annual basis in the Summary Investment Schedule that is required under SSAP No. 1 and Appendix	LG

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	A-001, *Investments of Reporting Entities*. This section of this Note highlights the importance of the accounting methods used by an insurer for each of its invested assets. Although any material differences between the insurer's accounting methods and the AP&P Manual should be highlighted in the first section of this Note, the individual sections of this invested asset section should be reviewed for their consistency with the above disclosure and to determine if the insurer has used any unusual accounting methods.	
D	The analyst should review the auditor's report and the information provided in Section (D) to gain an understanding of the principal conditions and events about the insurer's ability to continue as a going concern; managements evaluation of the significance of those conditions or events; and management's plan that alleviate substantial doubt about the insurer's ability to continue as a going concern as prescribed in the going concern evaluation and going concern disclosures discussed in SSAP No. 1. Going concern conditions or events are potentially significant to the financial solvency of the insurer and should be investigated by the analyst thoroughly to understand the underlying issues, assess the impact of the condition or event and determine what steps the insurer is taking to mitigate the issue. The analyst may need to contact the insurer if information in the annual statement is not sufficient to complete the analysis.	ST

Note 2 – Accounting Changes and Corrections of Errors

This Note includes four sections focused on general changes in accounting principles and/or corrections of errors and is required as a result of *SSAP No. 3—Accounting Changes and Corrections of Errors*. The information provided in this Note can be helpful in assessing the continuing operations of the insurer.

Section		*Risks*
1	The analyst should use the information provided in this Note to determine the initial impact that any change in accounting principle or correction of an error had on the insurer's financial position and determine if further changes are expected based on the knowledge of the insurer and its business. In cases where the insurer's total capital and surplus decreased by 5% or greater, special attention should be given. The NAIC prescribes specific accounting rules to maintain consistency among insurers, thereby increasing comparability. New accounting rules are generally designed to highlight issues that previously were not addressed, but also may highlight a general concern within the accounting profession or the industry. As a result, the change in accounting principles may highlight the exposure that an insurer has to a particular issue or risk.	LG, OP
2	The analyst should use the information provided in this Note to understand any errors the insurer has corrected and determine the financial impact of the correction. Special attention should be given in cases where the insurer's total capital and surplus decreased by 5% or greater as a result of the correction. SSAP No. 3 allows corrections of errors to be reported as direct charges to surplus. SSAP No. 3 and *SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items* should be reviewed in greater detail to understand what type of unusual items are direct charges to surplus. Because the classification of an item as a correction of an error is recorded directly to capital and surplus, the analyst should consider the reporting of the item and the effect that it could have on the insurer's ability to pay dividends. Even though the focus within the industry is on the capital and surplus of an insurer and not its earnings, a transaction that is recorded directly to capital and surplus and identified as a correction of an error should be reviewed carefully.	LG, OP
3	The analyst should use the information provided in this Note to understand any change in	OP

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	accounting estimates, which are also required by SSAP No. 3. The most important concept in reviewing this part of the Note is to determine the effect that the change will have on the insurer in the future. The Note does not require that the insurer disclose the impact of the change on future periods. However, the analyst should use the information provided to determine if the likely future effect is material.	
4	If amended financial statements are filed, the reporting entity should disclose that the prior period was restated, as well as the reason for the restatement.	OP

Note 3 – Business Combinations and Goodwill

This Note has three primary sections focused on: 1) statutory purchases; 2) statutory mergers and assumption reinsurance transactions; and 3) impairment losses. For this disclosure, the analyst should consider the overall purpose and strategic intent of the transactions and the prospective impact on operations.

Section (Statement Type)		*Risks*
A	The statutory purchase method is probably the most common. The accounting guidance for the statutory purchase method is discussed in *SSAP No. 68—Business Combinations and Goodwill* and *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.* Under the statutory purchase method, the insurer records goodwill when the purchase price paid for the investment exceeds the statutory book value of that investment. Section (A) of this Note focuses on the goodwill and requires the insurer to disclose all pertinent information on the business combination, as long as the insurer reports unamortized goodwill as a component of the investment. This section of the Note does not require any information to be reported if the insurer has no remaining unamortized goodwill because any balance sheet risk would be minimized once the goodwill was fully amortized. The analyst should use this Note to gain a better understanding of the asset recorded on this investment. The analyst should also use the information, along with his or her understanding of the underlying investment, to determine if the value of the unamortized goodwill appears to be reasonable. SSAP No. 68 provides specific guidance on determining if an impairment in the asset has occurred.	OP, ST
B	The accounting guidance for statutory merger is also discussed in SSAP No. 68. SSAP No. 68 references SSAP No. 3, which requires that the statement of operations for the two years presented be restated as if the merger had occurred on January 1 of the year the merger occurred. Section (B) of this Note focuses on the transaction that occurred and requires the insurer to disclose all pertinent information related to the merger. This includes financial information on each of the companies before the companies were merged. The restated numbers, along with the information in the Note, allow the analyst to better understand the true financial impact of the merger and the expected continuing operations of the surviving insurer.	OP, ST
C (L, H)	Assumption reinsurance transactions are unique for Life, Health and Fraternal insurers. Accounting guidance is discussed in *SSAP No. 61—Life, Deposit-Type and Accident and Health Reinsurance*. Through assumption reinsurance, the transaction effectuates a novation and thereby extinguishes the ceding company's liability. Regulatory approval of such transactions is generally required, so the analyst should first confirm that transactions reported have been submitted and approved based on the requirements of the state. The analyst should review the transaction filing to determine if any issues were identified. Similar to other business combinations, the analyst should use the	OP, ST

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	information to gain an understanding of the goodwill, amortization of goodwill, and the financial and strategic impact of the transaction.	
C (P,T) or D (L, H)	As described above, the analyst should use the information in the first two parts of this Note to obtain a greater understanding of the business combinations into which the insurer has entered. The analyst should use the information in those parts to determine if the value of any unamortized goodwill appears reasonable, but should also use the information in Section (C) and of this Note to obtain a greater understanding of any impairments that have actually been recorded by the insurer. The analyst should use this information together to determine if the value of the unamortized goodwill appears to be reasonable.	OP, ST

Note 4 – Discontinued Operations

This Note provides certain information on discontinued operations. It should be noted that SSAP No. 24 requires that an insurer report its results from discontinued operations consistent with its reporting of continuing operations. The following should be disclosed in the period in which a discontinued operation either has been disposed of or is classified as held for sale under SSAP No. 24.

Section		*Risks*
A–D	The analyst should use the information disclosed in the Note to obtain an understanding of circumstances that lead to the disposal or expected disposal of operations of a business segment. Sometimes, the insurer's decision to dispose of a segment of business is voluntary and may either allow the insurer to generate a significant amount of cash or might allow the insurer to focus on other segments of business. Other times, the insurer's decision to dispose of a segment of business may be involuntary and might be needed to generate cash to support the other lines of business or to reduce the amount of future losses to which the insurer is exposed. Generally, an involuntary decision such as this is needed in order to alleviate the poor underwriting performance of the segment and can be positive for the insurer but may not always be in the best interests of all policyholders. The analyst should consider if the disposal was approved by the domiciliary state and if a plan of run-off was also approved.	OP, ST

Note 5 – Investments

This Note focuses on:

A. Accounting for mortgage loans, including mezzanine real estate loans and the allowance for credit losses as required as a result of *SSAP No. 37—Mortgage Loans*.

B. Recording of the investment in loans that have been recognized as impaired as required by *SSAP No. 36—Troubled Debt Restructuring*.

C. Information regarding the credit risk for the reporting entity and the methods and assumptions used in calculating the reserve for reverse mortgages as a result of *SSAP No. 39—Reverse Mortgages*.

D. Sources of prepayment assumptions for yield calculations and the risk exposure in asset-backed securities as required by *SSAP No. 43—Asset-Backed Securities*.

E. Insurer's policy on collateral requirements for repurchase agreements and/or securities lending transactions and accounting for the asset and income associated with it, as required by *SSAP No. 103—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*.

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F. Information regarding the insurer's policy or strategies for repurchase agreements, accounted for as secured borrowings transactions and collateral requirements associated with it, as required by *SSAP No. 103*.

G. Information regarding the terms of the reverse repurchase agreements and collateral requirements for any repurchase agreements accounted for as secured borrowings transactions the insurer has, as required by *SSAP No. 103*.

H. Information regarding the insurer's policy or strategies for repurchase agreements, accounted for as sale transactions and collateral requirements associated with it, as required by *SSAP No. 103*.

I. Information regarding the terms of the reverse repurchase agreements and collateral requirements for any repurchase agreements accounted for as sale transactions the insurer has, as required by *SSAP No. 103*.

J. Recording of real estate investments that have been recognized as impaired and the reporting of receivables and improvements associated with retail land sale operations as required by *SSAP No. 40—Real Estate Investments*.

K. Information regarding the investment in tax credit structures and the accounting for the asset and income associated with it as required by *SSAP No. 93—Investments in Tax Credit Structures*.

L. Recording of restricted assets, which are assets pledged to others as collateral or otherwise restricted by the insurer.

M. Recording of the book/adjusted carrying value (BACV) of working capital finance investments in aggregate, as required by *SSAP No. 105—Working Capital Finance Investments*.

N. Disclosures regarding the offsetting and netting of assets and liabilities as required by *SSAP No. 64—Offsetting and Netting of Assests and Liabilities*.

O. Disclosure regarding 5GI securities as defined in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual).

P. Disclosures regarding short sales within the reporting period, including settled and unsettled, as required by *SSAP No. 103*.

Q. Disclosures regarding prepayment penalties and acceleration fees.

R. Reporting of shares of a qualified cash pool.

S. Reporting of aggregate collateral loans by qualifying investment collateral, pursuant to *SSAP No. 21—Other Admitted Assets.*

The information provided in this Note is helpful to the analyst in reviewing the financial statements and related investment schedules for income, and gains and losses.

Section, Part		*Risks*
A, 1–3	The analyst should use the information provided in section (A) of this Note to help quantify the insurer's investment in mortgage loans, including mezzanine real estate loans, and assess the impact of impaired loans; determine whether the insurer followed the guidelines as prescribed by SSAP No. 37 to record the carrying value of the loan; and what allowances for credit losses on impaired loans have been made by the insurer.	CR, MK
A, 4–5	The analyst should pay particular attention to the amount of mortgage loans deemed to be impaired. Under SSAP No. 37, a mortgage loan is considered to be impaired when, based on current information and events; it is probable that an insurer will be unable to collect all amounts due as stated in the contractual terms of the mortgage agreement. The analyst should note information the insurer provided for impaired loans (aggregated by type—Farm, Residential Insured, Residential All Other, Commercial Insured, Commercial All Other,	CR, MK

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	Mezzanine), including the total investment in impaired loans at the end of each period and the allowance for credit losses. The insurer should have also disclosed the amount of investment in impaired mortgage loans for which there is no related allowance for credit losses.	
A, 6	The insurer should have calculated the average investment in impaired loans during the period and the amount of interest income recognized during the time when the loans were impaired. The analyst should compare the amount of investment income incurred on mortgage loans for the year and compare to the amount of cash received on mortgage loans for the same time period. The analyst should verify the reasonableness of the average balance of impaired loans for the period in question.	CR, MK
A, 7	The analyst should review the activity in the allowance for credit losses account, including the balance in the allowance for credit losses account at the beginning and end of each period, additions charged to operations, direct write-downs charged against the allowance, and recoveries of amounts previously charged off.	CR, MK
A, 8–9	The analyst should use the information provided for mortgage loans derecognized as a result of foreclosure to evaluate the impact on assets and the collateral recognized on the foreclosed mortgage loans.	CR, MK
B	The analyst should use the information provided in Section (B) of this Note to determine whether the insurer has recorded the investment in loans recognized as impaired as prescribed by SSAP No. 36. The analyst should evaluate the insurer's investment in loans impaired and the terms agreed upon for debt restructuring. The analyst should review the amount of commitments, if any, to lend additional funds to debtors owing receivables whose terms have been modified in troubled debt restructuring. The insurer may accept cash, other assets, or an equity interest in the debtor in satisfaction of the debt even though the value received is less than the amount of the debt, if the insurer concludes that the recovery of the loan can be maximized.	CR, MK
C	The analyst should review the information provided in Section (C) to determine whether the insurer followed the guidelines as prescribed by SSAP No. 39 in accounting for reverse mortgages. The statement requires that the individual reverse mortgages be combined into groups for purposes of providing an actuarially and statistically credible basis for estimating life expectancy to project future cash flows. The analyst should review the methods and assumptions the insurer uses in calculating the reserve to offset the risk associated with the mortgage loan. Since the reverse mortgages are non-recourse obligations, the loan repayments are generally limited to the sale proceeds of the borrower's residence, and the mortgage balance consists of cash advanced and interest compounded over the life of the loan and premium that represents a portion of the shared appreciation in the home's value. To the extent the reverse mortgages are material, the analyst should evaluate the reserve established by the insurer to offset the value of the asset underlying the mortgage loan. Reverse mortgages are subject to the risks of mortality, collateral, and interest rate and should be recorded net of an appropriate actuarially calculated valuation reserve. The assumptions for calculating the reserve, cash flow projections, and evaluation of risk should be reviewed annually.	CR, MK
D	The analyst should consider the information provided in Section (D) to determine how closely the insurer followed the principles of valuation and prepayment assumptions of asset-backed securities as prescribed by SSAP No. 43. As described in SSAP No. 43	CR, MK

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	paragraphs 48f, 48g and 48h, insurers are also required to disclose certain aggregate information about securities with recognized other-than-temporary impairments and impaired securities (fair value is less than cost or amortized cost) for which other-than-temporary impairments have not been recognized in earnings. Prepayments are a significant and variable element in the cash flow of a asset-backed security because they affect the yield and determine the expected maturity against which the yield is calculated. As interest rates fall, the prepayment of the mortgages accelerates and shortens the duration of the underlying security. This causes the insurer to reinvest assets sooner than expected at potentially lower interest rates. This is called prepayment risk. In contrast, rising interest rates slow repayment and can significantly lengthen the duration of the security and create extension risk. The insurer should periodically review sources used to determine prepayment assumptions and cash flows and make changes when necessary. In doing so, the insurer should use relevant valuation sources and rationale to determine prepayment assumptions. Asset-backed securities should be revalued using either the prospective or retrospective adjustment methods. As a rule, prepayment assumptions should be applied consistently across portfolios to all securities backed by similar collateral with respect to coupon, issuer, and age of collateral. To the extent that interest rates have changed materially from the prior year, the analyst should review the Note carefully to better understand the insurer's assumptions and develop more specific questions regarding the impact of the rate changes on the portfolio.	
E, 1–2	The analyst should use the information provided in Section (E) to gain an understanding of the insurer's policy for requiring collateral or other security under repurchase agreements and/or securities lending agreements. Insurance companies invest in repurchase agreements to purchase securities with the intent to resell them at a stated price on a specified date within 12 months of the purchase. Under SSAP No. 103, repurchase agreements should be accounted for as collateralized loans. It should be noted that the underlying securities should not be accounted for as investments owned by the insurer, but rather as short-term investments. The analyst should review the description of the security underlying the agreement, as well as the book value, fair value, interest rate, and maturity date. To the extent the insurer has significant repurchase agreements, and interest rates have changed significantly, the analyst should determine whether the estimated fair value of the security has fallen below the amount agreed upon in the repurchase agreement and if additional collateral was required.	CR, MK
E, 3	Per SSAP No. 103, if the insurer or its agent has accepted collateral that is permitted by contract or custom to sell or repledge, the insurer should disclose certain information by type of program (repurchase agreement, securities, lending or dollar repurchase agreement) regarding the collateral including aggregate amount of contractually obligated open positions, (the fair value or cash received for which the borrower may request the return of on demand), positions under 30-day, 60-day, 90-day, or greater than 90-day terms and the fair value as of the date of each statement of financial position presented of that collateral and of the portion of that collateral that it has sold or repledged. This allows the analyst to determine if there is a risk that the value of reinvested collateral may not be sufficient to cover the amount of collateral that could be requested to be returned to the borrower.	CR, MK
E, 4	Under SSAP No. 103, securities lending transactions administered by an affiliated agent in which "one-line" reporting of the reinvested collateral is optional at the discretion of the reporting entity, the aggregate value of the of the reinvested collateral that is "one-line" reported and the aggregate reinvested collateral that is reported within the investment	CR, MK

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	schedules should be disclosed by the insurer.	
E, 5	The reporting entity should also provide information by type of program (repurchase agreement, securities lending, or dollar repurchase agreement) the amount of the reinvestment of the cash collateral and any securities which the entity or its agent receives as collateral that can be sold or repledged. This should include the aggregate amount of the reinvested cash collateral (amortized cost and fair value). The reinvested cash collateral should be broken down by the maturity date of the invested asset: under 30 days, 60 days, 90 days, 120 days, 180 days, less than 1 year, 1 to 2 years, 2 to 3 years, and more than 3 years. If the maturity dates of the liability (collateral to be returned) does not match the invested assets, the insurer should disclose additional sources of liquidity to manage the mismatches.	CR, MK
E, 6	The analyst should use the information to understand contract terms and the collateral's current fair value on transactions where the collateral is not permitted by contract or custom to be sold or repledged.	CR, MK
E, 7	The analyst should use the information to understand the type of collateral held for securities lending transactions that extend beyond one year from the reporting date.	CR, MK
F – I	The analyst should use the information provided in Sections (F-I) to gain an understanding of the insurer's policy for requiring collateral or other security under repurchase agreements and/or reverse repurchase agreements. Insurance companies invest in repurchase agreements to purchase securities with the intent to resell them at a stated price on a specified date within 12 months of the purchase. Under SSAP No. 103, repurchase agreements should be accounted for as collateralized loans. It should be noted that the underlying securities should not be accounted for as investments owned by the insurer, but rather as short-term investments. For repurchase agreements, the analyst should determine whether the estimated fair value of the security has fallen below 95% and therefore requires additional collateral. For reverse repurchase agreements, the analyst should determine whether the estimated fair value of the security has fallen below 100% and therefore requires additional collateral.	CR, MK
J	The information provided in Section (J) of this Note can be helpful in quantifying the insurer's investment in real estate determined to be impaired. The analyst should use this information to determine whether the insurer has recorded the investment in real estate recognized as impaired as prescribed by SSAP No. 40R. In addition, if the insurer engages in retail land sales operations, the analyst should use this information to determine whether accounts receivable and expenditures have been accounted for properly as prescribed by SSAP No. 40. The analyst should consider the information disclosed in this section to evaluate the insurer's investment in impaired real estate. The analyst should note the amount of the impairment and how fair value was determined. Also, the analyst should use information in this section regarding retail land sales operations to assess the maturities and quality of accounts receivable, planned expenditures and recorded obligations for improvements.	CR, MK
K	The analyst should use the information provided in Section (K) of this Note to gain an understanding of an insurer's Investments in Tax Credit Structures (tax credit investments). The insurer is required by SSAP No. 93 to provide information that enables the users of the financial statements to understand the insurer's investments in projects that generate tax credits and other tax benefits from tax programs. The insurer is also required to provide details regarding the nature of investments in these projects, the effect of recognition and measurement of these investments, the balance recognized, a schedule of tax credits	CR, MK

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	expected to be generated for the subsequent five years, commitments or contingent commitments, if the project is currently subject to any regulatory reviews and the status of such review; modifications or events that result in changes to the program, and any recognized impairments and the nature of any impairments. The information can be helpful in the rare instances where insurers hold this type of investment to help identify the extent of the insurer's exposure and any issues regarding impairment write-downs.	
L	Section (L) requires the reporting entity to disclose the amount and nature of any assets pledged to others as collateral or otherwise restricted (e.g., not under exclusive control, assets subject to a put option contract, etc.) by the reporting entity. The analyst should review the detail on restricted assets provided in this Note for any restricted assets greater than 10% of total cash and invested assets. Restricted assets impact liquidity as they are not assets available to pay policyholder claims. Where collateral held is related to Modified Coinsurance (Modco) or Funds Withheld (FWH) reinsurance, review the information in this note in conjunction with credit, operational and strategic risk of the insurer's reinsurance program. The disclosure also identifies if securities held as collateral under Modco or FWH agreements are also pledged under other arrangements, in which case they would not be for the benefit of the reinsurer or available to fulfill the liabilities of the reinsurance contract. Further, where the company is engaged in material Modco and FWH arrangements, the analyst can use the detail of collateral received and held under Note 5L(4) to identify the types of assets held and gain an understanding of the materiality of the collateral BACV to the insurer's asset portfolio and related reinsurance liability.	CR, MK, ST
M	Section (M) requires the reporting entity to disclose certain working capital finance investments on an aggregate basis regarding the BACV, by NAIC designation as required by SSAP No. 10R. Per SSAP No. 105, working capital finance investments represent a confirmed short-term obligation to pay a specified amount owned by one party (the obligor) to another (typically a supplier of goods), generated as a part of a working capital finance investment program currently designated by the NAIC Investment Analysis Office. The information provided assists the analyst in the review of this Schedule D category. Like other Schedule D investments, the analyst should consider NAIC designation, other-than-temporary impairments and credit risk associated with the investment.	CR, MK
N	Section (N) for Life/Accident and Health (A&H) insurers, Fraternal Societies and Health entities only requires the reporting entity to disclose certain quantitative information (separately for assets and liabilities) when derivative, repurchase and reverse repurchase, and securities borrowing and securities lending assets and liabilities are offset and reported net in accordance with a valid right to offset per SSAP No. 64. Assets and liabilities that have a valid right to offset but are not netted because they are prohibited under SSAP No. 64 are not required to be captured in these disclosures. The information in this note assists the analyst in gaining a better understanding of the netted assets, if material, by providing the gross and offset amounts.	CR, MK
O	Section (O) requires the reporting entity for each annual reporting period to provide a comparable disclosure to the prior annual reporting period of the number 5GI securities, by investment type, and the BACV and fair value for those securities, per the P&P Manual, Special Reporting Instructions.	CR, MK
P	The analyst should use the information provided in Section (P) of this Note to gain an understanding of an insurer's utilization of short sales. The insurer is required by SSAP No. 103, for unsettled short sale transactions, to provide the amount of proceeds received and	CR, MK

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	the fair value of the securities to deliver, with current unrealized gains and/or losses, and the expected settlement timeframe (# of days), including current transactions that were not settled within three days. For settled short sale transactions, the aggregate amount of proceeds received and the fair value of the security as of the settlement date with recognized gains and/or losses, including the aggregated fair value of settled transactions that were not settled within three days and that were settled through a securities borrowing transaction.	
Q	Section (Q) requires the reporting entity to disclose the following: the number of CUSIPs sold, disposed or otherwise redeemed and the aggregate amount of investment income generated as a result of a prepayment penalty and/or acceleration fee.	CR, MK
R	Section (R) requires the reporting entity to disclose its share of cash pools by asset type: cash, cash equivalents and short-term investments. This information may be used in assessing available liquidity.	LQ

Note 6 – Joint Ventures, Partnerships and Limited Liability Companies

This Note focuses on investments in joint ventures, partnerships and limited liability companies that exceed 10% of the admitted assets of the insurer and specific information on impairments.

Section		*Risks*
A, B	The accounting guidance for the above types of investments is addressed in *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies*. SSAP No. 48 defines a corporate joint venture as a corporation owned and operated by a small group (the joint ventures) as a separate and specific business or project for the mutual benefit of the members of the group. SSAP No. 48 defines a general partnership as an association in which each partner has unlimited liability, and a limited liability company as a hybrid organization that falls between a corporation and a partnership, whereby the owners have limited liability to their percentage ownership or equity interest in the company. These types of investments are potentially problematic because of their illiquid nature and their various valuation methods. Sometimes accounting treatments are not in accordance with statutory guidance, including—but not limited to—goodwill, non-admitted assets and fair value adjustments (e.g., the reporting for limited partnerships in which the entity has a minor ownership interest). The analyst should use the information included in this Note to gain a better understanding of the type and amount (exposure) of these investments, and if any such investments have been impaired. The analyst should use the Note to determine if these investments are valued in accordance with the appropriate accounting method, generally the equity method of accounting according to SSAP No. 48. The analyst should also determine if the company has disclosed a carrying value that is different from the quoted market price and whether the amount of the difference is material. Finally, the analyst should use this Note to evaluate the relationship of the insurer's overall risk in these types of investments compared to its equity position.	CR, MK, LQ

Note 7 – Investment Income

This Note focuses on the insurer's basis for non-admitting due and accrued investment income as required as a result of *SSAP No. 34—Investment Income Due and Accrued*, *SSAP No. 26—Bonds* and *SSAP No. 32—Preferred Stock*. The Note also discloses the amount the insurer non-admits upon determining collectability of due and

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accrued investment income. The information is helpful to the analyst in reviewing the financial statements and related exhibits and schedules for real estate, mortgage loans, and long-term bonds.

Section		*Risks*
A, B	The analyst should use the information provided in Section (A) to understand the insurer's rationale for determining assets as nonadmitted. The analyst should review investment schedules A, B and D to assess the materiality of assets in near default or impairment. In conjunction, the analyst should review the investment income earned exhibit for reported due and accrued investment income. SSAP No. 34 defines investment income due as investment income earned and legally due to be paid to the insurer (i.e., receivable) as of the reporting date. Investment income accrued is investment income earned as of the reporting date but not legally due to be paid to the insurer until subsequent to the reporting date. Investment income should be recorded as an asset on the balance sheet. However, the analyst should review *SSAP No. 4—Assets and Nonadmitted Assets* to obtain an understanding of the distinction between an asset that has a probable future economic benefit versus an asset that is unavailable to meet policyholder obligations due to encumbrances or third-party interests. The nonadmitted asset should not be included on the balance sheet, nor should the balance for investment income due and accrued. To the extent the nonadmitted investment income is material, the analyst should question the collectability of the remaining investment income due. The analyst should review SSAP No. 26, SSAP No. 32 and *SSAP No. 5— Liabilities, Contingencies and Impairments of Assets* to obtain an understanding of the principle of asset impairment and the collection of investment income. The analyst should also review SSAP No. 37 for further understanding of impairments of mortgage loans. If an asset is determined to be in default, it is probable that the investment income due and accrued balance is uncollectable and should be written off and charged against investment income. Interest can be accrued on mortgage loans in default if interest is deemed collectable. But if interest is deemed uncollectable, it cannot be accrued, and any previously accrued amounts should be written off and charged against investment income. If a mortgage loan in default has interest 180 days past due that has been determined to be collectable, all accrued interest should be reported as a nonadmitted asset.	MK, LQ

Note 8 – Derivative Instruments

This Note focuses on:

A. The exposure to market risk, credit risk and the cash requirements of each category of derivative instruments and is required as a result of *SSAP No. 86—Derivatives*.

B. The insurer's investment strategy and objectives for holding or issuing derivative financial instruments as also required under SSAP No. 86.

C. How each category of derivative instrument is reported in the financial statements as required by SSAP No. 86.

D. Identification of whether the reporting entity has derivative contracts with financing premiums.

E. The portion of the unrealized gains or losses on derivatives that represents derivatives excluded from the assessment of hedge effectiveness.

F. The portion of the unrealized gains or losses on derivatives that represents derivatives no longer qualifying for hedge accounting.

G. Details about derivatives accounted for as cash flow hedges of a forecasted transaction.

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H. Aggregate, non-discounted total premium cost and the premium due in each of the following four years, and thereafter.

For additional discussion of derivative instruments, see Section IV. – A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations.

Section		*Risks*
A	Derivative instruments are often complex and involve substantial risk of loss. The analyst should use the discussion provided in Section (A) of this Note to evaluate the impact of the derivative instruments on the insurer's risk exposure. Derivatives are financial market instruments used by some insurers to minimize the risk of a change in value, yield, price, cash flow, quantity of assets or liabilities, or future cash flows. Transactions entered into for the purpose of reducing market changes related to price or interest rate or currency exchange rate risks are *hedging* transactions. Because the market rates and indices from which derivatives derive their value can be volatile, the value of these instruments may fluctuate significantly, resulting in significant gains and losses.	MK, ST
B	The analyst should use the information provided in Section (B) to gain an understanding of the insurer's objectives for investing in or issuing derivative instruments, as well as the investment strategy for achieving those objectives. Insurance companies primarily invest in derivative instruments for hedging activities. SSAP No. 86 provides criteria for transactions to qualify as *hedging* vs. *other than hedging*. Most insurance regulators prohibit insurance companies from entering into speculative transactions. An analyst should consider the assets, liabilities, or future cash flows for which the derivative transactions were entered into or issued to hedge against.	MK, ST
C	The analyst should consider the information disclosed in the balance sheet and summary of operations, as well as the supporting information in Schedule DB and the exhibits for investment income and realized and unrealized gains and losses. Accounting procedures for derivatives vary widely depending on the nature of the derivative. SSAP No. 86 provides specific guidance for accounting procedures for the various categories of derivatives. The analyst should give special attention to this Note if derivative investment income accounts for more than 5% of net investment income, 10% of capital and surplus, or if the insurer is experiencing capital losses on derivative instruments of more than 10% of capital and surplus.,	MK, ST
D	The analyst should consider the information disclosed in Section (D) to determine if the insurer has derivative contracts with financing premium. SSAP No. 86 provides guidance regarding scenarios in which the premium cost is paid at the end of or throughout the derivative contract.	MK, ST
E	The analyst should consider the information disclosed in Section (E) in conjunction with information provided in the balance sheet and summary of operations as well as the supporting information in Schedule DB and the Exhibit of Capital Gains (Losses). The gain or loss on a derivative designated as a hedge and assessed to be effective is reported consistently with the hedged item. However, if the company's risk management strategy for a particular hedging relationship excludes a specific component of the gain or loss on the hedging derivative from the assessment of hedge effectiveness, that excluded component of the gain or loss shall be recognized as an unrealized gain or loss. For example, if the effectiveness of a hedge with an option contract were assessed based on changes in the option's intrinsic value, the changes in the option's time value would be recognized in unrealized gains or losses. Time value is equal to the fair value of the option less its intrinsic value.	MK, ST

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F	The analyst should consider the information disclosed in Section (F) to help in determining whether the derivative qualifies for hedge accounting. A derivative instrument is either classified as an effective hedge or an ineffective hedge. Derivative instruments used in hedging transactions that meet the criteria of a highly effective hedge shall be considered an effective hedge and valued and reported in a manner that is consistent with the hedged asset or liability which is referred to as hedge accounting. Under hedge accounting, the valuation method used for the derivative shall be consistent with the valuation method used for the hedging item, either amortized cost or fair value. Derivative instruments used in hedging transactions that do not meet the criteria for an effective hedge shall be accounted for at fair value and the changes in the fair value should be recorded as an unrealized gain or loss referred to as fair value accounting.	MK, ST
G	The analyst should consider the information disclosed in Section (G) to help in determining if a forecasted transaction is eligible for designation as a hedged transaction in a cash flow hedge. The forecasted transaction must be verifiable and the probability should be supported by observable facts. The length of time until a forecasted transaction is projected to occur and the quantity of the forecasted transaction should be considered in determining probability. Included in the circumstances that should be considered in assessing the likelihood a transaction will occur is the extent of loss or disruption of operations that could result if the transaction does not occur.	MK, ST
H	The analyst should use the information provided in Section (H) to gain an understanding of the insurer's aggregate, non-discounted total premium cost for these contracts and the premium cost due in each of the following four years, and thereafter. The aggregate fair value of derivative instruments with financing premiums excluding the impact of the deferred or financing premiums is also provided in this section.	

Note 9 – Income Taxes

Background

When the NAIC codified statutory accounting principles, it developed three fundamental concepts to be used in the development of all accounting principles. One of these principles was recognition. Because the recognition principle requires liabilities to be recognized as they are incurred, and because deferred tax assets (DTAs) and deferred tax liabilities (DTLs) result from transactions or events that have already occurred, they must be recognized in the financial statements. Said differently, the transaction or event has already occurred, and *SSAP No. 101—Income Taxes, A Replacement of SSAP No. 10 and SSAP No. 10* simply requires the recognition of the tax consequences of that transaction or event in the financial statements. Note that SSAP No. 101 became effective Jan. 1, 2012. A detailed primer on types of DTAs and DTLs is provided below. In addition, SSAP No. 101 Exhibt A contains an extensive Implementation Question and Answer section.

Income Tax Assets

Current income tax recoverables include all current income taxes, including interest (net of federal tax), reasonably expected to be recovered in a subsequent accounting period, whether or not a tax return or claim has been filed with the taxing authorities. These amounts are to be recorded and admitted if they are reasonably expected to be recovered. Current income tax recoverables are reasonably expected to be recovered if the refund is attributable to overpayment of estimated tax payments, errors, carry-backs, or items for which the reporting entity has substantial tax authority, as that term is defined in Federal Income Tax Regulations.The determination as to whether "substantial tax authority" exists requires an analysis of the tax law and its application to the relevant facts. Substantial authority is present if the weight of the authorities supporting the tax treatment is substantial relative to the weight of authorities supporting a contrary position.

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Deferred Tax Liabilities and Deferred Tax Assets

DTLs represent temporary differences that will result in future taxable amounts. DTAs represent temporary differences that will result in future deductions and operating losses, capital losses, and tax credit carryforwards. However, those unfamiliar with deferred taxes might not understand what is meant by the term "temporary differences." Because an admitted DTA will result in an increase in capital and surplus, the analyst should obtain an understanding of what is included in the insurer's DTA. Because a net DTL will result in a decrease in capital and surplus, the analyst should obtain an understanding of what is included in the insurer's DTL.The easiest way to understand the concept of a temporary difference is to review an example of one.

Temporary Difference Example – Proxy DAC

One of the most common types of temporary differences for life insurers is deferred acquisition expenses. *SSAP No. 71—Policy Acquisition Costs and Commissions* requires that all costs incurred in the acquisition of new and renewal insurance contracts shall be expensed as incurred. However, for tax purposes, insurers are not allowed to deduct (expense) all of these costs up front. Instead, the Internal Revenue Service (IRS) requires that an insurer set up what is known as a Proxy DAC (deferred policy acquisition expense) asset.

The Proxy DAC asset that is set up by insurers for tax purposes is based on a percentage of net premiums from specified insurance contracts (e.g., life, annuity, and A&H), not to exceed the insurer's actual expenses for the year. The capitalized costs are then amortized on a straight-line basis over a 120-month period (60 months for certain small insurance companies), beginning on the first day of the second half of the taxable year. Proxy DAC reverses ratably over the amortization period. Setting up the Proxy DAC for tax purposes has the effect of spreading out an insurer's deductions. To the extent that an insurer was allowed to receive the deduction for these expenses when they were incurred, it would provide for an ineffective matching of an insurer's revenues (taxable income) with expenses (deductions). Many of the other temporary differences that exist for insurance companies recognize these same differences in revenue and expense streams. The following illustrates the temporary difference that exists for Proxy DAC.

Proxy DAC Example:

Insurer XYZ incurred $10 million of policy acquisition expenses to establish ordinary life policies in the current year, which brought in $100 million of premium income in that same year. For statutory purposes, all of these costs are expensed in the current year since the expenses have been incurred. As a result, the insurer's book income is reduced by the entire amount in the current year. For tax purposes, the insurer establishes a Proxy DAC asset of approximately $7.1 million ($100 million premium income multiplied by 7.07%—IRS percentage). The insurer will amortize this asset (for tax purposes) over the next 10 years, resulting in annual amortization of $710,000. However, in the current year, the insurer will only be allowed to amortize $355,000, because the amortization cannot begin until the first day of the second half of the taxable year. As a result of the above, the insurer sets up the following on its statutory and tax balance sheets:

	Stat	Tax	Diff	DTA
Deferred Acquisition Costs	$0	$6,745,000	$6,745,000	$2,360,750

The $0 recorded for statutory purposes reflects that the insurer has expensed the entire amount of expenses in the current period. It also reflects that the insurer will have no more expenses recorded in the financial statements in the future for these costs. The $6.7 million recorded for tax purposes reflects the maximum allowable Proxy DAC, in accordance with the IRS calculation, less the first year's amortization. It also represents an additional $6.7 million of expense (or deductions) that the insurer will record in the future for these costs. Because the insurer will have the ability to deduct these expenses on its tax return in the future, the temporary difference (difference between book and tax) that has been created with respect to these costs represents an asset to the insurer. It is an asset because it will result in future deductible amounts. The DTA ($2.4 million) is calculated by multiplying the temporary difference by the insurer's

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corporate tax rate (35%), because this is the amount that taxes will be reduced in the future as a result of the temporary difference. This is just one example of how temporary differences are calculated under SSAP No. 101 and one example of the type of temporary differences that exist on an insurer's balance sheet. Below is a listing of other temporary differences that are common to insurance companies.

Other Common Temporary Tax Differences

Property/Casualty and Health Insurance Companies

Discounting of Unpaid Loss Reserves: This difference is similar to the reserve revaluation for life insurance companies because it results in higher reserves for statutory purposes than for tax purposes. The IRS requires companies to discount all types of reserves (the IRS discount tables vary by products), which results in lower reserves for tax purposes. Because this difference will represent higher future deductions for the insurer, this temporary difference will result in a DTA.

Change in Unearned Premiums: This temporary difference is similar to that which exists for life insurers for Proxy DAC, because it is the IRS's attempt to match a company's expenses with its revenues. For tax purposes, an insurer must include 20% of the annual change in unearned premiums in income. This temporary difference will reverse as the unearned premium is earned. Although the calculation varies from the Proxy DAC, it usually results in the same effect, a DTA.

Life, A&H and Fraternal Insurance Companies

Reserve Revaluation – This is perhaps one of the largest differences that exist for a life insurer and results from the difference in how reserves are calculated for statutory purposes compared to tax purposes. Because the statutory reserves are calculated on a conservative basis, and because the IRS would consider overstated reserves to be aggressive, tax reserves are always lower than statutory reserves. Using the same balance sheet approach, as above, this type of difference would result in a DTA because the insurer will take lower deductions (compared to statutory) in the early years (past years) and will take higher deductions in future years.

Reserve Strengthening – Statutory accounting requires that reserve strengthening, as well as reserve reductions, be recorded immediately. Tax requires that companies take these items in over a period of time to match the companies' expenses with its revenues. Because of this, temporary differences can result. If the above results in higher reserves for statutory purposes, a DTA will result. If the above results in lower reserves for statutory purposes, a DTL will result.

All Insurance Companies

Accrued Market Discount: For statutory purposes, SSAP No. 26 requires insurers to accrue any market discount into income over the life of the bond. For example, if a bond is purchased for $900 thousand with a par value of $1 million, the $100 thousand discount is accrued into income (increases investment income) over the life of the bond. This has the effect of adjusting the investment income on a bond to reflect the true yield on the initial investment, $900 thousand in this case. However, for tax purposes, companies generally do not amortize this market discount into income and, instead, are taxed on the gain ($100 thousand ($1 million for consideration received when the bond matures minus $900 thousand cost paid)) when the bond matures. A similar type of effect would result if the insurer sold the bond before it matured. Because the above temporary difference will result in future taxable income when the bond matures or is sold, this type of temporary difference will result in a DTL. The insurer can also have DTAs on its bonds if it has purchased them at a premium. These types of differences are common for all types of insurance companies because they hold large amounts of bonds.

Unrealized Gains/Losses: This temporary difference is similar to that which exists for accrued market discount. It will result in a DTL if an insurer has recorded a significant amount of unrealized gains or, if an insurer has recorded a significant amount of unrealized losses, it will result in a DTA. The difference applies to all types of companies, but basically results from the general cash basis that the IRS uses for calculating tax expense for any given year. The difference results because, for tax purposes, gains and losses are not recognized until they are realized (until the asset is sold). For statutory purposes, stocks are marked to market, and any changes are

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reflected in an insurer's change in surplus section as unrealized gains/losses. The only thing different about this item is that SSAP No. 101 requires unrealized gains and losses to be shown net of tax. So the change in the DTA or DTL resulting from this temporary difference will run through the change in unrealized gains and losses in the insurer's change in surplus section instead of running through the change in DTA/DTL line that has been set up in the same section of the NAIC Blank.

Balance Sheet Approach

As noted in the above example, SSAP No. 101 uses what is known as a balance sheet approach to measure an insurer's temporary differences. This is consistent with *Statement of Financial Accounting Standards* (FASB) *No. 109*, but differs from the approach used in *FASB No. 96*, which uses an income statement approach. The balance sheet approach is simpler than the income statement approach because it does not require the insurer to schedule out the temporary differences that exist. In other words, the insurer does not need to know what the insurer's book to tax differences will be in future years to perform this calculation. However, SSAP No. 101 does use some conservatism that requires the insurer to determine what will reverse in the next year or subsequent three-year period when applicable.

Admission of Deferred Tax Assets

The admission of deferred tax assets generally requires the expectation of future taxable income or the ability to recover previous taxes paid under a carryback. The conservative nature of statutory accounting limits the admissability of deferred tax assets as they are not assets that can be utilized immediately for policyholder claims. The admitted portion of adjusted gross DTAs is based upon the three component admission calculations included in paragraph 11 of SSAP No. 101. Prior to the admission calculation, gross DTAs are adjusted by the statutory valuation allowance, which reduces the gross amount of DTAs to the amount that is more-likely-than not to be realized by the entity. All entities may admit adjusted gross DTAs as the sum of:

(1) Federal income taxes paid in prior year that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with IRS tax loss carryback provisions, not to exceed three years, including any amounts established in accordance with the provision of SSAP No. 5R.

(2) The reporting entity shall admit:

a) The amount of adjusted gross DTAs, after the application of paragraph 11.a, expected to be realized within the applicable period following the balance sheet date limited to the amount determined in paragraph 11.b.ii.

b) An amount that is no greater than the applicable percentage of statutory capital and surplus as required to be shown on the statutory balance sheets of the reporting entity for the current reporting period's statement filed with the domiciliary state commissioner adjusted to exclude any net DTAs, electronic data processing (EDP) equipment, and operating system software and any net postive goodwill.

(3) Amount of gross DTAs (after 1 and 2) that can be offset against existing DTLs. If an entity meets RBC requirements per paragraph 11.b of SSAP No. 101, after admitting DTAs based upon the sum of 1, 2 and 3 above, an entity that is subject to RBC requirements or is required to file an RBC Report with the domiciliary state, shall use the *Realization Threshold Limitation Table – RBC Reporting Entities* in this component of the admission calculation. For mortage guaranty insurers or financial guaranty insurers that are not subject to RBC requirements and not required to file an RBC Report with the domiciliary state, and the reporting entity meets the minimum capital and reserve requirements for the state of domicile, the reporting entity shall use the *Realization Threshold Limitiation Table – Financial Guaranty or Mortgage Guaranty Non-RBC Reporting Entities* in this component of the admission cacluation. If the reporting entity 1) is not subject to RBC requirements, 2) is not required to file an RBC Report with the domiciliary state, 3) is not a mortgage guaranty or financial guaranty insurer, and 4) meets the minimum capital and reserve requirements, then the reporting entity shall use the *Realization Threshold Limitation Table – Other Non-RBC Reporting Entities*.

See SSAP No. 101 for other specifics of the calculation.

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Reporting

As mentioned above, a change in the amount of DTAs and DTLs from one period to the next is recorded directly to capital and surplus through a line within the capital and surplus section of the insurer's financial statements. Even though DTAs and DTLs are calculated on a gross basis, they should be reported in the balance sheet on a net basis. That is, if the DTA exceeds the DTL, the net should be reported as a net DTA on the assets page. Or if the DTL exceeds the DTA, the net should be reported as a net DTL on the liabilities page. In addition, the "additional" admitted DTA is to be reported separately in the *aggregate write-ins for gains and losses in surplus* line and in the *aggregate write-in for special surplus funds* line.

Disclosure

The disclosure requirements of SSAP No. 101 are rather extensive and require the insurer to disclose:

A. Financial components (assets, liabilities, and surplus impact) of the deferred taxes.

B. Any DTLs that are not required to be reported as a liability in connection with paragraph 31 of FASB 109.

C. Significant components of its current income taxes incurred.

D. Types and amount of temporary differences that affect the insurer's effective tax rate.

E. Certain information on operating loss and tax credit carry forwards.

F. Certain information on consolidated tax returns, if applicable.

G. An estimate of the range of the reasonably possible increase in the total liability.

Section	*Financial Components*	*Risks*
A	The analyst should use the information required in Section (A) of this Note to determine the overall impact that SSAP No. 101 has had on the financial position of the insurer. The first section requires the insurer to report its gross, adjusted gross, admitted and non-admitted DTAs by tax character, total DTLs by tax character as well as the net change during the year by component, total non-admitted DTAs and overall surplus impact. SSAP No. 101 also requires the disclosure of certain information resulting from the application of paragraph 11 of SSAP No. 101, including if the insurer elected to admit DTAs; the increased amount and change in admitted adjusted gross DTAs; components of the calculation and RBC level; amounts of admitted DTAs; admitted assets, surplus and TAC in the RBC calculation; and the increased amount of DTAs, admitted assets and surplus and, finally, the impact of tax-planning strategies on the determination of adjusted gross DTAs and the determination of net admitted DTAs, by percentage and tax character. As indicated above, this accounting is consistent with the concept of recognition. However, as also indicated above, there are limitations put on the amount of DTAs that an insurer can admit. Using information from the balance sheet and the Note, the analyst should also determine if the insurer has appropriately netted its DTAs with its DTLs. Because a significant amount of ratios compare various items to net admitted assets, those ratios can be distorted if an insurer has not reported these items on a net basis as required by SSAP No. 101. The analyst should also determine if the insurer has appropriately limited the DTA to 10% of capital and surplus. Under SSAP No. 101, if the insurer is subject to RBC requirements and meets the requirements outlined in SSAP No. 101 paragraph 11, the insurer may elect to admit a higher amount of adjusted gross DTAs up to a limit of 15% of capital and surplus. It should be noted that the 10% limitation requirement within SSAP No. 101 actually includes some additional calculations that make the limitations even more conservative.	OP

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Section	*DTLs Not Reported as a Liability*	*Risks*
B	The analyst should use the information required in Section (B) of this Note to better understand the financial position of the insurer. Paragraph 31 of FASB 109 allows a DTL resulting from a temporary difference not to be recorded in certain circumstances. One circumstance listed in paragraph 31 of FASB 109 is a temporary difference resulting from a stock life insurer's policyholders' surplus account. (See the Internal Revenue Code for further discussion.)	OP
Section	*Significant Components of Income Taxes Incurred*	*Risks*
C	The analyst should use the information required in Section (C) of this Note to better understand the components of an insurer's total income taxes incurred. This section provides the analyst with information on investment tax credits and operating loss carry forwards, adjustments for enacted changes in tax laws that are not disclosed elsewhere as well as disclosures of adjustments to gross DTAs due to changes in circumstances that cause a change in judgment about the realizability of related DTAs. The analyst should pay particular attention to the adjustments for enacted tax laws to determine if the insurer has used the correct statutory tax rates in the calculation of its DTAs and DTLs. SSAP No. 101 prohibits the use of anticipated tax rates in its application.	OP
Section	*Types of Temporary Differences*	*Risks*
D	The analyst should use the information required in Section (D) of this Note to understand the significant temporary differences of an insurer. This disclosure could be the most helpful part of this Note. The disclosure requires the insurer to compare the expected tax expense (based on the corporate tax rate) with the actual incurred tax expense. This disclosure also requires the insurer to divulge all significant reconciling items between the two amounts. Again, this disclosure can be helpful in analyzing the significant temporary differences that an insurer maintains.	OP
Section	*NOLs and Carry Forwards*	*Risks*
E	The analyst should use the information required in Section (E) of this Note to understand if the insurer's DTA includes a provision for a net operating loss. The calculation limits an insurer to those DTAs that can be utilized within one year. However, if a significant portion of the DTA includes an operating loss carry forward, the analyst should consider if the insurer will be able to utilize the amount within one year or three years as applicable.	OP
Section	*Consolidated Financial Statements if Applicable*	*Risks*
F	The analyst should use the information required in Section (F) of this Note to determine if the insurer has appropriately applied the principles of SSAP No. 101 to its financial statements regardless of a consolidated tax return being prepared. SSAP No. 101 allows the allocation of taxes between affiliated entities that file a consolidated tax return, but the basic requirements of SSAP No. 101 still must be met. The analyst should review the disclosure to ascertain that the insurer has not avoided the recording of any DTLs through its income tax allocation agreement.	OP
Section	*Range of Reasonably Possible Increase in Liability*	*Risks*
G	The analyst should use the information required in Section (G) of this Note to understand if the insurer has disclosed an estimate of the range of the reasonably possible increase in total liability within 12 months of the reporting period, or a statement that an estimate of the range cannot be made. Refer to SSAP No. 5 and SSAP No. 101 for accounting guidance.	OP

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Potential Reporting Problems

As illustrated above, the reporting requirements of this Note and the complications in calculating an insurer's deferred taxes are quite significant. Most insurers do not have any internal tax department that can perform a deferred tax calculation. Because of this, many insurers will have to rely on a certified public accountant (CPA) firm to perform this calculation. The insurer's reliance on a CPA firm to perform this work on an annual basis might not present a problem, but it is anticipated that some insurers may not update the calculation on a quarterly basis. The analyst should review the change in the DTA and DTL on a periodic basis to determine if the change recorded is reasonable based on changes in the insurer's reserves and invested assets.

Note 10 – Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

As discussed in *SSAP No. 25—Affiliates and Other Related Parties*, related party transactions are subject to abuse because reporting entities might be induced to enter transactions that might not reflect economic realities or might not be fair and reasonable to the insurer or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny. Because of this, the purpose of this Note is to provide detailed information regarding all types of affiliates and transactions with affiliates. The accounting guidance for affiliates is addressed in SSAP No. 25 which defines an affiliate as an entity that is within the holding company system or a party that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity.

Section		*Risks*
A, B, C, D	The analyst should use the information in this Note to gain an understanding of the effects of the related party transactions on the financial statement and determine whether concerns exist regarding transactions with affiliates. The analyst should evaluate amounts owed by a related party to determine if there may be a significant collectability risk. The financial statements of the related party should be reviewed to determine the entity's ability to repay the amounts due. The analyst should understand the terms and manner of settlement of intercompany balances. Large or increasing amounts owed to the insurer from a related party may pose a liquidity risk should the insurer require immediate repayment and may also indicate an inability to repay the amount due to the insurer. Large or increasing amounts owed by the insurer to a related party may also pose a liquidity risk to the insurer because the payable may have resulted from an effort to move available cash to an affiliated entity that is experiencing cash flow problems. The terms and manner of settlement should be reviewed to determine if there are any unusual disclosures that might indicate that the terms and manner of settlement are other than arm's length. The analyst should check to see if the company disclosed any changes in the method of establishing the terms of the related party transaction from that used in the preceding period. It is critical to determine whether investments in affiliates are material and are properly valued. When investments in affiliates are significant, it is important for the analyst to review and understand the underlying financial statements of the affiliate. It is only through this process that the analyst can detect situations where the investments may be substantially overvalued.	CR, LQ, OP, ST
E	It is important to evaluate the effect of any guarantees or undertakings with affiliates that may have a substantial impact on the insurer in the future. For example, if the insurer has guaranteed additional capital contributions to a subsidiary to maintain minimal regulatory requirements, the analyst should attempt to assess the probability and timing of future	LQ, OP, ST

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	funding and its impact on the insurer.	
F, G	In cases where the insurer and other enterprises are under common ownership or control relationships exist, the analyst should evaluate the risk that the operating results or financial position of the insurer may pose. The risks may be significantly different than those that would have existed if the enterprises were autonomous. Unusual agreements or transactions with affiliates may not make good business sense in terms of the consequences to the insurer. The analyst should seek to understand the rationale for the agreements or transactions in order to determine any negative impact on the financial condition of the insurer and whether any regulatory action is appropriate.	CR, LQ, OP, ST
H, I, J, L, M, N, O	The amounts disclosed in the Notes to Financial Statements should be consistent with other schedules and filings. If the company is part of a holding company system, the company's current year Form B registration statement should include the appropriate disclosures agreeing with the Notes to Financial Statements. The Form B registration statement should also include the consolidated financial statements of the group. The analyst should use this information, or other information available on the consolidated group or the holding company alone (e.g., 10-K filing), to understand the amount of debt or cash flow requirements at the holding company level. Funds from the insurance companies are often needed to service debt at the holding company level, which can be a concern. For any current-year changes from the previous year, Form C should highlight these changes. If there were significant transactions or changes to agreements, a Form D should have been submitted requesting approval by the Department. A Form E (or other required information) would have been submitted if a merger or acquisition transaction involved a competitive impact. The insurer may also disclose the payment of extraordinary dividends. Schedule Y disclosures should be consistent with the Note. Significant changes in corporate structure may materially impact the insurer's future financial condition and generally require prior regulatory approval. The analyst should use the balance sheet value (admitted and non-admitted) disclosed in Section (M) and Section (N) of this Note to evaluate and gain an understanding of the book value and monetary effect of the subsidiary, controlled and affiliated (SCA) investments on assets, net income and surplus. The analyst should refer to SSAP No. 97 in regard to aggregate gross value and for additional guidance. Investments in SCA may affect liquidity as these investments may not be readily marketable and converted to cash to meet claims obligations. The analyst should also assess and understand the business purpose, valuation and the investment return on these types of investments. The analyst should refer to Section (O) of this Note in cases where the insurer's share of losses in an SCA exceed its investment. The insurer is required to disclose its share of losses, regardless of any guarantees or commitments of future financial support. The analyst should refer to SSAP No. 97 and SSAP No. 5.	CR, LQ, OP, ST

Note 11 – Debt

This note discloses information related to all other debt, including capital notes as provided by *SSAP No. 15—Debt and Holding Company Obligations*. SSAP No. 15 requires a full description of the type of borrowing, (e.g., amounts, interest rates, collateral, interest paid, debt terms, covenants and any violations) and information related to agreements with the Federal Home Loan Bank (FHLB).

Section		*Risks*
A	The analyst should use the information in this Note to review the insurer's total debt. In cases where the insurer's total debt exceeds 10% of capital and surplus, special attention	ST, LQ

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	should be given. For all debt, the analyst should verify that the insurer has a sufficient matching of assets to meet the debt repayment schedule given its current cash flow needs and the maturity of investments. If any new debt has been reported, the analyst should evaluate the reasons or need for additional funding. Another important area to review is repayment conditions, restrictions, or covenants. In particular, the analyst needs to be aware of any violations of the covenants or restrictions and possible ramification (e.g., collateral pledged) to the insurer for these violations. The analyst should also determine if there are any provisions in the debt to require early payment. For capital notes, the analyst should evaluate the quality of assets received in exchange for the note and determine if the insurer has properly valued the assets.	
B	The analyst should review any agreements the insurer has entered into with FHLB. The analyst should evaluate the type of funding (advances, lines of credit, borrowed money, etc.) and intended use of the funding. The analyst should also evaluate the amount of collateral pledged to FHLB, the amount of FHLB stock purchased as part of the agreement, and the total borrowing capacity currently available to the insurer. In particular, the analyst needs to be aware how assets and liabilities related to the agreement with FHLB are classified within the general and separate accounts, and the elements that support these classifications. FHLB agreements that are reported as deposit-type fund contracts are reported in Note 31, while FHLB agreements reported as debt are reported in Note 11.	ST, LQ
C	Section C provides disclosures on short-term and long-term unused commitments and lines of credit for financing arrangements for the current and prior year. The analyst should review this information in conjunction with an overall assessment of available liquidity as it identifies undrawn amounts available as well as terms and conditions in accordance with SSAP No. 15.	ST, LQ

Note 12 – Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefits

This Note requires the insurer to disclose:

A. Details of reporting entity-sponsored defined benefit plans as required by *SSAP No. 102—Pensions* and *SSAP No. 92—Postretirement Benefits Other Than Pensions*

B. Investment policies and strategies

C. Classes and fair value of assets

D. Narrative description of the basis used to determine expected long-term rate-of-return-on-assets

E. Details of defined contribution plans and other postretirement benefit plans as required by SSAP No. 102 and SSAP No. 92

F. Multi-employer plans as required by SSAP No. 102 and SSAP No. 92

G. Parent or holding company sponsored plans as required by SSAP No. 102 and SSAP No. 92

H. Postemployment benefits and compensated absences that do not meet the conditions for accrual as a liability as required by *SSAP No. 11— Postemployment Benefits and Compensated Absences*

I. The impact the Medicare Modernization Act has on postretirement benefits as discussed in SSAP No. 92 and INT 04-17

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Section		*Risks*
A	As discussed in SSAP No. 102, a defined benefit plan defines the amount of the pension benefit that will be provided to the plan participant at retirement or termination. The analyst should use the information provided in this first section of the Note to gain an understanding of the insurer's defined benefit plan and to determine if the costs and changes in liabilities associated with the plan have a material impact on the insurer.	OP
B	The description on investment policies and strategies and other factors that are pertinent to understanding those policies and strategies—such as investment risk, risk management practices, permitted and prohibited investments and the relationship between plan assets and benefit obligations—should give the analyst an indication of the reporting entities' risk appetite.	OP
C	The fair value of each class of plan assets as of each date for which a statement of financial position is presented enables the analyst to assess the inputs and valuation techniques used to develop fair value measurements of plan assets at the reporting date.	OP
D	The analyst should use the narrative description to understand the basis used to determine the overall expected long-term rate-of-return-on-assets assumptions, such as the general approach used, the extent to which the overall rate-of-return-assets assumption was based on historical returns, and adjustments made to those historical returns in order to reflect expectations on future returns.	OP
E	As defined in SSAP No. 102, a defined contribution plan defines the amount of the reporting entity's contributions to the plan and its allocation to plan participants. Less disclosure is required for this type of pension plan. In Section (E), the reporting entity is required to disclose the cost recognized for the defined contribution plan separately from the amount of cost recognized for defined benefit plans, and a description of significant changes to the plan. The analyst should evaluate the plan disclosures to determine the impact to the financial statements.	OP
F	Section (F) of this Note provides information on multi-employer plans similar to Section (E). As with defined benefit and defined contribution plans, the analyst should evaluate the impact of costs and changes in liabilities for multi-employer plans on the operations and balance sheet of the insurer.	OP
G	Employees of many reporting entities are members of a plan sponsored by a parent company or holding company, where the entity that participates is not directly liable for the plan obligations. The analyst should use the information to evaluate the net expense for the holding company's qualified pension and other postretirement benefits for which the insurer is allocated and determine the impact of this expense on the entity's operations.	OP
H	As defined in SSAP No. 11, postemployment benefits are all types of benefits provided by an employer to former or inactive employees or agents, their beneficiaries, and covered dependents after employment but before retirement. Compensated absences include benefits such as vacation, sick pay, and holidays. Generally, a liability is accrued for postemployment benefits and compensation for future absences when several conditions are met as discussed in SSAP No. 11, paragraph 3. In a situation where a reporting entity does not accrue a liability for postemployment benefits and compensation of future absences in accordance with SSAP No. 11 because the amount cannot be reasonably estimated, that fact and the reasons shall be disclosed in the Notes to Financial Statements. The analyst should evaluate the type of benefits disclosed and the reasons they could not be estimated to determine if there is concern regarding a potential impact to the financial	OP

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	statements.	
I	Section (I) of this Note applies only to the sponsor of a single-employer defined benefit postretirement health care plan where the employer has concluded that prescription drug benefits available under the plan are actuarially equivalent to Medicare Part D, thereby qualifying for the subsidy under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The analyst will want to consider any disclosures the insurer makes per SSAP No. 92, such as a reduction in the net postretirement benefit, amortization, reduction in current period service cost or interest cost, or any other significant changes.	OP

Note 13 – Capital and Surplus, Dividend Restrictions and Quasi-Reorganizations

This Note covers key areas of an insurer's overall capitalization.

Section		*Risks*
A–J	The first portion of the Note (#1–#10) is capital and surplus. The analyst should be familiar with the overall holding company structure of the insurer before reviewing and analyzing the information included in this Note. The analyst should use the information in this area of this Note to obtain a greater understanding of the capital structure of the insurer. The first item of this Note provides the number of shares of capital stock authorized, issued, and outstanding as of the statement date. Items #2–#10 of this Note disclose restrictions on dividends and surplus, along with other information on the company's capital and surplus. These items should be reviewed by the analyst to determine the amount of the insurer's surplus that is available to meet policyholders' liabilities. When considering the overall capital structure of the insurer, the analyst should take into account any recent Form A filings made by the insurer. If there is any change in the capital stock of the insurer, the analyst should consider if a Form A was necessary and, if it was filed, reviewed, and approved by the insurance department.	ST
K	The analyst should use the information in the second portion of the Note to obtain a greater understanding of the insurer's surplus note obligations. The analyst should be able to determine if the insurer has issued any surplus notes recently. Insurers must have prior insurance department approval for the issuance of surplus notes and each payment. The analyst should review any new surplus notes to verify appropriate approvals were given for the issuance of surplus notes. Additionally, the analyst should verify: 1) the proper accounting for the notes and any associated interest; 2) the payment schedule for repayment and if the insurer will be able to meet this schedule; 3) the type and quality of assets received in the transaction; 4) any guarantees, support guarantees or related party transactions associated with the surplus note issuance; and 5) if the notes were issued to a parent or affiliate or related party. If the notes were issued to an insurance affiliate, the analyst should consider reviewing the affiliate's financial statements to verify the notes are appropriately reported by the other entity.	OP
L, M	The third portion of this Note provides information on quasi-reorganization. Insurers must receive prior regulatory approval for quasi-reorganizations. The analyst should verify approval was given. Quasi-reorganizations are generally rare and are usually only allowed if certain conditions are met. If the insurer has received prior approval, the analyst should verify proper disclosures and accounting for this transaction. (See *SSAP No. 72—Surplus and Quasi-Reorganizations* for further discussion.)	ST

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Note 14 – Liabilities, Contingencies and Assessments

This Note focuses on: contingent commitments, assessments, gain contingencies, claims related extra contractual obligation and bad faith losses stemming from lawsuits, product warranties (property/casualty (P/C) insurers only), joint and several liabilities, and all other contingencies. The accounting guidance for contingencies is addressed in SSAP No. 5 and for specific items, in *SSAP No. 35—Guaranty Fund and Other Assessments*; SSAP No. 97, *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*; and SSAP No. 48.

Section (Statement Type)		*Risks*
A	Contingencies are defined in SSAP No. 5 as an existing condition, situation, or set of circumstances involving uncertainty as to possible loss or gain to an enterprise that will ultimately be resolved when one or more future event(s) occur or fail to occur. It is important for the analyst to ensure the company has reported all contingent commitments to an SCA, joint venture, partnership, or limited liability company (SSAP No. 97 and SSAP No. 48) and investments in tax credit structures (SSAP No. 93). The Note requires detailed disclosure of guarantees on indebtedness of others, for example a guarantee on the indebtedness of a subsidiary.	LG, OP
B	Assessments, including guaranty fund assessments and other assessments, could also have a material impact on the company's surplus. The analyst should refer to SSAP No. 35R for specific statutory reporting guidance and required disclosure in this Note.	LG, OP
C	Per SSAP No. 5, a gain contingency is defined as an existing condition, situation or set of circumstances involving uncertainty as to possible gain to an enterprise that will ultimately be resolved when one or more future events occur or fail to occur. A gain is defined as an increase in surplus which results from peripheral or incidental transactions of a reporting entity and from all other transactions and other events and circumstances affecting the reporting entity except those that result from revenues or investments by owners. Gain contingencies are not to be recognized in a reporting entity's financial statement. If a gain contingency is realized subsequent to the reporting date, but prior to the issuance of the financial statement, the gain is disclosed in the Notes to Financial Statements but the unissued financial statement should not be adjusted to include the gain. The gain is generally realized when non-cash resources or rights are readily convertible to known amounts of cash or claims to cash. The analyst should review the Note for any estimate of potential contingent gains.	OP
D	Situations may arise where an insurer is involved in an extra contractual obligation lawsuit, including bad faith lawsuits. These extra contractual liabilities and expenses may arise out of the handling of an individual claim or a series or group of claims. Any adjustment expenses arising from such lawsuits are reported as adjusting and other per SSAP No. 55. The analyst should review the claims details to determine how much an insurer has in losses stemming from extra contractual obligations or bad faith claims from lawsuits.	LG, OP
E (P)	As discussed in SSAP No. 5, product warranties are excluded from the initial recognition and initial measurement requirements for guarantees and therefore a guarantor is not required to disclose the maximum potential amount of future payments. The analyst should refer to SSAP No. 5 for disclosure requirements.	LG, OP
E, F (P)	As discussed in SSAP No. 5, when the insurer has a joint and several liability arrangement, where the total obligation amount is fixed at the reporting dates, it	LG, OP

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	should be reported as the sum of the following: 1) the amount the insurer has agreed to pay among its co-obligors; and 2) any additional amount the insurer expects to pay on behalf of its co-obligors.	
F, G (P)	As discussed in SSAP No. 5, loss contingency estimates are recorded as a charge to operations if it is both probable that a liability has been incurred or an asset has been impaired at the reporting date, and the loss or impairment can be reasonably estimated. If a loss contingency is not recorded because only one of the conditions is met, the loss contingency or impairment of the asset is disclosed in the Notes when there is at least a reasonable possibility that a loss may have been incurred. The analyst should review the Note for any potential loss estimates. The loss contingency estimates should be analyzed to project the impact that future events may have on the balance sheet and whether they have the potential to materially affect the insurer's future operations.	OP

Note 15 – Leases

This Note focuses on the disclosure of items related to lessee arrangements and lessor business activities.

Section, Part		*Risks*
A, 1–2	As defined in *SSAP No. 22—Leases,* a lease is an agreement conveying the right to use property, plant, or equipment usually for a stated period of time. Under SSAP No. 22, all leases are considered operating leases. For lessees, rent on an operating lease is charged to expense over the lease term as it becomes payable. The analyst should review part (1) and part (2) of Section (A) to the *Annual Statement Instructions* to determine the impact of current and future rental expense on the insurer's operating expenses and, ultimately, operating income. Any restrictions imposed by the lease agreements (such as dividend restrictions or additional debt) should be noted and examined to ensure that they would not pose a threat to the insurer's operations or conflict with statutory regulations.	OP
A, 3	Per SSAP No. 22, a sale-lease back transaction involves the sale of property, plant, or equipment by the owner and a lease of the asset back to the seller. Under a normal leaseback transaction, the seller-lessee records the sale, removes the assets and related liabilities from its balance sheet, and accounts for the lease as described above. If the leaseback transaction includes continuing involvement provisions (such as seller-lessee obligation to repurchase and investment return guarantees), it is accounted for under the deposit method. According to SSAP No. 22R, under the deposit method, the seller recognizes no profit or loss on the sale, does not record notes receivable, and continues to report in its financial statements the property and the related existing debt (even if it has been assumed by the buyer). Lease payments decrease, and collections on the buyer-lessor's note, if any, increases the seller-lessee's deposit account. Leaseback transactions occur for several reasons. Under a normal leaseback transaction, the insurer's appropriate asset and associated debt are removed from the balance sheet, and a gain/loss is recorded. Companies may choose to do this to reduce debt leverage, gain additional funds, or restructure (related to affiliated leasebacks). The analyst should review part (3) of Section (A) to determine which leaseback transaction the insurer has chosen and to gain a better understanding of how the transaction impacts the financial statements.	OP
B, 1	Section (B) relates to the disclosure of the lessor's business activities. Part (1) of Section (B) includes the description, cost/carrying amount by major class of property, related depreciation, future rentals, and contingent rentals. Per SSAP No. 22, operating leases for	OP

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	lessors shall be included with or near property, plant, and equipment in the balance sheet and depreciated in the lessor's normal policy. Rental income shall be reported as income over the lease term as it becomes receivable according to the provisions of the lease. Initial direct costs shall be deferred and allocated over the lease term in proportion to the recognition of rental income. The analyst should review part (1) of Section (B) to gain an understanding of the terms of the lessor's leases and how they are classified on the balance sheet and income statement. Lessors that complete this section may rely on leasing for revenue, net income, and assets. The analyst should review property-type asset concentrations and examine the lessor's current and future profitability reliance on its rental income.	
B, 2	Generally, leveraged leases are those in which the lessor acquires, through the incurrence of debt (such that the lessor is substantially "leveraged" in the transaction), property, plant, or equipment with the intentions to lease the asset(s) to the lessee. The lessor is required to record its investment net of the nonrecourse debt. Thus, investment in leveraged leases includes rental receivables net of that portion of the rental applicable to principal and interest on the nonrecourse debt, investment tax credit receivables, the estimated residual value of the lease asset, and unearned and deferred income. Leveraged leases are unique in that the rental income must be sufficient to cover the debt payments and administrative expenses associated with the lease equipment. The analyst should review part (2) of Section (B) to determine the profitability and reporting treatment of leveraged leases. In addition, the analyst should examine the components of net investment in leveraged assets to judge the accuracy of the amount.	OP

Note 16 – Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

This Note is required by *SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures*.

SSAP No. 27 applies to, but is not limited to, short-term investments, bonds, common stocks, preferred stocks, mortgage loans, derivatives, financial guarantees written, standby letters of credit, notes payable, and deposit-type contracts. Off-balance sheet financial instruments are not recognized on the balance sheet because they fail to meet some of the criterion for recognition as an asset or liability as defined in SSAP No. 4 and SSAP No. 5. However, due to the nature of the instrument, they pose a financial risk to the insurer. Concentration of credit risk exists where financial instruments share activity, region, or economic characteristics that would impair their ability to meet contractual obligations if affected by changes in economic or other conditions. Concentrations pose a risk to the insurer when significant fluctuations in one area of the financial market result in material adverse financial consequences. Off-balance sheet financial instruments and financial instruments with concentrations of credit risk are therefore required to be disclosed in the Notes.

Section		*Risks*
1	Part (1) of this Note, the insurer has identified the face amounts of financial instruments with off-balance sheet risk, listed by class. The analyst should use the first part of this Note to assess the level of materiality of an insurer's investment in financial instruments with off-balance sheet risk.	CR, MK, LQ
2	Part (2) discusses the credit risk, market risk, cash requirements of the instrument and the accounting policies related to the instrument. The analyst should use Part (2) to gain an understanding of the nature and terms of the financial instruments, including the nature of the risks involved, and to review the related accounting policies disclosed in this part of the Note. An analyst should use the discussion in the second part of the Note to evaluate the impact of the off-balance sheet risk on the insurer's total risk exposure.	CR, MK, LQ

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3	The analyst should use Part (3) of this Note to evaluate the risk to the insurer for a default on the terms of the contract or the risk to the insurer should the collateral or other security for the amount due have no value for the insurer. As in the second part, the analyst should use the information disclosed in this part of the Note to evaluate the impact of the risks of default and collateral with no value on the insurer's total risk exposure.	CR, MK, LQ
4	Part (4) focuses on the insurer's policies for requiring collateral or other security to support financial instruments subject to credit risk and requires the insurer to disclose the nature and description of the collateral or other security. Part (4) discloses collateral requirements and provides a description of the collateral or other securities supporting the financial instruments. The analyst should use the information provided in this part of the Note in the evaluation of the risks associated with the insurer's collateral.	CR, MK, LQ

Note 17 – Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

This Note focuses on the transfer of receivables reported as sales as is required by *SSAP No. 42—Sale of Premium Receivables* and the transfer and servicing of other financial assets and wash sales as required by SSAP No. 103.

Section, Part		*Risks*
A	Section (A) requires an insurer to disclose the proceeds received and the amount of gain or loss recorded on the sale of any premium receivables. The analyst should use this information to determine the overall impact that the sale of the insurer's premium receivables might have on its financial position. The analyst should also consider if the insurer has other premium receivables on its balance sheet and determine what type of impact the sale of its remaining premium receivables would have on its financial position. In assessing the potential impact that the sale of the remaining premium receivables would have on the insurer, the analyst should consider the quality of the receivables sold, if known, and any anticipated changes in the economy that could affect the value of the receivables. The analyst should also consider reviewing information in the insurer's annual audit report on fair value of financial instruments as required by SSAP No. 27.	OP, MK
B, 1	Section (B), Part (1) requires an insurer to disclose certain information on loaned securities, including the amount, as well as the Company's policy for requiring collateral and the type of collateral held. The analyst should use this information to help understand the types of investing and financing contracts the insurer uses to maximize profits and liquidity.	OP, MK
B, 2	Section (B), Part (2) requires an insurer to disclose a description of inherent risk in servicing assets and servicing liabilities, as well as contractually specified fees, and quantitative and qualitative information about the assumptions used to estimate the fair value.	OP, MK
B, 3	Section (B), Part (3) requires an insurer to disclose certain information regarding servicing assets and liabilities that are subsequently measured at fair value. The analyst should use this information to help understand the materiality of the servicing process in relation to the insurance operations.	OP, MK
B, 4	Section (B), Part (4) requires an insurer to disclose certain information regarding securitized financial assets in which the transfer is accounted for as a sale when the transferor has continuing involvement with the transferred financial assets. In addition, the insurer is required to provide a sensitivity analysis or stress test showing the hypothetical effect on	OP, MK

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	the fair value of those interests of two or more unfavorable variations from the expected levels for each key assumption that is reported. The analyst should use this information required to evaluate the possible impact of adverse outcomes highlighted in the sensitivity analysis or stress test.	
B, 5	Section (B), Part (5) requires an insurer to disclose requirements for transfers of financial assets accounted for as secured borrowing.	OP, MK
B, 6	Section (B), Part (6) requires an insurer to disclose any transfers of receivables with recourse. The analyst should use this information to gauge the materiality of possible effects of recourses associated with transfers of receivables.	OP, MK
B, 7	Section (B), Part (7) requires an insurer to provide a description of the securities underlying dollar repurchase and dollar reverse repurchase agreements, including book values and fair values. It also requires the insurer to provide the maturities for securities subject to dollar repurchase agreements and securities subject to dollar reverse repurchase agreements.	OP, MK
C	Section (C) requires an insurer to disclose certain information regarding its use of "wash sales" as defined in SSAP No. 103. The analyst should use this information to help understand the purpose and types of various financial contracts the insurer uses.	OP, MK

Note 18 – Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

This Note focuses on the profitability of uninsured and partially insured A&H plans under administrative services only (ASO) contracts and Administrative Service Contract (ASC) plans,and Medicare or similarly structured cost-based reimbursement contracts. The accounting guidance is in *SSAP No. 47—Uninsured Plans*. An uninsured A&H plan may be either an ASO plan or an ASC plan. (Title companies do not complete this Note.)

Section		*Risks*
A, B, C	Under an ASO plan, claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the reporting entity, whereby the funds are provided to the reporting entity prior to claim payment. Under an ASC plan, the reporting entity pays claims from its own bank accounts and only subsequently receives reimbursement from the uninsured plan sponsor. Uninsured A&H plans also include federal, state or other government department funded programs, such as Medicare cost contracts where there is no underwriting risk to the reporting entity. Under uninsured plans, the reporting entity performs administrative services, such as claims processing for a third party that is at risk and does not provide insurance. As such, the plan bears all of the insurance risk, and there is no possibility of underwriting loss or liability to the administrator. However, the administrator may be subject to credit risk. ASC contracts are particularly subject to credit risk due to the fact that the reporting entity pays claims from its own bank account and then relies on reimbursement from the plan sponsor. Uninsured plan administrators face risks associated with these plans in that all costs incurred under the contract might not be reimbursable, and revenues may be adjusted based on subsequent challenges of costs included in filed cost reports, the terms of the contract or other external factors. The analyst should determine the extent that administrators are exposed to these threats. This Note provides detail for the analyst to use in determining if the insurer is profitable in its servicing of uninsured plans. It also provides information necessary to establish the extent to which the insurer depends on uninsured business. If an insurer's profitability is	CR

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	concentrated in the administration of uninsured plans, it faces greater exposure to the threats listed in the paragraph above. The analyst should examine the administrator's claim and fee revenue from uninsured plans to total claim and revenue volume to determine if the administrator faces concentration risk. The analyst should also use this Note to perform a more comparable analysis of general insurance expenses from one year to the next because the reimbursements on these types of plans are netted against an insurer's general expenses.	

Note 19 – Direct Premium Written/Produced by Managing General Agents/Third-Party Administrators

This Note requires the insurer to disclose the amount of direct premiums written through each managing general agent (MGA) and third-party administrator (TPA) that exceeds 5% of surplus. (Title companies do not complete this Note.) This Note is required by *SSAP No. 53—Property and Casualty Contracts-Premiums* and *SSAP No. 54—Individual and Group Accident and Health Contracts*. MGAs and TPAs produce or solicit business for an insurer and also provide one or more of the following services: underwriting, premium collection, claims adjustment, claims payment, and reinsurance negotiation. MGAs and TPAs are used by insurers to increase the volume of business written or to facilitate entry into new lines of business or geographical locations. (See Section III, Operational Risk Assessment for procedures on MGAs and TPAs.)

Section		*Risks*
N.A.	The analyst should use the information to calculate the percentage of aggregate business produced by the listed MGAs and TPAs compared to total direct premiums written to determine whether this amount is material. The analyst should compare the current percentage to that of the previous reporting period. It is critical to determine whether there has been an increase in the percentage of aggregate business written by MGAs and TPAs. If the increase is significant, it might indicate that the insurer has contracted new MGAs and TPAs or is increasing overall production to improve cash flow.	OP, RP
N.A.	For each MGA and TPA that meets the disclosure requirement of this Note, the insurer is required to disclose information detailing the name and address of the MGA and TPA, the federal employer identification number, whether the entity holds an exclusive contract, the types of business written, the type of authority granted (e.g., underwriting, claims payment, etc.), and total premium. The analyst should review the lines of business written by each MGA and TPA. The analyst should determine whether the insurer recently began writing a new line of business or has experienced a significant increase in writings for a particular line of business that the MGA and TPA produce. It is important to review the loss experience by line of business and determine whether the MGA and/or TPA produced significant writings for a line that is experiencing an excessive loss.	OP, RP

Note 20 – Fair Value Measurements

Fair value is generally an estimate of the value that a particular asset might bring in the marketplace. There are three levels in which an insurer may use to determine the fair value measurements of certain balance sheet items. The analyst should use this Note as guidance to determine what elements and methods an insurer used to derive fair value for its assets and/or liabilities, And, additionally, to assess that the value obtained is fair between two specific parties in a transaction, taking into account the respective advantages and disadvantages that each would stand to gain from the transaction.

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Section		*Risks*
A	During the review process, the analyst should ascertain the level within the fair value hierarchy that the insurer chose to utilize in determining its fair value measurements. These levels or components refer broadly to the assumptions that insurance entities would use in pricing the asset or liability, including assumptions regarding risk. The analyst should review the inputs the insurer utilized in pricing whether it was Level 1 measurements which included live market quotes; Level 2 observable inputs using pricing derived from those assumptions that market participants would use in pricing based on market data obtained from sources independent of the reporting entity; or Level 3 unobservable inputs using the insurer's own assumptions developed based on the best information available under the current circumstances. If the insurer used Level 3 assumptions, the analyst should determine whether a reconciliation of the assets and/or liabilities (including realized and unrealized gains or losses, purchases, sales, and transfers) ties to the estimated value as assigned by the insurer. Investments reported at net asset value (NAV) shall not be captured within the fair value hierarchy but shall be separately identified.	MK
B, C	In reviewing assets and liabilities at fair value on a recurring basis, the analyst should evaluate the sources and valuation techniques used to measure fair value and assess any changes in valuation methods and related components, if any, during the period. The analyst should identify and assess the assumptions utilized in determining fair value in pricing assets or liabilities, including risk assumptions such as investment and market risk and the effect of those measurements on earnings (or changes in net assets) for any given period.	MK
D	In reviewing assets and liabilities at fair value on a nonrecurring basis, the analyst should assess the inputs used to develop those measurements. The analyst should evaluate the insurer's rationale for utilizing its own valuation techniques and related inputs to develop assumptions in determining fair value versus the observable inputs based on actual market data.	MK
E	Section (E) requires an insurer to disclose information that helps reviewers understand the nature and risks of the investments and whether the investments, if sold, are probable of being sold at amounts different from NAV per share.	MK

Note 21 – Other Items

This Note is required by various SSAPs, INTs and other sources and focuses on:

A. Unusual or infrequent items as required by SSAP No. 24

B. Troubled debt restructuring for debtors as required by SSAP No. 36

C. Other miscellaneous amounts not recorded in the financial statements that represent assets pledged to others as collateral in accordance with SSAP No. 1

D. Business interruption insurance recoveries, including information related to the nature and aggregate amount of losses and recoveries recognized due to business interruption

E. State transferable and non-transferable tax credits

F. Subprime mortgage-related risk exposure and related risk management practices

G. Use of retained asset accounts for beneficiaries (life/A&H insurers, fraternal societies and health entities only)

H. Insurance-linked securities (ILS) contracts

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Section		*Risks*
A	Section (A) requires the insurer to disclose the nature and financial effect of any unusual or infrequent items. Under SSAP No. 24, an insurer is required to account for any unusual or infrequent item using the same lines that are used to report continuing operations. Section (A) allows the analyst to understand the impact that the event or transaction considered unusual or infrequent items have had on each of the financial statement line items and in total. This Note should be used to better understand the impact of the item on the insurer's overall financial position and allows the analyst to more easily compare the financials of the current period with prior periods.	CR, LQ
B	Section (B) requires the insurer to disclose specifics regarding any troubled debt restructuring that occurred within the past year, including a description of the terms and the gain or loss recorded on the restructure. The analyst should use this information to obtain a greater understanding of the impact that such a transaction may have had on the insurer's current year financial statements. If the current year gain (or loss) was material, or if the insurer holds significant investments in other loans, the analyst should consider asking the insurer for detailed information on other mortgage loans to determine if similar events are likely to occur on other loans.	CR, LQ
C	Section (C) requires the insurer to disclose various items that do not meet the definition of an asset, a liability, revenue or expense as defined within the AP&P Manual but are relevant to the overall financial position of an insurer. Such items include amounts not recorded in the financial statements that represent segregated funds held for others. The analyst should review the information in this section to determine the overall materiality of each of the items and determine the potential impact that the item could have on the financial statements if certain events or transactions occur that require the items to be recorded in the financial statements. To the extent material, the analyst should gain a better understanding of the facts pertaining to each by discussing the item with the insurer.	CR, LQ, OP
D	Section (D) requires the insurer to disclose information related to business interruption insurance recoveries received during the period. This information includes the nature of the event that resulted in losses, the aggregate amount of the recoveries and the line items on the statement of operations in which those recoveries are classified, and the amounts defined as extraordinary items. The analyst should review this information to determine if these recoveries have had a material impact of the operations of the insurer.	CR, OP
E	Section (E) requires the insurer to disclose information regarding state and federal tax credits. The total unused tax credits represent the entire tax credits available. The information includes the following: 1) the carrying value of tax credits disaggregated by transferable/certificated or non-transferable gross of any related tax liabilities by jurisdiction and in total; 2) the total unused tax credits by jurisdiction disaggregated by transferable/certificated or non-transferable; 3) the method of estimating utilization of remaining tax credits or other projected recovery of the current carrying value; 4) the impairment amount recognized by the reporting period, if any; 5) the identity of tax credits by transferable/certificated and non-transferable classifications, and the admitted and nonadmitted portions of each classification; and 6) any commitment or contingent commitment to purchase tax credits. To the degree the amount of the transferable tax credits is material to the insurer, the analyst should perform a more in-depth review.	OP
F	Section (F) requires the insurer to disclose information pertaining to subprime mortgage related risk exposure and related risk-management practices in the statutory financial statements, regardless of materiality. The analyst can find definitions of commonly recognized characteristics of subprime mortgage loans, as well as the sources of exposure,	LQ, CR, MK

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	in the NAIC *Annual Statement Instructions*. The insurer should provide a narrative description of the definition of the exposure to subprime mortgage related risk as well as a discussion of the general categories of information considered in determining the exposure, the direct exposure through investments in subprime mortgage loans, the direct exposure through other investments, and the underwriting exposure to subprime mortgage risk through mortgage guaranty or financial guaranty insurance coverage. To the extent exposure is material to the insurer additional analysis should be performed.	
G	Section (G) for life/A&H insurers, fraternal societies and health entities only requires the reporting entity to disclose information regarding its use of retained asset accounts for beneficiaries. For purposes of this disclosure, retained asset accounts represent settlement of life insurance proceeds which are retained by the insurance entity within its general account for the benefit of the beneficiaries. Amounts held outside of the insurance entity, (e.g., in a non-insurance subsidiary), affiliated or controlled entity accounted for under SSAP No. 97, such as an interest-bearing account established in the beneficiary's name with a bank or thrift institution (and subject to applicable Federal Deposit Insurance Corporation coverage) are only required to be described in the context of the structure of the reporting entity's financial statements; however, quantitative information regarding retained asset accounts transferred outside of the reporting entity are not required.	LQ
H	Section (H) requires the insurer to disclose information regarding when they receive possible proceeds as the issuer, ceding insurer or counterparty of ILS. ILS can be defined as securities whose performance is linked to the possible occurrence of pre-specified events that relate to insurance risks. It should be noted that, while catastrophe bonds may be the most well-known type of ILS securities, there are other non-cat bond ILS, including those based on mortality rates, longevity and medical-claim costs. ILS may be used by an insurer, or any other risk-bearing entity in addition to the purchase of insurance or reinsurance. The analyst should use the information disclosed to determine whether the insurer received possible proceeds as the issuer, ceding insurer, or counterparty of ILSs as a way of managing risks related to directly-written insurance risks or assumed insurance risks as an alternative to reinsurance transactions.	CR, MK, ST

Note 22 – Events Subsequent

Subsequent events are required to be disclosed per *SSAP No. 9—Subsequent Events*. Subsequent events are events or transactions that have occurred subsequent to the balance sheet date, but prior to the issuance of the financial statements and auditor's report, which have a material effect on the financial statements and, therefore, require adjustment and/or disclosure in the statements. Subsequent events are considered either Type I Recognized Subsequent Events and Type II Nonrecognized Subsequent Events. Type I focuses on events that provide additional evidence with respect to conditions that existed at the date of the balance sheet and affect the estimates inherent in the process of preparing financial statements. Type I recognized subsequent events or transactions provide relevant information to evaluate the financial condition of an entity. Type I events are recorded in the financial statements and, if material, disclosed in the Notes to Financial Statements. Type II focuses on events that provide evidence with respect to conditions that did not exist at the balance sheet date but arose subsequent to that date. Type II nonrecognized subsequent events provide relevant information needed to evaluate the information in the financial statements. This includes disclosure of the assement payable under Section 9010 of the federal Affordable Care Act. Type II events are only disclosed in the Notes to Financial Statements.

Section		*Risks*
1	The analyst should use the information disclosed in Type I of this Note to determine what impact recognized subsequent events had to the financial statements for the current	OP

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	period. SSAP No. 9 requires that the criteria, conclusion, and circumstances surrounding material Type I financial statement adjustments be disclosed in the Notes to Financial Statements. Not adjusting the financial statements would create a misleading picture of the insurer's financial position because the conditions existed at the date of the balance sheet and affect the reported line item estimates. For these reasons, analysts should review Type I recognized subsequent events disclosed in this Note in conjunction with the financial statements to get a clear picture of the changes in the insurer's financials and the reasons behind them.	
2	The analyst should use the information disclosed in Type II of this Note to assess and quantify the impact that nonrecognized subsequent events—having conditions that did not exist at the balance sheet date but arose subsequent to that date—would have on the current and future financials of the insurer. While Type II events do not result in an adjustment to the current financial statements, they do provide additional knowledge and information on pending financial effects. The impact that Type II events have on net income, asset and liability balances, capital and surplus, cash flow, and insurer structure should be carefully examined. Pro forma supplements, if provided, should also be incorporated into the analysis. For the annual reporting period ending Dec. 31, 2013, and thereafter, a reporting entity subject to the assessment of the federal Affordable Care Act (ACA) shall provide a disclosure of the assessment payable in the upcoming year consistent with the guidance provided under SSAP No. 9. The disclosure shall provide information regarding the nature of the assessment and an estimate of its financial impact, including the impact on its RBC position as if it had occurred on the balance sheet date. In accordance with SSAP No. 9, the reporting entity shall also consider whether there is a need to present pro forma financial statements regarding the impact of the assessment, based on its judgment of the materiality of the assessment. In addition, for annual reporting periods ending on or after Dec. 31, 2014, the reporting entity should disclose the amounts reflected in special surplus in the data year. The disclosure should provide information regarding the nature of the assessment, the estimated amount of the assessment payable for the upcoming year (current year and the prior year), amount of assessment paid (current and prior year) and written premium (current and prior year) that is the basis for the determination of the fee assessment to be paid in the subsequent year. The disclosure should also provide the total adjusted capital (TAC) and authorized control level (ACL) before and after adjustment to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The reporting entity should also provide a response and statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date. The analyst should review the health care procedures in Section III.B.9 Strategic Risk Assessment.	OP

Note 23 – Reinsurance

This Note's sections vary by statement type. The analyst should gain a better understanding of the insurer's reinsurance program and any risk the insurer is exposed to under the program.

Reinsurance is a vital part of an insurer's risk management and financial stability. Certain transactions or conditions of an insurer's reinsurance could have a significant and disparaging impact on its financial health. Dependence on reinsurance or its potential effect on the insurer's surplus is part of the NAIC hazardous financial condition standards as stated in the Model Hazardous Financial Condition Law. These standards include the ability of the assuming reinsurer to perform its obligation to the ceding reinsurer. As stated therein, "There

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should be sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and classes of business as well as the financial condition of the assuming reinsurer (credit risk to the insurer)." Whether any affiliate, subsidiary, or reinsurer is insolvent, threatened with insolvency, or delinquent in payments of its monetary or other obligations (reinsurance and business risk to the insurer) is another part of the standards. Therefore, an assessment of the financial stability of the reinsurer is an extremely important task of the analyst.

P/C and Title Insurers

Section (Statement Type)		*Risks*
A	The analyst should use the information provided in Section (A) to determine if the insurer has had any individual unsecured reinsurance recoverables in excess of 3% of policyholders' surplus. If so, the analyst should review the unsecured aggregate recoverable pertaining to that reinsurer, or if part of a group, the total unsecured aggregate recoverables for the entire group.	OP, ST, CR
B	The analyst should use the information provided in Section (B) to determine if any disputed recoverables have been noted. If so, the analyst should issue an inquiry to the insurer to determine the steps being taken to recover the amount(s). The analyst might want to question the validity of the credit being taken for disputed items.	OP, ST, CR
C	The analyst should use the information provided in Section (C) to determine the potential impact of the cancellation of reinsurance agreements.	OP, ST, CR
D	The analyst should use the information provided in Section (D) to determine if any uncollectable reinsurance has been written off. If so, the analyst should determine the financial impact the reinsurance written off will have on the financial statements and on the level of risk of the insurer.	OP, ST, CR
E	The analyst should use the information provided in Section (E) to determine if the insurer has had any commutation of reinsurance. If so, the analyst should determine the financial impact the commutation will have on the ceding company (its domestic) and should request a pro-forma financial statement reflecting the effects of the commuted agreement.	OP, ST, CR
F	The analyst should use the information provided in Section (F) to determine if the insurer has entered into any retroactive reinsurance agreements. If so, the analyst should send a request to the insurer asking for the accounting entries associated with the agreement. Due to the potential for abuse involving the creation of surplus, special accounting treatment has been developed. The analyst should determine whether the insurer has properly accounted for the new retroactive reinsurance (ref. *SSAP No. 62—Property and Casualty Reinsurance*, Section 28).	OP, ST, CR
G	The analyst should use the information provided in Section (G) to determine if the insurer has entered into any reinsurance agreements that do not transfer both components of insurance risk (underwriting risk and timing risk) and are accounted for as a deposit. SSAP No. 62, Section 35, provides accounting guidance.	OP, ST, CR
H (P)	The analyst should use the information provided in Section (H) (for P/C insurers only) to determine if the reporting entity has entered into any agreements that qualifies them to receive P/C run-off accounting treatment pursuant to SSAP No. 62. A property and casualty run-off agreement is not a novation, as the transferring insurer or reinsurer remains primarily liable to the policyholder or ceding entity under the original contracts	OP, ST, CR

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	of insurance or reinsurance.	
I, H (T)	The analyst should use the information provided in Section (I) to determine if there has been a ratings downgrade on any of the certified reinsurers and the resulting impact. See SSAP No. 62 for additional guidance.	OP, ST, CR
J (P)	The analyst should use the information provided in Section (J) (for P/C insurers only) to determine if the reporting entity has been approved for the use of reinsurer aggregation contracts covering asbestos and pollution liabilities in accordance with SSAP No. 62. The analyst should review the terms of the retroactive reinsurance agreement, including the established limits and collateral as security and the amount of unexhausted limit as of the reporting date. The analyst should use this information to determine the impact on the provision for reinsurance the impact including the impact on overdue amounts.	OP, ST, CR

Life/A&H, Fraternal and Health Insurers

Section		*Risks*
A	The analyst should use the information provided in Section (A) to get a better understanding of the reinsurers and to determine the potential impact of the cancellation of reinsurance agreements.	OP, ST, CR
B	The analyst should use the information provided in second Section (B) to determine if any uncollectable reinsurance has been written off. If so, the analyst should determine the financial impact the reinsurance written off will have on the financial statements and on the level of risk of the insurer. Under SSAP No. 61R, "The ceding and assuming companies must determine if reinsurance recoverables are collectable. If it is probable that reinsurance recoverables on paid or unpaid claims or benefit payments will be uncollectable, consistent with SSAP No. 5R, these amounts shall be written off through a charge to the Statement of Income utilizing the same accounts which established the reinsurance recoverables."	OP, ST, CR
C	The analyst should use the information provided in the third Section (C) to determine if the insurer has had any commutation of reinsurance. If so, the analyst should determine the financial impact the commutation will have on the ceding company (its domestic) and should request a pro-forma financial statement reflecting the effects of the commuted agreement.	OP, ST, CR
D	The analyst should use the information provided in Section (D) to determine if there has been a ratings downgrade on any of the insurer's certified reinsurers and the resulting impact. See SSAP No. 61 for additional guidance.	OP, ST, CR
E, F, G (L)	Section (E) and (F) requires the insurer to report specific information on reinsurance of variable annuity contracts with an affiliated captive reinsurer including the type of benefits being reinsured, a description of the purpose of the transaction, terms of the reinsurance agreement, the ultimate risks involved, reserve credit and collateral. Section (G) requires disclosure of RBC shortfall by captive reinsurer for entities utilizing captives to assume reserves subject to XXX/AXXX captive framework. The analyst should use the information provided in Sections (E), (F), and (G) to understand the insurers reinsurance program and the financial impact with respect to its use of captive reinsurers for variable annuity contracts and XXX/AXXX reserves.	OP, ST, CR

Note 24 – Retrospectively Rated Contracts and Contracts Subject to Redetermination

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This Note requires the insurer to disclose general information regarding its premium volume under retrospectively written contracts. (This Note is not applicable to title insurers.) The accounting guidance for retrospectively rated contracts is addressed in *SSAP No. 66—Retrospectively Rated Contracts*. SSAP No. 66 defines a retrospectively rated contract as one that determines the final policy premium based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy) and the stipulated formula set forth in the policy. The periodic adjustments might involve either the payment of return premium to the insured or payment of an additional premium by the insured, or both, depending on experience. Policy periods do not always correspond to reporting periods, and because an insured's loss experience may not be known with certainty until sometime after the policy period expires, retrospective premium adjustments are estimated based on the experience to date. Contracts with retrospective rating features are referred to as loss-sensitive contracts.

Section		*Risks*
A, B, C	Although these types of contracts generally subject the insurer to less risk than more traditional contracts, the analyst should use the information in the Note to determine if the amount of retrospective premiums is material in relation to total net premiums written. This Note also requires the insurer to disclose how it determined the estimated premium adjustment. The disclosure should include all business that is subject to the accounting guidance provided in SSAP No. 66, including business that is subject to medical loss ratio rebate requirements pursuant to the Public Health Service Act or otherwise known as the ACA. The analyst should review the Note to determine whether the reported amount is recorded in compliance with statutory guidance.	PR/UW, RV
D	Section (D) requires reporting on the ACA medical loss ratio rebates. The analyst should use this information to assess if rebates were paid and/or liabilities established, as well as calculate the materiality and impact of rebates on the capital and surplus of the insurer.	PR/UW, ST
E (P)	For P/C companies, the analyst should compare the admitted amount reported in the Note for accrued retrospective premiums to what is recorded on the balance sheet.	PR/UW, RV
E, F (P)	One of the most significant new drivers of uncertainty attributable to the ACA is its premium stabilization program, ACA Risk Adjustment Program. This program primarily affects the commercial individual and small-group markets. The impact on a specific health entity will be somewhat dependent on its concentration in those markets. ACA Risk Adjustment Program is designed to provide protection to the health insurance entity by mitigating adverse financial outcomes; however, the program could have a negative impact as well. Moreover, the program includes a retrospective settlement process. The health entity's annual financial statements will include estimates of amounts payable or receivable under the program. However, these estimates may be uncertain in magnitude and direction, and may be large in relation to the forecasted annual net income for the affected lines of business. The analyst should monitor an insurer's writings and determine whether the insurer wrote any A&H insurance premium which is subject to the ACA Risk Adjustment Program. It is also recommended that the analyst identify whether the impact of underestimating the amount of health premium subject to the ACA Risk Adjustment Program is greater than their level of capital would allow. The analyst should review the health care chapter in VI.C. and ACA risk assessment within III. B.9 Strategic Risk Assessment. Any reporting entity that reports A&H insurance premium and losses on their statement that is subject to the ACA Risk Adjustment Program must complete the tables provided within Note 24 for the purpose of disclosure of the impact of Risk Adjustment Program	PR/UW, ST

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	on admitted assets, liabilities, and revenue by program for the current year even if all amounts in the table are zero.	

Note 25 – Changes in Incurred Losses and Loss Adjustment Expense

(For this Note, Health insurers should replace "Incurred Losses and Loss Adjustment Expense" with "Claims and Claim Adjustment Expense.")

Section		*Risks*
	This Note requires an insurer to report any reasons for changes in the provision for incurred loss and loss adjustment expenses (LAE) attributable to insured events of the prior year. This Note provides for supporting documentation if there is a change in the prior-year provision for incurred losses and LAE, or reserve development in the current year. Reserve development results from the company's initial estimates differing from the actual results, either through changes in the current reserves or differences in actual payments compared to prior reserves. Because reserve development is reflected in income as the changes incur, reserve development effectively transfers income or loss from the prior year to the current year. An increase in the provision for incurred losses and LAE or adverse development is a larger issue because it indicates that the surplus of the prior period was overstated. The provision for incurred losses and LAE is estimated and subject to some volatility. Although the instructions do not establish a specific threshold at which the company must complete the Note, when the development reaches 5% to 10% of surplus or higher, the analyst should reasonably expect some additional information regarding the reason for the change in the provision for incurred losses and LAE. The response to this Note should address the specific lines of business and/or policy types involved and to what extent the development is due to changes in incurred but not reported (IBNR), including bulk reserves, case basis reserve changes, or actual paid claim differences. In addition, the company is required to comment on whether additional premiums or return premiums resulted from the incurred development. The Note does not require the company to report the amount of development. If the development and/or the company's response to the Note cause the analyst some concern, prior reserve analyses might be reviewed, or the analyst might need to question the company's reserves and address supplemental procedures for unpaid losses and LAE.	RV

Note 26 – Intercompany Pooling Arrangements

This Note requires an insurer to report certain information on reinsurance pooling arrangements with affiliated insurers. (This Note is not applicable to Title insurers).

Section		*Risks*
A–G	The analyst should review the insurer's percentage of direct written business in comparison to the insurer's participation percentage in the pool. If the participation percentage assumed from the pool exceeds the percentage of direct written business, the analyst needs to consider the impact to the insurer and do any necessary follow-up. Reinsurance transactions between affiliated insurance companies do not reduce risk for the group but, instead, shift risk among affiliates. Reinsurance between affiliated companies presents opportunities for manipulation and potential abuse. In a group of affiliated insurers, interinsurer reinsurance may serve to obscure one insurer's financial condition by shifting loss reserves from one affiliate to another. Improper support or subsidy of one affiliate at	OP, CR, LQ, ST

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	the expense of another may adversely affect the financial condition of one or more companies within the group. The analyst should determine whether each member of the pool is obtaining reinsurance and ceding to the pool on a net basis, or whether the pool is obtaining reinsurance and each member of the pool is ceding to the pool on a direct basis. In the event that the pool is obtaining reinsurance, the analyst must determine if each pool participant is a party to the reinsurance agreement or if only the lead company is named. If there is a change in the pooling agreement, the analyst should determine if the insurer can support the change in the interinsurer pooling agreement, and determine if it appears that other affiliates are supporting any adverse results of the insurer or if the company is supporting adverse operating results of others.	

Note 27 – Structured Settlements

The purpose of this Note is to provide guidance on disclosing structured settlements and the transactions for reporting them in the financial statements. (This Note is not applicable to Health insurers)**.** The accounting guidance for structured settlements is addressed in *SSAP No. 65—Property and Casualty Contracts*. SSAP No. 65 discusses structured settlements, which are essentially extended periodic payments used by insurance companies in paying claims in order to ensure that the funds are available to meet the long-term needs of the claimant. They come through "arm's-length agreements" between the claimant and the other party, generally in settlement of litigation. A structured settlement is a completely voluntary agreement between the injured victim and the defendant. Under a structured settlement, an injured victim doesn't receive compensation for his or her injuries in one lump sum. Rather, the injured victim will receive a stream of tax-free payments tailored to meet future medical expenses and basic living needs.

Section		*Risks*
A–B	Historically, damages paid due to an injury lawsuit came in the form of a single lump sum. This kind of payment, especially in catastrophic injury cases, often placed the injury victim in a precarious position. The injured party would have all the funds in hand, but medical payments might continue for years. The victim would end up focusing on adapting to a new lifestyle that often involved unforeseen financial obligations. Today, structured settlements are flexible and can be designed for nearly any set of needs. They are funded through annuities so as to guarantee that the money promised at the time of the settlement is there when the payments are due. Reporting entities may purchase an annuity in which the entity is the owner and payee, or an annuity in which the claimant is the payee. A relatively simple payment schedule can be set up that provides for equal payments at set intervals—e.g., every month for 20 years—yet payments need not be in equal amounts. Someone who will need a new wheelchair every three years might elect to receive a larger payment every 36 months to help defray the cost. A structured settlement's inherent flexibility means that they are well suited to compensate victims for a wide variety of injuries. The analyst should use the information in this Note to gain a better understanding of the amount of structured settlements the insurer has entered into, as well as any specifics on the arrangements. It is important to determine whether the insurer has adequately disclosed the amount of reserves no longer carried. The extent that the company is contingently liable should be disclosed because there is some exposure under these types of settlements. The name, state of domicile, location of the insurance company and the aggregate statement value of annuities due from life insurers should be disclosed. A quick check on the financial rating of the life insurer might provide the analyst with some assurance that the insurer has the ability to meet its payments.	RV, OP

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Note 28 – Health Care Receivables

(For Health insurers only, Note 28 is for supplemental reserve and requires disclosure of discounting, the method, rate and amount of discount.)

This Note requires disclosure on pharmaceutical rebate receivables and information on risk sharing receivables. While this Note contains quarterly information, the disclosure is only required annually unless material changes occur. The Note for health care receivables is required by *SSAP No. 84—Health Care and Government Insured Plan Receivables*. Exhibit C—Implementation Guide of SSAP No. 84 provides additional accounting guidance for the practical application of SSAP No. 84. Note that when reviewing health care receivables, amounts from government insured plans may be admitted if they are in excess of 90 days, provided the receivable originates from the government.

Section, Part	*Pharmaceutical Rebate Receivables*	*Risks*
A	As stated in SSAP No. 84, pharmaceutical rebates are arrangements between pharmaceutical companies and insurers in which the insurer receives rebates based on the drug utilization of its subscribers. These rebates are recorded as receivables by the insurer and include both billed amounts and estimated amounts.	LQ
A, 1	Estimates are calculated using a variety of methods. Section (A) of the Note addresses the method used by the reporting entity to estimate pharmaceutical rebate receivables. As stated in Exhibit C of SSAP No. 84, the insurer should use the most accurate method possible utilizing historical information and should consider such things as contractual changes in rebate amounts, seasonality differences, changes in membership or premium revenue, changes in utilization for various rebate levels, etc. An analyst should use the information in the Note to gain an understanding of the method used for estimating receivables. If an insurer has not taken into consideration all of the factors that can impact the amount of the receivable, material differences might exist between the estimated receivable and the actual receivable. Section (A) of the Note also contains a table (from Exhibit A of SSAP No. 84), which discloses, for the most recent three years, the estimated balance of pharmacy rebate receivables, pharmacy rebates as billed or otherwise confirmed, and pharmacy rebates received. The simplest way to understand the table is with the example provided at the end of the Note. The disclosure for pharmaceutical rebates was developed to compare an insurer's actual pharmacy rebates to its estimated pharmacy rebates. By comparing the second column, titled Estimated Pharmacy Rebates as Reported on Financial Statements (the estimate), to the third column, titled Pharmacy Rebates as Invoiced/Confirmed (the actual amount), the analyst can gain an understanding of the insurer's ability to reasonably estimate their pharmacy receivables. If an insurer reported significant discrepancies between its estimated and actual receivable balances, the analyst may consider doing further analysis into causes for the discrepancy and the methods used by the insurer to calculate the estimated receivable.	LQ
A, 2	When reviewing this Note in conjunction with the balance sheet and statement of revenue and expenses, the analyst should consider that, while Column A of the Note should only reflect amounts recorded as admitted assets on the balance sheet, rebates on uninsured plans are included in the Note. Uncollected rebates on uninsured plans are only admitted to the extent that they exceed offsetting rebates due to the uninsured plan. Further, pharmacy rebates for uninsured plans (including admitted receivable balances) are reported as reductions in administrative expenses, while rebates on insured plans are	LQ

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	reported as a reduction in pharmacy claims expense on the Statement of Revenue and Expenses. The analyst should also be aware that, as stated in SSAP No. 84, adjustments to previously billed amounts (billed or confirmed in writing) would be included in the disclosure. This could result in variances between the estimate and the billed/confirmed amount. Any material variances should be explained in the Note. The analyst should consider additional analysis if any material variances exist that is not explained in the Note.	
A, 3	The Note was also designed to provide information on collectability. If, in accordance with SSAP No. 5R, it is probable the balance of a receivable is uncollectable, any uncollectable receivable shall be written off and charged to income. This also applies to risk-sharing receivables (discussed below). As in the example above, an analyst can use the information in the fourth, fifth, and sixth columns of the table to gain an understanding of the collectability of the receivables. Significant discrepancies between the actual amount of the receivables and the amount collected might indicate to the analyst that the insurer has not appropriately evaluated the collectability of pharmaceutical rebate receivables, and certain receivables should be written off if they are deemed to be uncollectable.	LQ
Section, Part	*Risk Sharing Receivables*	*Risks*
B, 1	SSAP No. 84 defines risk-sharing agreements as contracts between insurers and providers with a risk-sharing element based on utilization. These agreements can result in receivables due from providers if the actual utilization differs from the estimates. Section (B) of the Note should disclose the method used by the reporting entity to estimate its risk-sharing receivables. Gross receivable and payable balances should be disclosed in the Note if any receivable or payable amounts with the same provider have been netted. As stated in Exhibit C of SSAP No. 84, receivables consist of estimated amounts and billed amounts. The estimated amounts represent the reporting entity's best estimate of the receivable. When determining an estimate, an insurer should use the most accurate methods possible that utilize inception-to-date encounter data relative to outpatient surgery encounters, hospital days, etc. An analyst should use the information in the Note to gain an understanding of the method used for estimating receivables. If an insurer has not taken into consideration all of the factors that can impact the amount of the receivable, material differences might exist between the estimated receivable and the actual receivable. The Note also contains a table that discloses, for the most recent three years, the risk-sharing receivables estimated and reported in the prior year for annual periods ending in the current year; risk-sharing receivables estimated and reported for annual periods ending in the current year or in the following year; risk-sharing receivables invoiced as determined after the annual period; risk-sharing receivables not yet invoiced; and amounts collected from providers as payments. Exhibit B of SSAP No. 84 provides an illustration of the disclosure and an explanation of the amounts in the table. Exhibit C, Question #17 of SSAP No. 84 provides a detailed explanation of what should be reported in the columns for risk-sharing receivables (columns 3–6). In addition to the guidance in the SSAP, it is helpful to note that the sum of the columns titled "Risk-Sharing Receivable Invoiced" and "Risk Sharing Receivable Not Invoiced" should equal the balance in the column entitled "Risk-Sharing Receivable as Estimated and Reported in the Current Year," unless the company has invoiced amounts in a certain year and collected on that invoice in the current year.	LQ
B, 2	The purpose of this disclosure is to show how an insurer's risk-share balances have changed over time (i.e., estimated and billed amounts), to show how much of the receivable is estimated amounts or subsequently billed amounts, and to provide information on	LQ

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	collectability. An analyst's review of this section should be similar to the analysis of the pharmaceutical rebate receivable section of the Note. If an insurer reported significant discrepancies between their estimated and actual receivable balances, the analyst might consider doing further analysis to determine the causes for the discrepancy and to evaluate the methods used by the insurer to calculate their estimated receivable. Significant discrepancies between the actual amount of the receivables and the amount collected may indicate to the analyst that the insurer has not appropriately evaluated the collectability of risk-sharing receivables, and certain receivables should be written off if they are deemed to be uncollectable. Risk-sharing receivables from affiliated entities are included in this footnote and are reported as Health Care Receivables.	
C	The purpose of this disclosure is to show how much of health care receivables are attributed to Medicare Part D prescription payment plans receivables and the aging of those receivables. The analyst can use this information to assist in assessing any issues with collectability or impairment of recoverables.	

Pharmacy Rebates Example:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Invoiced/ Confirmed	Actual Rebates Collected Within 90 Days of Invoicing/ Confirmation	Actual Rebates Collected Within 91 to 180 Days of Invoicing/ Confirmation	Actual Rebates Collected More Than 180 Days After Invoicing/ Confirmation
12/31/2014	$150 (A)				
9/30/2014	130 (B)	$133 (C)	$62 (D)		
6/30/2014	142	143	138	$5	
3/31/2014	157	152	150	1	$1
12/31/2013	125	132	129	3	0
9/30/2013	123	129	125	1	0
6/30/2013	112	120	110	4	6
3/31/2013	110	118	118	0	0
12/31/2012	68	75	69	5	3
9/30/2012	60	59	58	1	0
6/30/2012	57	60	49	8	1
3/31/2012	45	50	48	1	1

This example assumes a financial statement date of Dec. 31, 2014, and further assumes full implementation of SSAP No. 84 retroactive to Jan. 1, 2012, with no transition. Exhibit C of SSAP No. 84 provides guidance on the implementation and transition periods.

A. The $150 represents the company's best estimate of rebates on drugs filled in the fourth quarter of 2014.

B. The $130 represents the company's best estimate of rebates to be received on drugs filled in the third quarter of 2014.

C. $133 is the actual amount of rebates determined for the third quarter of 2014, (i.e., the amount billed to the pharmaceutical company or confirmed to the pharmacy benefit manager). This amount was billed by Nov. 30, 2014. Therefore, the company estimated rebates of $130, but will actually receive $133 of rebates for the third quarter.

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D. Assuming the $133 was billed on Nov. 30, 2014, the $62 represents the actual rebates received by the company during December 2014. In subsequent disclosures, the company would "update" this to include amounts received in January and February of 2015.

The admitted asset balance for pharmacy rebates at Dec. 31, 2014, would equal $150 + 133 – 62 = 221. (A+C–D)

Note: The collection columns do not represent quarterly time periods; e.g., first quarter, second quarter. They represent the three months following the date of billing. For the 3/31/14 (first quarter of 2014) line, actual rebates would have to be billed by May 31, so the column titled "Actual Rebates Collected within 90 Days of Invoicing/Confirmation" would represent collections between June 1 and August 31 (assuming the company billed on May 30).

Note 29 – Participating Policies

This Note requires the insurer to disclose information on participating contracts as required by *SSAP No. 51—Life Contracts* and SSAP No. 54. This Note is not applicable to title insurers.

Section		*Risks*
N.A.	Participating policies are policies where the contract holder is entitled to share in the insurer's equity earnings through dividends. The dividend amount reflects the difference between the premium charged and the actual experience. A participating policy dividend may be paid in cash, applied to premiums, left on deposit to accumulate interest, or applied to the purchase of, for example, an increment of paid-up insurance or term life insurance. The purpose of this disclosure is to provide information about the relative percentage of participating insurance, the method of accounting for policyholders' dividends, the amount of dividends, and the amount of any additional income allocated to participating policyholders in the financial statements. Dividends paid on participating insurance could potentially impact the insurer's financial position; therefore, the analyst should review the disclosure to determine the extent of any impact policyholder dividends have on the insurer's financials.	OP

Note 30 – Premium Deficiency Reserves

This Note requires the insurer to disclose information on premium deficiency reserves as required by SSAP No. 53 and SSAP No. 54. This Note is not applicable to title insurers.

Section		*Risks*
N.A.	Premium deficiency reserves are established when anticipated losses, LAE, commissions and other acquisition costs, and maintenance costs exceed the recorded unearned premium reserve and any future installment premiums on existing policies. An additional liability for the deficiency and the corresponding charge to operations are recorded. This note requires the insurer to disclose the amount of premium deficiency reserves, the date of evaluation for premium deficiency reserves, and whether the reporting entity utilized anticipated investment income as a factor in the premium deficiency calculation. Premium deficiency reserves could impact the insurer's financial position; therefore, the analyst should review the disclosure to determine the extent of any impact on the insurer's financials.	RV

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The remaining Notes are divided into three sections: 1) P/C; 2) Life/A&H and Fraternal; and 3) Health.

Note 31 – High Deductible Policies (P/C)

This Note requires the insurer to disclose some basic information on high deductible policies. The information allows the analyst to gain a better understanding of the total credit risk the insurer is exposed to under these types of policies. The accounting guidance for high deductible policies is addressed in SSAP No. 65. High deductible plans are available from insurers; however, this type of plan is most often used with workers' compensation coverage. Under a high deductible plan, the insurer often settles all claims incurred under the policy (including claims that have yet to meet the deductible amount) and will need to recover the amounts from the insureds that fall within the deductible amount. In many states, the insured party is required to provide collateral for the deductible amount, while the insurer is responsible for periodically reviewing the financial viability of the insureds under the plan.

The liability for loss reserves under high deductible policies is determined in accordance with SSAP No. 55. Under SSAP No. 55, the insurer shall reserve losses from the inception of the policy period, not over the period after the deductible has been reached. Loss reserves established by the insurer should be net of deductible; however, no reserve credit should be permitted for any claim where any amount is due from the insured and determined to be uncollectable.

The insurers are permitted to report as an asset amounts recoverable from insureds for deductible reimbursements that are related to paid losses. The recoverable amounts need to be reported in accordance with policy provisions and be aged in accordance with their contractual due dates. Statutory accounting principles require an insurer to establish and report as non-admitted assets 10% of those deductible recoverable amounts due on paid losses that are in excess of the collateral specifically held and identifiable, on a per policy basis. In addition, any amounts in excess of the 10% that are not anticipated to be collected should also be non-admitted.

Section		*Risks*
A	The analyst should review the financial statements for reserve credit that has been recorded for high deductibles on unpaid claims. If the amount is material, it is crucial that the analyst request additional information from the insurer to determine that an excessive credit has not been taken against the outstanding reserves. It is also important for the analyst to review the financial statements to determine whether the assets (deductibles recoverable) that have been billed and recoverable on paid claims are not past due and determine whether the proper amount of assets have been reported as non-admitted assets.	CR, OP, RV
B	For unsecured high deductible recoverables, the analyst should review the information provided in the Note to determine whether the individual obligor is a part of a group under the same management or control, such as a professional employer organization (PEO), and evaluate the total unsecured aggregate recoverables on high deductible policies for the entire group and the impact on credit risk.	CR, OP, RV

Note 32 – Discounting of Liabilities for Unpaid Losses or Unpaid Loss Adjustment Expenses (P/C)

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This Note requires the insurer to report certain information on reserves that have been discounted using a tabular basis or a non-tabular basis, and certain information if the insurer has made any changes in the assumptions used to discount its reserves.

Section		*Risks*
A	The analyst should use the information required in this Note to determine if the insurer has discounted its unpaid losses and/or LAE and, if so, whether concerns exist regarding the amount of the discount or the interest rate used. Present value discounting of P/C loss reserves is generally not an accepted statutory accounting practice, except in the instances of fixed and determinable payments, such as those resulting from workers' compensation tabular indemnity reserves and long-term disability claims. However, some state insurance departments may permit insurers to discount certain other long-tail liability lines of business, such as medical professional liability, on a non-tabular basis. All discounting, other than tabular discounting, must be approved by the domiciliary state insurance department and must be disclosed in General Interrogatories Part 2, #4.1 and #4.2 of the Quarterly Financial Statement. This disclosure includes a discussion of the discount rates used and the basis for using those rates.	RV
B	When establishing discounted loss reserve liabilities prescribed or permitted by the state of domicile using a non-tabular method, the liability shall be determined in accordance with *Actuarial Standard of Practice No. 20, Discounting of Property and Casualty Loss and Loss Adjustment Expense*, but according to SSAP No. 65*,* shall not exceed the lesser of two minimum requirements. The first requirement provides that if the reporting entity's statutory invested assets are at least equal to the total of all policyholders' reserves, the insurer's net rate of return on statutory invested assets, less 1.5%, should be used. Alternatively, if the reporting entity's invested assets do not at least equal the total of all policyholders' reserves, the insurer's average net portfolio yield rate less 1.5%, as indicated by dividing the net investment income earned by the average of the insurer's current and prior year total assets, should be used. The second requirement provides that the current yield to maturity on a United States Treasury debt instrument with maturities consistent with the expected payout of the liabilities should be used.	RV
C	In addition to the above, if the rates used to discount prior accident years' reserves have changed from the previous Annual Financial Statement, the insurer is required to disclose the amount of discounted current reserves (excluding the current accident year) at current interest rate assumptions, the amount of discounted current reserves (excluding the current accident year) at previous interest rate assumptions, and the change in discounted reserves due to the change in interest rate assumptions.	RV

Note 33 – Asbestos/Environmental Reserves (P/C)

This Note provides specific information on the insurer's asbestos and/or environmental (A&E) business as addressed in SSAP No. 65. This Note assists the analyst in determining whether unpaid losses and/or LAE include A&E reserves and, if so, whether concerns exist regarding the amount of A&E reserves. These types of claims are not as predictable as other types of risks and can be long-tail in nature; therefore, it is more difficult to establish an accurate reserve.

Section		*Risks*
A–F	It is key to determine if an insurer has recorded the A&E reserves in accordance with SSAP No. 55. The analyst should review the Note to ensure that an insurer's case or IBNR	RV

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	reserving methodologies are consistent with those required in SSAP No. 55. It is also necessary to make certain that the entity is fully disclosing all amounts paid and reserved for losses and LAE for A&E claims on a direct, assumed, and net of ceded reinsurance basis. Special attention may be raised as net A&E unpaid loss and LAE reserves surpass 15% of policyholders' surplus or there are significant shifts in A&E reserving. It is critical to review the Actuarial Opinion and verify that the figures in the Opinion are consistent with those reported in the Note. The Opinion might also provide additional disclosures that could be valuable to an analysis, such as information on the specific lines of A&E business.	

Note 34 – Subscriber Savings Accounts (P/C)

Subscriber savings accounts (SSA) are defined in SSAP No. 72 as a portion of a reciprocal insurance company's surplus that has been identified as subscribers (policyholders) accounts. SSA is unique to reciprocals, as the policyholders are also the owners of the company.

Section		*Risks*
N.A.	The analyst should use the information in this Note to gain a better understanding of the amount and specifics of the insurer's SSA, including the conditions for repayment. There are two sources for deposits to SSAs. In the first, the individual subscriber may be the source of certain deposits to subscriber accounts, as some reciprocals may require subscriber contributions to join the reciprocal. In the second, the reciprocal is the source. By identifying as an SSA, a portion of its unassigned surplus is generated from its operations. The source of SSA deposits has a bearing on the proper financial statement presentation. The analyst might want to determine that the source of the funds from the individual subscriber is recorded as Other than Special Surplus. Likewise, the source of amounts from the reciprocals operations is reported as Unassigned Surplus. In this case, the individual subscriber accounts are merely an internal recordkeeping device and not an indicator of restrictions on the funds or an obligation to pay these amounts to the subscribers. The amount of surplus from operations that is identified as SSA is generally at the determination of the management of the company and its board of directors. SSA balances may be paid to subscribers, depending on domiciliary state law, upon termination of their association with the company, regardless of the source of the SSA. In this instance, any unpaid amounts owed to terminated subscribers must be reported as a liability. If the company has declared that it will distribute a certain amount of its Unassigned Surplus identified as SSA but has not actually distributed the amounts by the next reporting date, the company should decrease Unassigned Surplus by the amount approved and report the unpaid amount as a liability.	OP

Note 35 – Multiple Peril Crop Insurance (P/C)

This Note requires the insurer to disclose information regarding the unearned premium reserve and administrative expense payments associated with multiple peril crop insurance and its subsidized relationship with the Federal Crop Insurance Corporation (FCIC). The Note for multiple peril crop insurance is required by *SSAP No. 78—Multiple Peril Crop Insurance*.

Section		*Risks*
N.A.	A liability for unearned premium reserve is established to reflect the amount of premium	RV,

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	for the portion of the insurance coverage that has not yet expired. The Note requires the insurer to disclose the method used to compute the unearned premium reserve. FCIC subsidizes a percentage of premiums for administrative expenses associated with selling and servicing crop insurance policies, including the expense associated with adjusting claims. Catastrophic insurance is designed to provide farmers with coverage against extreme loss, whereas buy-up insurance covers more typical and smaller crop losses. The expense payment associated with the catastrophic coverage is recorded as a reduction of loss expenses, whereas the expense payment for the buy-up coverage is recorded as a reduction of other underwriting expenses. The insurer is required to disclose the total amounts received for each type of coverage. The analyst should review the disclosure to determine the extent of any impact these payments have on loss and underwriting expenses and net income.	OP

Note 36 – Financial Guaranty Insurance (P/C)

The underlying principles for financial guaranty insurance and accounting details are discussed in *SSAP No. 60—Financial Guaranty Insurance*. SSAP No. 60 defines financial guaranty insurance as protection against financial loss as a result of default, changes in interest rate levels, differentials in interest rate levels between markets or products, fluctuations in exchange between currencies, inconvertibility of one currency into another, inability to withdraw funds held in foreign countries as a result of government imposed restrictions, changes in value of specific assets or commodities, financial or commodity indices, or price levels in general. Financial guaranty insurance does not provide loss protection for events that occur due to fortuitous physical events, equipment operation failure or deficiency, or the inability to extract natural resources. Financial guaranty does not provide protection for losses related to various types of bonds (individual or schedule public official bonds, contract bonds, court bonds), credit insurance, guaranteed investment contracts, and residual value insurance.

Section		*Risks*
A, B	This Note requires the insurer to disclose information that enables the analyst to better understand the factors affecting the present and future recognition and measurement of financial guaranty insurance contracts. The analyst should review SSAP No. 60 to gain an overall understanding of financial guaranty insurance and the various risk/reserve requirements of each type of risk included in the Note. This will assist the analyst in understanding the overall risks in which the insurer is most exposed. This will also assist the analyst in determining any error by the insurer in reporting contracts that are (or are not) financial guaranty insurance that should (or should not) be reported under this Note.	RV

LIFE, A&H AND FRATERNAL INSURERS

Note 31 – Reserves for Life Contracts and Annuity Contracts (L/AH/F)

The disclosures included in this Note will assist the analyst in evaluating the adequacy of reserves reported in Exhibits 5 and 7 of the Annual Financial Statement. The insurer's Statement of Actuarial Opinion is an additional source of information that may be helpful in evaluating the disclosure reported in this Note. See section III.B.8.b.i Statement of Actuarial Opinion Worksheet for specific guidance on evaluating an insurer's Statement of Actuarial Opinion. Due to the scope and complexity of the issues related to the establishment of life and deposit-type contract reserves, the analyst may wish to consider referring unusual disclosures to a qualified actuary for further review.

Life insurance reserves represent the liability for future policy benefits. Life reserves represent in theoretical terms the present value of future benefits to be paid less the present value of future net premiums receivable

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under the contract. The future benefits include but are not exclusive to such benefits as death benefits, endowment benefits or cash surrender values. The primary purpose of establishing life reserves is to ensure that future commitments to policyholders and their beneficiaries are met. See Section III. B. Annual Reference Guide for Actuarial Opinion Assessment and Reserving Risk Assessment for specific guidance on evaluating an insurer's life reserves.

The principal guidance on establishment of life and deposit-type contract reserves is contained in SSAP 51 and *SSAP No. 52—Deposit-Type Contracts*. Detailed requirements regarding reserves are provided in Appendix A and C of the AP&P Manual. The Note requires specific disclosure relating to: 1) general reserving practices; 2) reserve methods for substandard policies; 3) deficiency reserves; 4) tabular interest and costs on life contracts; 5) tabular interest and costs on deposit-type contracts; and 6) other reserve changes. The following specific Appendices may provide further guidance to the analyst in evaluating the disclosures in this Note:

- Appendix A-585 establishes minimum reserving methods for universal life-type contracts
- Appendix A-620 discusses reserve requirements for accelerated benefits
- Appendix A-820 discusses provisions for reserving methodologies and assumptions used in computing policy reserves
- Appendix A-822 provides guidance on asset adequacy analysis
- Appendix C contains actuarial guidelines

Section		*Risks*
1	Disclosure of reserve practices required by SSAP No. 51 and SSAP No. 52 are illustrated in the NAIC *Annual Statement Instructions*. Actual disclosures included in the Note should be reviewed in relation to these typical illustrations. Unusual deviations or additional disclosures that appear material in relation to aggregate reserves reported by the insurer may be cause for further review. Specific attention should be given to material reserves disclosed in Exhibit 5, Section G, Miscellaneous Reserves, and in the footnotes to Exhibit 5.	RV
2	Substandard policies, or rated contracts, are those policies that were issued on lives that involved extra hazards due to physical condition, occupation, habits or family history and are therefore charged an extra premium. Reserving methods often differ for substandard policies. The analyst should use the information provided in the second part of this Note to evaluate these methods.	RV
3	A minimum reserve requirement is established in Appendix A-820 in situations where the gross premium charged is less than the valuation net premium (deficiency reserve). The analyst should use the third part of the Note to evaluate the amount of insurance in force that exists for which the gross premiums are less than the valuation net premiums. These deficiency reserves are typically reported as a separate item in Exhibit 5, Section G or may be reported with other life reserves in Section A.	RV
4, 5	Any disclosure that life contract or deposit-type contract tabular interest and/or costs were computed by a method other than that required by the NAIC *Annual Statement Instructions*, may be cause for further review. The analyst may refer to the NAIC *Annual Statement Instructions* for page 7, Analysis of Increase in Reserves During the Year, of the Annual Financial Statement, which describes a formula for calculating tabular interest, tabular less actual reserves released and tabular cost.	RV
6	Part six of this Note discusses other reserve changes that have occurred during the period. Significant changes in the valuation basis of reserves are reported in Exhibit 5A, and will be direct adjustments to the capital and surplus account on page 4 of the Annual Financial	RV

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	Statement. Disclosures may also relate to items reported on line 7 of page 7, Analysis of Increase in Reserves During the Year. Material amounts reported in the Annual Financial Statement or disclosed in the Note may be cause for concern and the analyst should consider whether further review by a qualified actuary is required.	

Note 32 – Analysis of Annuity Actuarial Reserves and Deposit Type Contract Liabilities by Withdrawal Characteristics (L/AH/F)

This Note provides information on the withdrawal characteristics of a reporting entity's annuities, deposit-type funds and other liabilities without life or disability contingencies and a reconciliation of total annuity actuarial reserves and deposit fund liabilities. The total of Part 1 should equal the total of Part 2, and the components of Part 2 should agree with the respective sections of Exhibits 5 and 7 of the general account Annual Financial Statement and Exhibit 3 and Page 3, Line 3 of the Separate Accounts Annual Financial Statement.

Section, (Part)		*Risks*
1 (A, B)	**Interest Rate Risk** The interest rate risk is the risk of losses due to changes in interest rates. The impact of interest rate changes will be greatest on those products where the guarantees are most in favor of the policyholder and where the policyholder is most likely to be responsive to interest rate changes. A mismatch of long-term or illiquid assets backing short-term liabilities could occur (the opposite could also occur). The Life RBC formula uses essentially the same categories as this Note to determine interest rate risk on annuity and deposit-type (ADF) reserves. For RBC purposes, ADF liabilities that are not withdrawable or withdrawable with market value adjustment are generally considered low risk and are captured in Sections B and A (1), respectively, of this Note. ADF liabilities withdrawable at book value less a current surrender charge of 5% or more are generally considered medium risk and are captured in Section A (2) of this Note. ADF liabilities withdrawable at market value are not assigned interest rate risk under RBC and are captured in Section A (3) of this Note. However, ADF liabilities that are withdrawable at book value without adjustment are generally considered high-risk and are captured in Section A (5) of this Note.	MK, LQ, RV
1 (E)	The analyst should review this Note and the information above to consider the overall interest rate risk that an insurer is exposed to. (The RBC formula also nets reinsurance ceded and policy loans, and adds modified coinsurance assumed, for the respective risk categories.)	MK, LQ, RV
1 (A–E)	**Liquidity Risk** In addition to interest rate risk, an insurer having ADF liabilities is subject to liquidity risk. Because this Note includes information on the charges that policyholders are subject to, the Note can also be useful in determining the amount of policyholder liabilities that could potentially be withdrawn in a stress scenario or otherwise (for instance, rollovers). However, this Note does not disclose the additional liquidity risk that might exist in guaranteed interest contracts (GICs) due to features imbedded in the contracts and the sophistication of GIC contract holders. GICs and other types of funding agreements are generally sold to sophisticated buyers, and high ratings are demanded by the marketplace (such as minimum ratings of AA- from Standard & Poor's and Aa3 from Moody's Investors Services). However, a highly rated	MK, LQ, RV

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	insurer might enter into a fronting arrangement with a weaker reinsurance partner. In the event either or both the fronting insurer or the reinsurance partner do not manage their risks appropriately, they could both be destabilized by a "run on the bank." For insurers having significant direct and assumed exposure to GICs, it may be appropriate for the analyst to obtain additional information regarding the characteristics of the products being written by the insurer, with particular emphasis on features that may subject the insurer to significant liquidity risk. Such features may include contracts that allow for the surrender at book value in the event of a drop in credit ratings or seven-day to one-month put options. The institutional investors that invest in GICs and Funding Agreements seek safety. An external event such as a rating agency downgrade, general economic conditions resulting in a mismatch of an insurer's asset/liability yield curve or maturity distribution, or adverse publicity regarding the insurer, a reinsurer, a competitor, or the Company's peer group, could cause a stress scenario. It is imperative that a GIC issuer understands the risks imbedded in its contracts and has sound asset/liability management and liquidity risk management programs, and a specific contingency plan in place to deal with a stress scenario.	
2 (F)	The insurer should reconcile total annuity reserves and deposit fund liabilities amount disclosed to the appropriate sections of the Aggregate Reserves for Life Policies and Contracts Exhibit and the Deposit Funds and Other Liabilities without Life or Disability Contingencies Exhibit, of the Life, A&H Annual Statement and the corresponding lines in the Separate Accounts Statement.	MK, LQ, RV

Note 33 – Analysis of Life Actuarial Reserves by Withdrawal Characteristics (L/AH/F)

This Note provides information on the amount of account value, cash value and reserve for the breakouts of life insurance by withdrawal characteristics, separately from General Account products, Separate Account with Gurantees products and Separate Account Nonguaranteed products.

Section		*Risks*
A - E	The analyst should review this Note and consider the overall risk that an insurer is exposed to. Please refer to the Interest Rate Risk and Liquidity Risk noted in Note 32 for additional guidance.	LQ, RV
F	The insurer should reconcile total life insurance reserves amount disclosed to the appropriate sections of the Aggregate Reserves for Life Policies and Contracts Exhibit (Exhibit 5) of the Life, Accident and Health Annual Statement and the corresponding lines in the Separate Accounts Statement. The reconciliation is a single presentation including all amounts from the sections on Individual Life insurance and Group Life Insurance.	LQ, RV

Note 34 – Premium and Annuity Considerations Deferred and Uncollected (L/AH/F)

This Note illustrates the premium and annuity considerations deferred and uncollected for each of the following business lines: industrial business, ordinary new and renewal business, credit life, and group life and annuity. The section includes uncollected and deferred premiums and annuity considerations, for each line of business listed above, on a gross basis and net of loading.

Section		*Risks*
N.A.	The reporting of deferred and uncollected premium and annuity considerations are addressed in SSAP No. 51. Per SSAP No. 51, uncollected premiums are gross premiums that	CR, LQ

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	are due and unpaid as of the reporting date, net of loading. Per SSAP No. 51, deferred premiums are modal (monthly, quarterly, semiannual) premium payments due after the valuation date, but before the next contract anniversary date. Reserves are calculated assuming payment of the current policy year's entire net annual premium, but the actual premiums are often paid in installments throughout the year. As such, reserves are overstated by the amount of modal premiums (net of loading) due between the valuation date and the next contract anniversary date. As a result, this asset is reported to offset the overstatement of the policy reserve. Deferred premium assets represent a liability offset and cannot be liquidated for solvency needs. The analyst should examine deferred premium assets in relation to total assets to help identify a liquidity problem. Additionally, high concentrations of uncollected premiums could point to collection problems and persistency problems.	
N.A.	Loading is the difference between net and gross premium. It represents the portion of a product's price designed to reimburse the insurer for its operating expenses, specifically commissions, premium taxes, and general operating expenses (excluding benefit and investment costs). Both uncollected and deferred assets are reported net of loading. This difference of recording the premium revenue and the corresponding asset requires that the change in the loading amount thereon for the period be recorded as an expense. When the load is negative (i.e., net premium is greater than the gross premium), it represents a deficiency reserve. Companies use deficiency reserves to lower the cost of a policy either to gain market share or because their own mortality experience is significantly better than the assumptions used in statutory accounting. Deficiency reserves, as captured in Exhibit 5, should be examined to determine if the insurer is relying too heavily on its experience to cover loading related expenses.	CR, LQ

Note 35 – Separate Accounts (L/AH/F)

This Note discloses detailed information on the reporting entity's separate account activity, a description of the general nature and characteristics of separate accounts business conducted by the insurer included in the company's Separate Accounts Statement as prescribed by *SSAP No. 56—Separate Accounts*, and a reconciliation of the amounts reported as transfers between the general and separate accounts in their respective summary of operations.

Separate accounts are authorized by state statutes to allow insurance companies to accumulate assets without investment restrictions for specific purposes pursuant to product agreements. SSAP No. 56 defines separate accounts as segregated pools of assets owned by a Life/Health insurer in which the investment experience is credited directly to the participating policies. Generally, performance is not guaranteed. Separate accounts were first used primarily to fund pension accounts. Now they are used for investment type products with unique life options and/or guaranteed returns. The investment income and any realized and unrealized capital gains or losses emanating from the separate account assets are credited or charged against the separate account policyholders. Separate accounts fund the liabilities for variable life insurance and annuities, modified guaranteed life insurance and annuities, or various group contracts under pension or other employee benefit plans.

SSAP No. 56 states that the separate account statement reports the assets, liabilities and operations of the separate account. Moreover, the Separate Accounts Annual Statement is concerned primarily with the recording of the cash flow of funds related to investment activities and obligations of the separate accounts and to document the transfer of funds between the separate account and the general account. Certain products found in the separate accounts contain risks that are the responsibility of the general account. Some of these are: Modified Guaranteed Annuities, Modified Guaranteed Life, and separate accounts established and filed with the regulator that provide guaranteed benefits – such as interest rate guarantees built into the product.

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Section		*Risks*
A	Section (A) provides a detailed summary of the general nature of the reporting entity's separate account activity on the general account. In reviewing this note, the analyst should be able to identify those assets on the separate account that are legally isolated from claims on the general account. This note should also provide a total for those products on the separate account that have guarantees that are backed by the general account. This should include providing the total maximum guarantees, the amount of risk charges paid to the general account over the prior five-year period as compensation for the risk transferred to the general account and the total amount of guarantees paid by the general account to the separate account over the past five years. The analyst should gain an understanding of general account guarantees on separate account products. If the General Interrogatories indicate that the insurer provides guarantees on separate account assets, then there should be some risk charges paid to general accounts. Otherwise the insurer is not charging any risk fees for providing guarantees that could result in contingent liabilities to the general account. Note that while group products require risk charges, there may be no requirements for risk charges on individual products. The analyst should determine whether there were any securities lending transactions within the separate account and conduct a separate review of the amount of loaned securities within the separate account. The analyst should determine whether the investment policies and procedures for the separate account differ from those for the general account. *Note that new reporting in Note 35A for disclosures where the general account provides an inherent or ultimate guarantee, such as with pension risk transfer (PRT) or registered index-linked annuity (RILA) products, and other related disclosures (2025-09BWG and SSAP Ref. #2024-10), are effective for 1-1-2026; however, early adoption is permitted and disclosures may be available at Annual 2025 for insurers who adopt early. The disclosures identify if reisk charges have been provied to the general account, confirm the inclusion of these separate account produts within asset-liability testing, discuss securities lending and repurchase/reverse repurchase agreements in the separate account, and fair value of asset transfers that do not reflect sales in eschange for cash beteen the general account and separate account.*	OP, RV
B	Section (B) focuses primarily on the impact that separate accounts activities may have on the general account. It should help to answer the question, to what extent is the general account at risk due to the separate account products. Most of the exposure to the general account is caused by the nature and structure of the products held in the separate account. The general account may have inherent financial risk due to the potential deficiency in the assets of separate accounts backing minimum payment or guarantee products. An example is a variable annuity contract containing a guarantee for the return of consideration paid on the death of the contract holder occurring within a certain time period. Any excess of the benefit paid over the separate account asset value is charged against the general account. The analyst should determine whether and to what extent the general account is at risk. Part A is the most critical for making that determination. With many of the separate account products, the policyholder absorbs the entire investment risk. However, other types of separate accounts products include guarantees in the form of minimum death benefits, minimum interest rates and waiver of surrender charge under certain conditions. Any minimum guaranteed obligation must be recorded on the general account of the insurer since, by definition, the entire asset transferred to the separate account is at risk.	OP, RV

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	More specifically the analyst should review the information provided in this section of the Note to determine if the company (general account) has any liability to its separate account caused by imbedded obligations or guarantees granted to products recorded in the separate account. They should evaluate the quantitative breakdown for each of the risk categories – indexed, non-indexed, with guaranteed rates no greater than 4%, with rates greater than 4%, etc. – as reported to determine whether the amounts are large enough to cause significant risk to the general account. In the case of investments involving equity indexed separate accounts, the risk to the general account is normally minimal. The risk on these products is normally minimal because investments are usually hedged. Non-indexed separate accounts with interest guarantees in excess of a year that do not exceed 4% are moderately risky. The risk on these products is moderate because in a market downturn, the insurer could have difficulty providing this return, but in most cases, the guarantee should be easily obtained. However, this risk would generally have to be picked up by the general account. Non-indexed separate accounts with an interest guarantee in excess of a year that exceeds 4% are at the highest risk. The risk on these products can be high because in a market downturn, the insurer may not be able to meet the guarantee with the assets supporting the risk. Non-guaranteed separate accounts consist of variable separate accounts where the benefit is determined by the performance and/or market value of the investments held in the separate account. The accounts are low risk, nominal expense and minimum death benefit guarantees. The analyst should note whether the reserves were established with withdrawal characteristics such as subject to discretionary withdrawal, have a market value adjustment or withdrawal at book value without a market value adjustment and with or without surrender charge. The analyst should refer to Note 12 for further discussion of various types of liquidity risk for the various products. However, in most cases, liquidity risk for the insurance company for most separate account products is limited.	
C	In Section C, the analyst should verify whether the reconciliation provided by the insurer disclosing the amount reported as transfers to and from separate accounts in the Summary of Operations of the separate account statement agrees to the amount reported as net transfers to or from separate accounts in the Summary of Operations of the general account statement.	OP, RV

Note 36 – Loss/Claim Adjustment Expenses (L/AH/F)

This Note discloses the balance of liabilities for unpaid loss/claim adjustment expenses, incurred loss/claim adjustment expenses, the payment of loss/claim adjustment expenses and estimates of the average salvage and subrogation. Life and annuity contracts are not subject to this disclosure requirement.

Section		*Risks*
1–3	The reporting of claim liabilities and claims adjustment expenses are addressed in SSAP No. 55. SSAP No. 55 addresses claim adjustment expenses on A&H contracts and managed care contracts. Claims adjustment expenses are those costs that are expected to be incurred in connection with the adjustment and recording of A&H claims. Certain claim adjustment expenses reduce the number or cost of health services thereby resulting in lower premiums or lower premium increases. Claims adjustment expenses can be divided into cost containment expenses and other claim adjustment expenses and are further defined in SSAP No. 55. An analyst should review the Note and the liability for unpaid claims, unpaid losses and loss/claim adjustment expenses to determine if they appear reasonable. Further analysis	RV

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	may be necessary to determine if the method used to calculate the liability is consistent with SSAP No. 55. If the reserve development and/or the company's response to the Note cause the analyst some concern, prior reserve analyses may be reviewed or the analyst may need to question the company's reserves and loss/claim adjustment expenses and address supplemental procedures for reserves.	
4	Salvage refers to the amount received by an insurer for property on which the insurer has paid a claim. Subrogation refers to the right of an insurer to pursue any course of action against a third party for a loss to an insured for which the insurer has paid a claim and to receive reimbursement from the third party. SSAP No. 55 states that the estimated amounts of salvage and subrogation recoverables shall be determined in a manner consistent with the accounting guidance for estimating the liability for claim reserves, claim liabilities, unpaid losses and loss/claim adjustment expenses. Salvage and subrogation are deducted from the liabilities for unpaid claims or losses.	RV

HEALTH INSURERS

Note 31 – Anticipated Salvage and Subrogation (H)

This Note requires a health entity to disclose salvage and subrogation recoverables. The accounting guidance for salvage and subrogation is included in SSAP No. 55. Salvage refers to the amount received by a health entity for property on which the health entity has paid a claim. Subrogation refers to the right of a health entity to pursue any course of action against a third party for a loss to an insured for which the health entity has paid a claim and to receive reimbursement from the third party. SSAP No. 55 states that the estimated amounts of salvage and subrogation recoverables shall be determined in a manner consistent with the accounting guidance within the SSAP for estimating the liability for claim reserves, claim liabilities, unpaid losses and loss/claim adjustment expenses. Salvage and subrogation are deducted from the liabilities for unpaid claims or losses.

Section		*Risks*
N.A.	SSAP No. 55 requires a health entity to disclose estimates of anticipated salvage and subrogation including amounts recoverable from second injury funds, other governmental agencies, or quasi-governmental agencies, where applicable. An analyst should review the Note and the liability for unpaid claims and losses to determine if the estimated recoverable appears reasonable. Further analysis may be necessary to determine if the method used to calculate the recoverable is consistent with SSAP No. 55 and to determine the impact on the balance sheet of any large recoverable amounts.	RV

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Medical Insurance Markets

There are a number of different entities that are licensed or authorized to do business in Health insurance. These entities may be licensed differently and subject to entity specific accounting rules and regulations. They may also report their annual and quarterly financial data on differing NAIC statement blanks and calculate risk-based capital (RBC) requirements on entity specific RBC blanks. Although some differences in treatment remain, codification and changes in reporting blank requirements and RBC rules recognize the similarities between these types of entities. In addition, the various types of entities may focus on differing methods of providing health coverage. Health insurance is a very encompassing line of business. It includes the primary lines, comprehensive major medical, dental and vision, plus similar products, but it also includes disability, long-term care (LTC) and other non-traditional health coverage that entities covered by this Handbook may underwrite.

The primary risk for Health entities in the medical insurance market is that the premiums charged may not cover the cost of the services provided or benefits paid. This can happen when health care cost increases are more than those estimated when premiums are calculated. Health care insurance premiums are driven primarily by the claims costs that they pay for. Rising health care costs and the related increase in the numbers of uninsureds are topics of national concern, but few understand all of the forces behind these issues and how they affect health entities. Health care claims costs are driven by the overall cost of health care and the increase in the number and types of services covered.

1. Different Types of Health Carriers

Many Blue Cross Blue Shield Plans and Delta Dental plans are licensed as Hospital, Medical and Dental Service or Indemnity Corporations (HMDIs). Health Maintenance Organizations (HMOs) generally provide prepaid health service and may be licensed by State Insurance Departments and/or issued Certificates of Authority by other state regulatory bodies (e.g., the State Department of Health). Health entities licensed as Limited Health Service Organizations (LHSOs) are organized to provide a single specific type of coverage such as dental or vision.

The HMDIs, HMOs and LHSOs were consolidated into one statutory financial reporting blank and one RBC formula in 2001. Although the accounting has been standardized, each are subject to state laws and regulations based upon their state license. These entities generally issue managed care contracts that pay participating providers of medical care directly with limited expense to the policyholder. HMDIs tend to provide service benefits via Preferred Provider Organizations (PPO) and HMO lines of business, and some offer indemnity policies similar to those offered by Life and Accident and Health (Life/A&H) insurers and Property/Casualty (P/C) insurers.

Companies licensed as Life or A&H file the Life/A&H blank and use the Life RBC formula. Some Blue Cross Blue Shield Plans are licensed as Life/A&H carriers, possibly with a separate income statement and supporting exhibits for the HMO line. Companies filing the Life/A&H blank are subject to some accounting rules that differ from the rules followed by Health blank or P/C blank companies (e.g., mostly involving the Asset Valuation Reserve (AVR) and Interest Maintenance Reserve (IMR) requirements). The Life RBC formula often results in higher RBC requirements due to its treatment of individual health insurance and other factors. After the Health Statement Test is implemented, a company that writes more than 95% health[1] will use the Health RBC formula and file the Health blank and hence will be considered a health entity for purposes of this handbook, but the company will still be subject to some laws and regulations specific to Life/A&H insurers such as the Standard Valuation Law. Life insurers will be required to perform asset adequacy analysis pursuant to the requirements of the state's valuation manual. In contrast to most asset

[1] For the purposes of the Health Statement Test, "health" is defined to include comprehensive major medical, dental and vision, plus similar products. Premiums for health coverage like disability income (DI) and long-term care insurance (LTCI) do not count toward the 95% requirement. The 95% rule must be passed based on both earned premiums and reserves.

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adequacy analysis, for most health entities, it will generally be sufficient to consider the adequacy of the future premiums (assuming that short-term assets exceed short-term liabilities).

State law may also permit insurance companies to be licensed to write only A&H business. Such insurance companies generally will not be subject to the Standard Valuation Law and will file a Health blank.

P/C companies also have certain accounting standards that are not applicable to health entities**,** a different statutory blank, and a different RBC formula. There are a small number of Blue Cross Blue Shield Plans that are licensed as P/C carriers. After the Health Statement Test is implemented, a P/C company that meets the Health Statement Test will use the health RBC formula and file the Health blank.

Life/A&H insurers and P/C insurers generally issue indemnity policies, which reimburse policyholders a set dollar amount for claims they pay or make direct payments to providers who have been assigned payments (under the policy), by the policyholder.

Many health entities develop their own PPOs that sometimes resemble HMOs. There are several large national provider groups—Independent Provider Associations (IPAs)—that have created PPOs, contracting with providers for discounts and entering into contracts with insurers to supplement insurers' networks locally or nationally to render health services to policyholders of the health entity. PPOs can also perform medical management such as utilization review and inpatient pre-authorization. IPAs are normally not allowed to assume insurance risk for the services provided by its contracted providers and often contract directly with self-funded employers. In some states, IPAs are required to be licensed by the Insurance Department.

A term that is sometimes used is "risk bearing entity" (RBE). While in the past RBE has often been used as a generic term for any type of entity that is taking on insurance type risk, the *Health Maintenance Organization Model Act* (#430), NAIC uses the term RBE to refer specifically to provider groups and similar unlicensed entities that take insurance type risks from health entities. In some states, RBEs are required to do special reporting to insurance regulators, and some states require special licenses for RBEs to monitor for solvency. This occurred in the early years when IPAs were paid a capitation for services and then paid the contracted providers on a reduced fee-for-service basis as they are assuming insurance risk. If the IPA became insolvent because the costs of health care being provided were more than the capitation payments, the health entity was responsible for finding other providers for its members. Over the past 10 years, such network arrangements have become more commonplace, and more attention has been paid to ensure financial solvency. New payment arrangements, with more sophisticated technology to enable them, are now seen. Federal programs to encourage value-based payment and the development of Accountable Care Organizations (ACOs) have stimulated providers and insurers to work together as well.

More detail on types of coverage and underlying arrangements is presented in the Health Lines of Business section.

2. Health Care Cost Increases – General

Pressures come from many directions - from new technologies, new specialty drugs, new medical devices, new treatments, new ways to provide health care, an increased number of preventive care mandates that help in identifying underlying conditions, and mandated requirements to cover additional services. Health entities in the voluntary market face the financial pressures to keep premiums down while still covering all the services they insure. Overall, the cost of health care is increasing much more than general inflation.

Despite the common belief that the aging of America and the high cost of medical malpractice are driving these costs, those factors are not the main drivers of the increase in health care premiums. The key drivers of health care premium increases are advances in medical technology and subsequent increases in utilization, excess price inflation for medical services, drugs and the new biologics, cost-shifting, the high cost of regulatory compliance, and patient lifestyle choices (e.g., physical inactivity and increases in obesity). The overall cost of health care also increases as the services are used more. The average number of services used by Americans is also increasing. As with any industry, use of services increases with advertisement.

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Aggressive prescription drug advertising stimulates increased use of many prescription drugs. And lower co-payments for prescriptions have masked the true cost to the consumer and contributed to higher demand.

We see more cures for certain conditions and more treatments for cancer. Yet new treatments, technology and drugs add cost to the health care market in two ways. First, they provide new and often expensive services to the range of treatments available. Second, those procedures, along with the use of long-term treatments or drugs—sometimes for the rest of the patient's life—potentially add many years of higher health care consumption to a person's life.

3. Health Care Cost Increases – Insurance Issues

The cost of health insurance is affected by the factors that contribute to overall health care costs, and by economic pressures. First, when services are covered by insurance there is a tendency by individuals to use more services. An individual that has to pay for services directly may decide that they are not worth the cost, but if the services are virtually free to the consumer or are available at a significantly reduced cost, then the individual will have more of a tendency to utilize them.

Individuals with high health care costs are more likely to purchase more comprehensive insurance and are less likely to drop their coverage. In a totally voluntary health insurance market, segments of the market would become too expensive as self-selection (also known as adverse-selection or anti-selection) crowds out the price-sensitive healthy individuals, leaving the frequent users of health care. The health insurance market in the United States is primarily paid for by employers, with employees paying only a small part of their insurance premiums. This eliminates many of the problems of self-selection, but its effects on premiums can be seen in the individual and small group markets where there is more self-selection. The changes made in the individual and small group markets since the federal Affordable Care Act (ACA) went into effect beginning in 2010—and with revised market rules, essential health benefits (EHB) mandate, and health insurance exchanges and the Small Business Health Options Program (SHOP) that went into effect January 1, 2014—saw the challenges of adverse selection. Health entities have to be careful that their benefit designs are not appreciably richer than the competition or include benefits not found elsewhere in the market, as they run the risk that self-selection will drive up their health care claims cost.

Legislators have often urged coverage for health care services that might otherwise not be covered by insurers in their states. Sometimes providers whose services are not covered under health policies lobby state officials to mandate their services be covered. At other times, individuals with special needs, or their public advocates, lobby to have benefits, such as treatments for infertility, covered by all health plans. As these benefits are mandated, they lead to more utilization in the insured population than prior to the mandate, thereby increasing the health care costs of insured individuals.

Another reason that the cost of health insurance may increase faster than overall health care costs is "deductible leveraging." This phenomenon occurs when the insured person must pay some "corridor" amount that is not covered by the insurance policy (first-dollar deductible, copayment, etc.), and the corridor is not proportionate to the full claim amount. Deductible leveraging reflects the fact that, if the insured person's responsibility for payment is limited to a fixed dollar amount, then the health entity must pay the entirety of any remaining medical cost increase and not just a proportionate share. This perhaps can be seen most clearly from an example. Insurance coverage provides for payment of medical expenses in excess of a $1,000 deductible. If a person's medical expenses are $1,500, the health entity will pay $500. If the expenses increase by 10% in the next year, to $1,650, and the deductible has not been changed, then the health entity will pay $650, an increase of 30% over the health entity's prior-year payment of $500. Since the health entity's expense has increased 30%, that increase, and not merely the underlying 10% increase, will have to be reflected in premium rates. The impact of deductible leveraging can be mitigated only by shifting additional costs directly to the insured. It is noted that many plans adjust their copayments and deductibles for inflation on an annual basis.

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The combination of the general and insurance cost increases described above have resulted in two phenomena. First is an increase in Employment Retirement Income Security Act (ERISA) uninsured plans. These plans are often administered by health entities and are referred to as Administrative Service Only (ASO) or Administrative Service Contract (ASC) plans. The plan designs and coverages are more flexible and are not regulated by State Insurance Departments. Second is an increase in the number of employers discontinuing sponsored coverage, leading to increases in the number of uninsured and in the size of the voluntary individual market.

The issue of increased cost and its impact on availability can be addressed through various risk sharing methods including the following:

- Premium risk sharing – the most obvious is experience rating of large employers.
- Claim risk sharing – the use of deductibles and coinsurance or co-pays shares the risk with the claimant and is designed to encourage the use of only necessary services.
- Health Savings Accounts (HSAs) – the use of a federally qualified high-deductible health plan (HDHP) linked to a health savings account is increasingly used by employers that contribute to the dedicated health savings account[2] (that is portable, belonging to the employee/accountholder) that employees can use in covering the deductible and other federal tax-eligible health expenses.
- Provider risk sharing – the use of capitation, withholds, provider discounts, bundled payments, value-based payments and plans to encourage quality care through bonuses, shared savings and shared risks programs that share the risks and rewards of effective health coverage with the providers.
- Stop-loss risk – this risk relates to infrequent but very high cost claims. Health entities may transfer this risk through excess-of-loss reinsurance. For individual stop-loss coverage, the reinsurer provides payments to the health entity when a single claim exceeds a specified loss figure, generally called retention. Stop-loss may have a high individual limit (above the limit applied to an individual, where the health entity is assuming risk, the health entity would be at risk) and/or an aggregate limit (e.g., when the total claims for the group exceeds some factor times the expected claims).

  Integrated health plans, which are health care providers and health systems that offer integrated health insurance, also use stop-loss coverage. And health entities also assume individual or aggregate stop-loss risk from other health entities. Health entities also assume the risk of infrequent but very high-cost claims from self-insured employers having ASO/ASC contracts or from capitated providers. To attract ASO business or encourage provider risk-sharing, the health entity may need to offer insurance (assume the risk) against the most costly claims.

  A health entity's past experience when using any of these risk-sharing approaches should be part of the analyst's assessment. Note that the manner in which they can be used will differ from market to market.

4. Regulatory Landscape

The health insurance industry is highly regulated. Besides the mandated benefits and review of payment methodologies mentioned above, there are state and federal regulations in financial and non-financial operations of all health entities. Historically, insurance has been regulated at the state level, unless preempted by ERISA. In recent history, there are more and more federal laws and regulation of health entities. Typically, the federal regulation will prevail unless the state regulation is more restrictive.

Analysts should be familiar with federal regulations on a high level and have a detailed understanding of state regulations that affect financial issues. On a federal level, ERISA preempts self-insured employer

[2] A health savings account (HAS) is a tax-exempt trust or custodial account the employee sets up with a qualified HSA trustee to pay or reimburse certain medical expenses they incur. To be eligible for an HSA, the individual must be enrolled in a high-deductible health plan (HDHP).

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groups from state laws. The self-funded uninsured plans are exempt from premium tax and state mandated benefits. The Health Insurance Portability and Availability Act (HIPAA) is a federal law that, among other things, specifies requirements for guarantee issue and renewability for individual and small group health insurance. HIPAA also has rules for claims data coding and privacy of health information. HIPAA was also amended by the ACA, and subsequent rulemaking regarding individual and small group product renewals, modifications and terminations has gone into effect after Jan. 1, 2014.

One of the risks that health entities face is state or federal requirements that they did not anticipate when pricing their products, or the risk that the cost of complying is higher than they estimated when calculating premiums. A health entity can be placed at a competitive disadvantage if it is subject to a state law that does not affect its competitors. This happens when a law applies to one segment of the market and not to another. For example, certain health entities may be subject to certain state rating restrictions that do not apply to other types of health entities.

The ACA included new rate review requirements for state insurance regulators that went into effect in 2012 and rate filing requirements for health entities that went into effect Jan. 1, 2014. The ACA medical loss ratio (MLR) provision went into effect in 2011. This ACA provision requires health insurance companies to spend no less than 80% in the individual and small group market and 85% of premium dollars in the large group market on health and medical care quality improvement, or else be required to provide a rebate to their policyholders. The NAIC Annual Statement Supplemental Healthcare Exhibit assists state insurance states regulators in identifying the unadjusted components that comprise the MLR calculation (not the final federal MLR). The exhibit is also intended to provide a means to compare individual financial results of healthcare business and its impact upon insurance companies.

State health insurance regulation covers both financial and market conduct. Financial regulations include deposit requirements, RBC requirements, and mandated benefits. Market conduct requirements can affect financial strength if they become expensive to administer, such as adding to costs by reducing the ability to control waste and fraud or through defensive medical insurance administration. Certain entities such as HMOs have some or all aspects of their business regulated by state agencies other than the state insurance department.

Guaranty Associations – In the event that a health entity becomes insolvent, a state guaranty association may make payment of claims for which the insolvent entity does not have sufficient funds, within prescribed limits. (Note that HMOs are not members of guaranty associations in all states, and in states where HMOs are not members, the claims of insolvent HMOs will not be paid by the associations.) The cost of funding these benefits is assessed against the association members, who may in turn receive the right to offset their assessments against future premium tax payments or to recover the assessments by some other means such as premium surcharges.

For HMOs, most states have adopted some version of Model #430, which protects policyholders in several ways. If an HMO becomes insolvent, the other HMOs in the state are obligated to issue policies to the "orphaned" policyholders of the insolvent entity. Also, all HMO contracts with network providers must include clauses that the providers will "hold harmless" or not bill policyholders for services if the HMO is unable to pay. These protections do not protect policyholders from non-network provider claims and do not guarantee the policyholders can purchase coverage at their current premium rates or have access to their current providers.

State law may also require HMOs to establish a plan to address the risk of insolvency in order to ensure at least temporary continuation of coverage to policyholders. Some of the methods used may include insolvency reinsurance, special deposits and third-party financial guarantees.

5. Public Insurance Products

Public health care programs, including Medicare and Medicaid, cover a large portion of the population. Medicare and Medicaid mitigate their costs by paying enabled reduced amounts to providers that are set by

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law. Every year, the cost trends for Medicare and Medicaid must be within governmental budgets. Since these cost trends are, as a result, frequently lower than the increase in medical inflation, the result is "cost shifting" to hospitals and physicians, who then may charge more to non-Medicare and non-Medicaid patients in order to make up the difference. This cost shifting exacerbates the tendency for private (non-public) health insurance costs to increase at a rate exceeding the overall rate of medical inflation. States have increasingly used Medicaid funded programs to insure children and the working poor to counteract the increase in the uninsured population. Most public health products are fully supported by federal or state programs (Medicare and Medicaid) although some health entities may also be involved on a risk-taking basis. In most of these cases, the health entity must provide all the care/benefits that the program requires but is paid a fixed fee by the program (e.g., Medicaid HMOs, Medicaid Managed Care Organizations (MCOs), and Medicare Advantage and Medicare Part D for prescription drugs). These sub-markets involving health entities have different risks than the primary markets (non-government) since the primary markets do not have fiscal constraints. The Health Lines of Business section below will describe these risks.

Public Employee Plans – Many states provide health coverage for their employees through contracts with a health entity. Regardless of whether the health entity retains the risk, or whether the state retains the risk, and the health entity serves as administrator, these are really no different than private insured plans or uninsured ASO/ASC plans of large employers, with one exception. Frequently because of budget problems, the state may have temporary difficulty keeping the funding of its health coverage current. While statutory accounting does not require receivables from state groups and other large public programs to be non-admitted after 90 days. Analysts should make sure that the amount held is truly payable within a reasonable time.

Assessment Plans – Some health coverage may be provided through programs where the premium is not intended to cover the health care costs and administration (e.g., high risk pools or small employer reinsurance pools) and health entities are subject to assessments for the pool's deficiency. Assessments may be required to cover the costs of the insolvency of another health carrier or health entity through a state's guaranty fund assessments. Assessments may be prescribed by legislatures to address unpaid amounts demanded by providers. In most situations these assessments are reasonably small but cannot be forecasted with any accuracy. Analysts should review the history of assessments paid by the entity and any requests that are outstanding to determine that appropriate liabilities have been established, and premium adequacy tests reflect anticipated costs. Note that most of these assessment programs have escape clauses so that health entities in financial trouble do not have to pay their assessments. Unfortunately, few health entities are willing to request this public declaration of financial trouble because of the impact on their business.

Assigned Risk Plans – Some health coverage may be "forced issue" of standard rate coverage to a proportional share of a high-risk market (uninsurable or group-to-individual HIPAA eligibles). The inadequate revenue from these few individuals is expected to be subsidized within the standard rate for all lives. Proper recognition of the additional risk in premium assumptions is necessary, so that there is an adequate margin to cover potential additional costs of "after-the-fact" adjustments.

6. Private Insurance Products

These products make up the voluntary market as the insured (employer, employee, and individual) may decide to start or continue coverage by paying the required premium. As these premiums increase, the insured may opt to revise benefits or even drop the coverage. Health entities must, generally, renew any policy already issued unless they can offer similar policies to replace a terminated product (a HIPAA product withdrawal, which requires 90-day notices by federal law and in most states). If they have no other products to offer in that market (individual market or small group market) it would be considered a market exit, which would prohibit the health insurer from reentering that market for five years (a HIPAA market exit requires 180 days' notice by federal law). As noted elsewhere, some of the markets have specific additional requirements for guaranteed issues or mandated benefits and premium subsidization. These are described

in the Health Lines of Business section.

Health Lines of Business

This section describes the variations in lines of health insurance that can be written by a health entity. The Product Types section will describe in more detail the additional distinctions within the primary line of health coverage – comprehensive major medical.

These variations arise from the nature of the relationship between the health entity and the insured population, and the type or types of coverage provided by contract, including variations in provider networks and in processing.

Nature of the Relationship

The relationship may be direct (Individual), through employment (Employer Group), by affiliation (Association) or under a government-sponsored/subsidized arrangement. Distinctive risks for each of these relationships will differ by the type of coverage and will be discussed within the next subsection below.

- Individual coverage represents a small portion of the primary health coverage but is a larger share of certain other lines (disability income, LTC, specified disease and Medicare supplement). The contract may cover the insured as well as family members. The renewal provisions of individual contracts are important. Prior to the ACA, medical underwriting in the individual comprehensive insurance meant that if the insurance was cancelled, many of the insureds were not able to replace it because of their poor health. The ACA required the elimination of non-coverage of pre-existing conditions in the individual and small group markets beginning Jan. 1, 2014.[3] (Recent federal legislation is considering repeal of some portions of the ACA, but this is an area unlikely to change.)
- Employer Group coverage represents the largest portion of the primary health coverage lines and a growing portion for most other lines. The market needs to be sub-categorized into components because the regulations (and risks) of each sub-category are very different.
    - Small Group Market – Group size depends on state laws but is generally from 2-50 employees and applies only to primary health coverage. States (with limits defined by HIPAA) have adopted specific laws for guaranteed issue to these groups. Employers pay the premium with employees sharing the cost on a non-discriminatory basis (i.e., rates can vary depending on the age of the employee, the number of family members covered and location, but not based upon the employee's health). Some states mandate full community rating in this market. The ACA market rules mandate a version of adjusted community rating that allows age, number of family members covered, geography and smoking/non-smoking to be considered. ERISA rules allow for regulation of the insurance contract and most contracts are for participants all living in a single state, but some may include variations in benefits by state of residence of the insured employee to meet state mandates.
    - Large Group Market – Groups that are larger than the state definition of small group and again apply to primary health coverage. There generally are no guaranteed issue policies in this market, but there is also little problem for these groups to obtain coverage given their size and internal ability to spread risk. Employers pay the premiums with employees sharing the cost (generally only varies by employee-only versus family coverage) although many of these employers offer more than one plan to employees. This aspect creates potential risk for the health entity offering the richest benefit package unless the employee share is substantially higher than for other packages. Rates for this market are generally set based upon the experience of the group. In addition, the largest of these groups have considerable

[3] *https://www.gpo.gov/fdsys/pkg/CFR-2010-title45-vol1/pdf/CFR-2010-title45-vol1-sec147-108.pdf*.

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options for risk sharing, from fully insured, to complete retention of risk through ASO/ASC, to high deductible minimum premium policies or retrospective experience rating.

- Association Health Plans – Primary health coverage may be available for many employers (some are structured for individual professionals) through a common association. These arrangements will provide similar coverage and pooling to the employers (or individuals) who participate. Currently, these arrangements use a health entity to provide the insurance and the contract is subject to varying state regulation depending on the status of the contract and the manner in which states deal with certificates for out-of-state groups. The ACA affected individual professionals in Association Health Plans as owner-operators with no employees were not able to obtain group coverage through Association Health Plans but were rated as individuals.
- Other Types of Coverage – Most other types of employer-based coverage will be described below as a part of Affiliation coverage. Three areas of broad employer coverage are disability income (DI) coverage (which may be employer-pay or employee-pay but the benefits are defined in terms of salary and long-term disability versus short-term disability), Accidental Death & Dismemberment (which is provided or offered as multiples of annual salary) and cafeteria plans (where the employer contribution and additional pre-tax employee salary reductions can be used to select from a list of health and non-health benefits – this approach again creates risk to health entities with rich benefit packages).

- Affiliation coverage includes both primary health coverage (Association Health Plans above) as well as most other types of coverage. The affiliation may be the employer (but without any contribution), an association (e.g., American Association of Retired Persons (AARP)), a labor union or an interest group (Sierra Club). Besides primary health coverage, this can include the sale of limited pay/supplemental coverage ("workplace" sales of accident, specified disease, hospital indemnity, etc.), Medicare supplement, disability income, and LTC using a group contract where the certificate comes close to an individual policy contract. Premiums may be based on the entire group, the group within a state or the actual individual (with underwriting based premium variations - substandard, non-tobacco use discounts, etc.).
- Government Sponsored/Subsidized Arrangements include primary health care (Federal Employees Health Benefit Plan (FEHBP), Children's Health Insurance Plans (CHIP), Medicaid, Medicare Advantage), as well as the federal Long-Term Care Insurance (LTCI) offering to government employees, retirees, and military. When government units act as the employer, the coverage would be included in the above sections since these arrangements do not have unique risks. The ones mentioned in this paragraph have the 'normal' insurance risk plus added risks that deal with the federal regulations involved as well as the frequent exemption from state regulations.

Types of Coverage

The characteristics of each type of coverage that define the risks derive from the manner in which benefits are provided (breadth of coverage), the effect of changes in medicine and delivery of medical care (morbidity and claim costs) and specific regulations that apply (e.g., individual health insurance exchange Qualified Health Plans (QHPs), SHOP, Small Employer regulations, Medicare supplement standardized plans, LTC level premium and inflationary protection).

- Individual – Prior to the ACA, comprehensive coverage was frequently underwritten and, therefore, subject to rate variations based on the applicant's health to offset self-selection. States varied allowable underwriting practices and addressed the availability of individual coverage for people who met HIPAA eligibility for Group-to-Individual conversion. The unique risks for this market are the heightened impact of self-selection (both at issue and through the effects of healthier individuals lapsing coverage). However, the ACA's permanent risk adjustment program is intended to mitigate that risk by reallocating premium among issuers based primarily on the health status of individuals. There are high administrative costs relative to other relationship arrangements, both annually and for acquisition of new business. The increased access under the ACA for the uninsured through state or federally facilitated health exchanges added additional

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administrative costs for QHP insurers and represented increased risk volatility and higher claims costs in the individual market. Each year since 2010, there were mandated changes in coverage or market rules, creating more regulatory challenges in the individual insurance market. From a regulatory point of view, this market will typically be a smaller portion of the health entity's total business.

One aspect of risk is to review the health entity's participation in a state's health benefit exchange, or the state's other provision for offering coverage to the uninsured and HIPAA eligible. States may use various approaches—such as high-risk pools, reinsurance pools or group conversion policies—other than through an assessment or may require all or some to offer specific coverage even if the individual would not pass normal underwriting rules. These are issues that may be reconsidered by Congress, and if given the option to do so, in the states.

- Small Employer – Variations by state are key in determining the unique risks for this market. Prior to the ACA, state insurance regulators would need to consider the benefit packages that were required to be offered and pricing allowances for demographic differences (e.g., age, sex, location) or health (claims experience and morbidity). Post ACA, each state selected the EHB package that would be required beginning on Jan. 1, 2014 (except for pre-2010 grandfathered plans or pre-2014 grand mothered plans). The ACA adjusted community rating also eliminated rating by gender, industry or health status. The degree of limitations and the share of the market together create different levels of risk to health entities. Some allowances for demographics and/or health allow companies with a small share of the market to participate while the lack of any pricing allowance (i.e., community rating) presents a much higher risk for a company with a 1% share than a company with a 25% or greater share, since it is unlikely that all companies will end up with exactly their share of the small employers with the highest actual costs. As in the case of individual coverage, the ACA's permanent risk adjustment program is intended to mitigate the associated risk. In addition, administrative costs are higher for small employers than for large employers where much of the administrative work is done by the employer's own staff or through consultants and TPAs. Most small employers rely on the health entity and its local agent or broker to provide these services.

  Small employers appear to be more willing to change carriers (price sensitive), as they are less involved in the administrative details and fewer people are affected than when a large employer changes carriers. This creates greater potential for self-selection by small employers, particularly for the very small employers with two to five employees where the "boss" may be aware of the need for medical care by key employees and revise/obtain coverage to meet those needs.

  Some small employers seeking lower costs are using self-insurance with stop-loss coverage to avoid state mandates and allow greater flexibility in rating – they can avoid subsidizing other small groups when their own employees and families are healthy. Others may seek to avoid paying for the high-cost individuals by looking for ways to have these individuals find non-group coverage. Some states enacted purchasing groups or alliances for small groups. By early 2009, at least 28 states had created or authorized such cooperatives by state law or regulation. However, many of those programs are no longer operational, utilizing the standards of the ACA small group markets instead.

- Large Employer – This market is less affected by self-selection at the employer level (contracts can offer experience rating or the use of ASO/ASC). There is little subsidy of less healthy groups as the rates are designed to cover the actual costs for each employer and the implications of changing plans is dealt with annually prior to offering choices to employees. This market will frequently use and directly pay benefit consultants and TPAs to meet specific needs (e.g., Request for Proposals for specified benefit packages, enrollment and claims management), so the premiums have less expenses included.

  A health entity's risk in this market relates to the impact of losses from experience rated contracts (since an employer's health plan gains on an experience rated contract cannot be used to offset losses, the ability of the health entity to "carry-forward" and recover some portion of the gains in later years is dependent upon the employer remaining with the health entity until the recovery or forgiveness of the employer's experience rated gain) and the potential impact of employee choice among health plans with different

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"price/benefit" options. Cafeteria plans are the most frequent basis for presenting these offerings on an annual basis to employees. Current health status will affect the employee's own choice – to pay more for richer benefits that will meet the medical need versus paying much less for a high deductible option when no use of the coverage is anticipated.

- Association Health Plan – This market has unique risks in the manner in which the actual members obtain coverage and in the retention of members. In addition, increased state and federal regulatory oversight may add to administrative costs or limit the areas where the plan can be marketed or the market to which it can be marketed.

- FEHBP – This market is subject to very different federal regulation and is exempt from most state regulation. This results in separate reporting of premiums and claims on the Health blank and distinct RBC treatment. Benefit packages and rates must be determined well in advance of the contract period and for some health entities (BC/BS plans) the package may be developed and rated by a national organization, but the results affect the entity. Rate stabilization reserves are established to reduce the potential that a loss from a single year's results will affect the health entity's results.

- Medicaid – Some health entities' primary focus is this government market. For others, it may be minor or one of several major markets. The key risk is assessing the income received from the state against the package of benefits and the cost of administration. In most cases the health entity has little negotiating ability for either benefits or rates and must decide on a take-it or leave-it basis. The more important the line is to covering costs and maintaining a network, the harder it is to leave. There is increased use of managed care arrangements in this market, where now more than 70% percent of the Medicaid market is now managed care[4].

- Medicare Advantage and/or Medicare Prescription Drug Plans (Part D) – This market is primarily for individuals over age 65 but includes the disabled. It allows the entity to define benefit packages, subject to meeting required benefits provided by Medicare. Medicare Advantage programs (Part C) almost all include managed care arrangements. The different types of Medicare Advantage plans include HMOs, PPOs, Private Fee for Service (PFFS), Special Needs Plans (SNPs) and Medical Savings Account (MSA) plans (structured like HSA plans). Carrier income comes from the federal Centers for Medicare & Medicaid Services (CMS) for the federal share and the normal beneficiary monthly payment for Medicare Part B. Health entities may charge additional premiums for added benefits or use savings from the cost of Medicare benefits to finance them. A key risk is the variation in actual income from CMS resulting from risk adjustment and the effects of annual open enrollment involving a population focused on their health care needs. Additionally, the majority of Medicare Advantage plans incorporate the Medicare Part D program (referred to as MA-PDs), which can have additional risks and costs. And some carriers offer stand-alone Medicare Prescription Drug Plans, especially those that also offer supplemental coverage.

- Supplemental Coverage – This coverage is generally sold by another company than the carrier for primary health coverage. It may coordinate with (e.g., Medicare supplement), be in addition to (e.g., hospital indemnity) or may be unrelated to the primary health coverage (e.g., accidental death and dismemberment (AD&D)). In certain cases, the coverage may be an addition by the primary carrier (e.g., dental or vision supplements). Except for these last examples, the coverage is almost always paid fully by the insured, even if sold using a group policy or offered through the employer/workplace, often called voluntary options. As such, these products are generally guaranteed renewable so only the premium may be changed and termination by the carrier is not an option. The risks relate to the amount of underwriting or waiver of normal rules (for sufficient applicants from an employee group or when required by law—e.g., Medicare supplement open enrollment requirements) and the actuarial pricing adjustments, if any, needed to maintain a reasonable relationship between premiums and claims over the life of the policy form. This

[4] *www.pwc.com/us/en/healthcare/publications/assets/pwc-the-still-expanding-state-of-medicaid-in-the-united-states.pdf - page 5*.

involves monitoring experience, filing for rate increases when necessary and obtaining timely approval when required as well as meeting statutory loss ratio standards.

- Level Premium Coverage – These types include products which anticipate the accrual of significant contract reserves (e.g., individual DI and LTC—both group and individual) as well as a number of products where the claim costs are generally level and small contract reserves are expected (e.g., specified disease and hospital indemnity). The products are either guaranteed renewable or in the case of many of the DI products, even non-cancelable. The risks are the same as those above for supplemental coverage as well as the potential risk that persistency experience may be better than assumed and the "lapse-supported" expectations of contract reserves being released will not occur or that investment income assumed in the contract reserves is not realized. Certain long duration products may have additional risks from longer life spans, less lapse (more persistency), changes in the standards for benefit eligibility (e.g., Activity of Daily Living assessment for LTC and disability for DI) and the terms for continuing benefits that result in higher claim costs (greater frequency of claims or more benefits paid for continuation than assumed in premiums or claim liabilities and reserves). Recent changes to the LTC Guidance Manual seek to address this to provide guidance to state insurance regulators regarding what constitutes a reasonable range of assumptions across the industry.

Product Types

Different products have different risk characteristics. Also, products called by the same name in different companies may have different risk characteristics based upon the contracts with the providers.

Medical products in general have different variations on a number of characteristics including:

- Covered benefits
- Deductibles
- Coinsurance
- Co-payments
- Maximum out-of-pocket expenditures
- Provider networks
- Pharmacy networks

Covered benefits define the types of services that will be covered by the medical policy. These are general inclusions of medically necessary services and general exclusions for experimental or cosmetic treatments. Experimental treatments are excluded because their efficacy has not yet been conclusively established, so they cannot be demonstrated to be medically necessary. Such treatments usually are paid for outside of the insurance marketplace through public and private financing of medical research. Beginning Sept. 23, 2010, the ACA requires insurers to cover participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition and not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial—even if the treatment's efficacy is not yet certain. Cosmetic treatments are excluded because they are not medically necessary. There is much debate concerning specific services and whether they are medically necessary or cosmetic procedures. Is a cosmetic treatment that reduces stress from having an abnormality medically necessary or cosmetic? When does a treatment cease to be experimental and become generally accepted? Proponents for a service often bring their case to the legislature and laws are passed mandating benefits that would otherwise not be included.

The other benefit characteristics determine how much of a medical expense is reimbursed by a health entity. Co-payments (co-pays) are payments made by the insured person at the time of service, for physician visits and prescription drugs. Co-pays are generally applicable when the services are rendered by the providers. Coinsurance is the cost sharing amount the insured person pays of the allowed amount (payment) to providers.

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In the individual and small group markets, co-pays, coinsurance and deductibles contribute to the annual maximum out-of-pocket amounts. Co-pays and coinsurance are not credited to deductibles. Prescription drug co-payments or coinsurance vary depending upon whether or not the drug is generic and may vary by drug classification or drug tiers. (Common tiers, for example, are generic, preferred branded, non-preferred branded and specialty). Emergency room co-payments are often higher to discourage inappropriate emergency room use and may be waived if the individual is admitted to the hospital.

Deductibles are fixed amounts applied annually and represent the portion of the medical expense that is shared by the insured individual and must be met before the health entity reimburses the insured health claims. Deductibles apply to most services, although the ACA enacted the requirement in 2010 for all comprehensive health insurance (individual, small and large group, and self-funded plans) to cover preventive services prior to deductible and with no cost-sharing. Deductibles and co-payments may vary by in-network services and out-of-network services but are more common for out-of-network services. An operational risk for insurers is that individuals may choose not to submit claims to a health entity for reimbursement until meeting their deductible amount, resulting in manual claims processing and sometimes incomplete data. This is less true with PPO arrangements, where the individual gets the advantage of lower contracted rates if they seek the services of a contracting provider but must submit a claim in order for the health entity to determine the contracted fee for the service.

Once the deductible amount is met, an individual pays a percentage of the allowed amounts for the claims until the maximum out-of-pocket expense is met. This is often referred to as coinsurance. Normally, the health entity will not make payments based upon the full charge of the claim, but determines the allowed amount for the service, and then determines if the insured is responsible for any deductible and coinsurance payments based on that amount. A maximum deductible usually applies for family coverage that is a multiple of the individual maximum. Some policies have an annual in-network maximum out-of-pocket and an out-of-network maximum out-of-pocket. After an individual meets his/her maximum out-of-pocket(s), the health entity pays 100% of the allowed amounts for covered services.

Medical products sold by health entities can incorporate varying degrees of managed-care elements. On the side of the least managed are the indemnity plans (no longer seen in comprehensive medical plans) and at the other extreme are the closed panel HMOs. Indemnity plans had become almost extinct until the backlash against managed care and patient protection initiatives resulted in many health entities moving to more indemnity type products.

Health insurers have also begun to focus on provider networks and creating tiered networks as a means of providing more affordable coverage while focusing on quality care. Other elements being incorporated to try to control benefit costs is value-based design utilizing ACOs, rewarding providers for quality of care with share savings or shared risk arrangements.

In the comprehensive medical plans, as employers attempt to protect themselves from rising health care costs and litigation, new types of plans are emerging. Some companies hope to solve the problem of rising health care cost by offering PPO products with high deductibles, federally qualified HDHP HSAs (previously mentioned). Not only do these plans pass on more of the health care cost to the individual, it is hoped that patients will become more conscientious consumers as they share more of their health care costs. High deductible plans must offer preventive care and may include several outpatient visits without being subject to deductibles. The result is that some physician and prescription drug services may be available with low or no co-pays while policies after deductibles generally pay for costly diagnostic procedures, treatments, surgeries and other expensive services such as hospital stays and rehabilitation. In addition to self-funded uninsured ASO/ASC plans, other alternatives to insured products have gained popularity as employers try to control benefit costs.

Employers look to financial tools for employees, such as high-deductible plans offered in conjunction with MSAs or other defined contribution arrangements. Funds contributed to the defined contribution accounts can be used to pay for services until the deductible or maximum out-of-pocket levels are met. Typically, there is a “corridor” between the fully-funded account balance and the plan deductible, for which the insured will be

entirely responsible. The expectation is that the insured will become a more efficient user of medical services, in order to minimize the risk of exhausting the account and having to pay out-of-pocket for costs that fall in the corridor. At the same time, the high-deductible insurance coverage will significantly protect the insured against the costs of catastrophic illness or injury. All of the products combining high-deductible insurance coverage with some form of spending account share those same basic principles, but there are many important differences in the details, such as: whether the accounts are funded by the employer or the employee, the tax treatment of contributions to the accounts, the types of medical expenses that can be paid for with funds from the accounts, the ability to carry over unused funds from one plan year to the next, portability from one place of employment to another, accrual of interest on account funds, whether the plans can be network-based, and, of course, details such as the level to which the account is funded and all of the usual variables (plan deductible, etc.) for the high-deductible insurance coverage.

Managed care techniques include the use of a primary care physician as a "gatekeeper" and other care management and cost control techniques such as:

- Requiring preauthorization for some services such as inpatient hospital admissions
- Requiring second surgical opinions for some surgeries
- Reviewing ongoing hospital stays to ensure that additional days were medically necessary
- Providing incentives to patients to use outpatient rather than inpatient facilities
- Moving patients to less intensive settings or into home health care
- Providing care managers or case managers to assist patients in their course of treatment and in navigating a complex medical system

As PPO plans added more managed care mechanisms and HMOs started to use contracted providers rather than their own panel providers, the two became more similar. This similarity increased as providers wanted to move away from capitated payments and HMOs offered benefits for out-of-network services.

HMO contracts with providers cover a spectrum of risk transfer to providers, which is designed to limit insurance risk. On the one end, HMOs can pay providers on a reduced fee-for-service basis or capitations with or without bonuses and withholds can be used to transfer risk to the providers. Global capitations transfer the most risk to the providers. Under global capitations, the provider group is responsible for all services under the global capitation agreement, which may include hospital, physician, lab, and prescription drug. Often the providers were protected from catastrophic losses by provider stop-loss coverage that limited claims to a specific dollar amount. More carriers are limiting the services under the capitation, leaving the health entity with the risk for non-capitated services. Capitation agreements have moved to only capitating primary care physician services. They can provide incentives to providers by using bonuses or withholds that are payable if certain claims cost criteria are met. Payment arrangements sometimes pay bonuses if claims per member per month (PMPM) are below a floor, return withholds if claims PMPM are between the floor and ceiling and retain withholds if claims PMPM are above the ceiling. Usually, the bonuses and withholds are graded between the levels. In this way, risk is shared with providers up to the ceiling. Above the ceiling, the health entity is at risk.

Even if providers are paid a reduced fee, risk can be reduced by having contracted primary care physicians perform a gatekeeper function that gives the responsibility for what services are provided to the contracted primary care physician (PCP). In a tightly managed HMO, the PCP must authorize all or most specialty care and hospitalizations. However, most HMOs have moved to an "open HMO" structure, allowing insured persons to receive care within the HMO without a required authorization from the PCP.

In point-of-service plans, members of HMOs may go out of the network and continue to have services covered. The circumstances, benefits, and amount of coverage are defined in the contract. Financial incentives such as deductibles and coinsurance attempt to encourage members to use the services of contracted physicians.

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Typically, the health entity is responsible for out-of-network claims, but some aggressive providers have wanted to take on all risk including the out-of-network services.

PPOs are used by HMDIs and insurers to bring elements of managed care to their products by contracting for discounted fees from participating providers and incorporating some of the new payment methodologies that focus on quality-based services and value-based benefit designs. They may also perform other managed care functions such as pre-authorization and utilization review and include case management for complex cases.

Company Financial Structure

Health entities may be organized as either for-profit, mutual, or not-for-profit companies. Each of these types of companies can have a different focus concerning premium structures and profit margins, but the financial structure alone does not dictate how management will run the company or interact with the public. For example, there are not-for-profit companies whose management conduct themselves just like their for-profit counter parts. In addition, the financial structure of the ultimate parent, if the health entity is a member of a holding company, will strongly influence behavior.

As a generalization, management in a for-profit health entity is responsible to their owners, usually stockholders, often of an unregulated parent holding company. Management in a mutual company is responsible to their policyholders and management in a not-for-profit entity has a greater mission to serve the public interest, which is exercised via its board of directors, which typically contains representatives from various sectors of the public. Mutual companies in principle can share profits with their policyholders by paying participating policyholder dividends, but in practice it is rare for health entities organized as mutuals to pay dividends. Instead, mutual companies, like their not-for-profit counterparts, often benefit policyholders by using excess profits from one year to keep premiums lower in subsequent years. Enabling legislation defining the ways that not-for-profit health entities can be established, varies by state. Some not-for-profit health entities can be chartered as charitable organizations responsible to the citizens of the state in which they are chartered. Historically, certain of these entities cover insured individuals that cannot get insurance elsewhere. Some, but not all, not-for-profit health entities are exempt from federal income tax due to their form of organization. Similarly, some, but not all, not-for-profit health entities have been given advantages, such as exemption from premium tax, by their domiciliary state. State law may dictate specific health entity responsibilities due to the tax waiver, or the law may only include a vague indication of what the health entity's responsibility is due to the waiver.

Access to capital varies between these types of health entities. Not-for-profit and mutual health entities typically do not have parent entities as a potential source of capital, nor do they have access to the equity markets. As a result, their primary source of capital is retained earnings, with surplus note issuance the principal means of obtaining external capital. For-profit health entities are more likely to be able to rely on parent entities as a source of capital, and in addition may be able to issue stock to raise needed funds.

Management is responsible for fulfilling the goals of the health entity including maintaining adequate capital and profitability. Profits from for-profit health entities are first used to maintain capital levels[5], then to meet obligations on debt issued, and then are available as dividends to owners or stockholders. Because owning stock is considered riskier than making loans, the profit rate of return needed on stock investments will be more than loan interest rates. This requirement for higher return is why for-profit health entities are seen as more focused on profits than not-for-profits. However, mutual, and not-for-profit health entities also need to generate operating gains in order to maintain capital levels and fund needed technology enhancements. Higher profits can come from charging higher premiums, keeping claims cost down, increasing investment earnings, or providing more efficient administration. In most markets, premiums are already very competitive leaving little room to charge excess premiums. Reducing claims costs through risk selection or managed care techniques has

[5] Risk-based capital (RBC) requirements will generally increase for the same number of covered lives because of medical trend increases.

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recently received significant backlash and are not as effective as they once were, in particular given the ACA's restrictions on underwriting. Generating increased investment earnings can be counterproductive due to high RBC charges assessed to those asset classes having higher expected returns. Therefore, many health entities focus on efficiency and innovation to allow them to generate the profits required. Innovation may focus on health education, providing quality of care information on the Internet, or other techniques that attempt to educate the health care consumer. Efficiency may be aimed at technological advances, such as electronic claim filing or other techniques that reduce administrative costs.

Health entities that increase their level of debt or leverage have to generate sufficient profits to meet scheduled principal and interest payments. If a health entity does not have the liquid financial resources to pay scheduled interest and principal payments, the lender can demand payment and the health entity could be forced into bankruptcy. Stockholders do not have a right to their invested funds and cannot force the health entity into bankruptcy.

When not-for-profit or mutual companies convert to for-profit status, the interests of the prior stakeholders need to be recognized. In the case of mutual companies, funds are set aside to provide dividend protection for participating policyholders, but as noted above it is rare for a mutual health entity to issue dividends. More generally, policyholders are given stock according to an actuarially determined allocation formula, one component of which is typically in proportion to the profit that they have contributed to the company. In the case of not-for-profit companies, a charitable foundation may be created with the surplus of the company and/or with stock of the converted company or parent company, regardless of whether or not the not-for-profit company had previously been chartered as a charitable organization. Also, the converted company will probably be subject to income and premium tax, if it was previously exempt.

Types of Ownership Structure

Closely related to a health entity's financial structure is their ownership structure. Many health entities are owned by parent organizations. A mutual company may not be owned by a for-profit organization, but a mutual company may own a for-profit company. Some mutual and not-for-profit companies have attempted to operate like a for-profit by creating a for-profit subsidiary and then moving assets and membership to their for-profit subsidiary. They can then sell stock in the subsidiary to raise capital. When this happens management may have the same pressures as they would in a full for-profit company.

Health entities can be related in holding company structures that in effect merge the management and interests of the individual subsidiaries. For example, a number of Blue Cross Blue Shield plans have been joined in holding company structures. This is particularly true for HMOs, which often must operate on a state-by-state basis via mono-state affiliates. When health entities are organized into a holding company structure, capital, assets, and profits can be moved between the entities. Ownership of one health entity by another can result in a "stacking" of capital, with the capital of the parent health entity dependent on the capital of the subsidiary health entity. Analysts should be aware of any regulatory restrictions on these transactions, which may limit movement of capital between entities.

One common method of moving capital to a weak health entity is through the use of a surplus note. The cash received by the entity is accounted for as paid-in-capital and not as a liability. Usually, the domiciliary state insurance regulator must approve repayment of the surplus note and may also be required to approve any payment of interest, or capitalization of interest, to the holder of the surplus note.

Operations can be centralized in one entity and the other affiliates pay a fee for the services provided through management and service agreements. Commonly centralized services include data processing, actuarial, investment management, accounting, and payroll. The service agreements may be merely a vehicle to move funds from one affiliate to another if the services are not supported by a cost/benefit analysis and/or service charges are not based upon a reasonable cost allocation methodology.

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Profitability can also be moved from one affiliate to another by moving policyholders from one entity to another. Profitable products and their policyholders can be moved to the controlling entity leaving the subsidiary in a weaker financial position. However, this type of transaction, such as movement of policyholders, may be subject to regulatory approval.

Reinsurance by one affiliate of the others can be used to manage capital and change RBC requirements. This can result in more centralized RBC than would exist without the reinsurance. Also, captive reinsurers can be used to move profits and capital requirements to another entity in another state.

Health entities that are owned by provider organizations such as hospitals have unique relationships in the community. A hospital may consider it advantageous to own a health entity so that patients can be directed to their facility. Losses in the health entity may be made up by profits from the increase in patient care. If the health entity's losses become too much, the hospital may decide to close the health entity rather than continue to support it.

Non-health insurance companies may own health entities or have significant health lines of business. A non-health insurer may see an advantage of offering multiple products to its policyholders. Having a health entity subsidiary allows it to offer health coverage as part of a package. This is becoming less common since the health market is changing so fast and profits are falling. It may not be enough of an advantage to offer "one stop shopping".

Solvency and Liquidity

There are two primary considerations in financial analysis of health entities - financial solvency and liquidity. The first looks at the assets compared to the obligations including a margin for adverse experience (i.e., reserves plus minimum capital). The second looks at the potential timing when cash is needed and the available sources of the cash requirements. Financial solvency focuses on the adequacy of reserves (for expected levels of the obligations, including expenses, not yet paid - conservatively estimated) and capital (for the unexpected) while liquidity focuses on the potential need for cash in unusual situations.

The adequacy of reserves and capital is determined by an analysis of the following:

1. The claim liability and claim reserve – determine if claim liabilities and reserves cover actual payments for existing obligations.
2. The assumptions underlying contract reserves – determine that an adequate portion of current premiums is being retained for future obligations.
3. The adequacy of current premiums (including unearned premium reserves and contract reserve changes) to cover all same period obligations – when inadequate, premium deficiency reserves are required so current premiums plus current reserves cover current and future obligations (claims and expenses).
4. The adequacy of existing capital – the RBC formula compares actual capital (in the form of Total Adjusted Capital (TAC)) to a minimum level for the risk of the health entity assuming adequate valuation of assets and reserves (in accordance with statutory accounting standards).

Note that when reserves are inadequate, the most likely source of funds to address this inadequacy is the capital of the health entity. Thus, determining that capital is adequate must start with a determination that reserves are adequate.

The liquidity of the health entity's assets should be determined by an analysis of the value of the assets under "forced sale" circumstances. Most health entities invest their funds in assets where immediate sale will produce a value consistent with the reported value (these values are prescribed by Statutory and GAAP accounting systems). An immediate need for cash that requires the liquidation of invested assets is, therefore, not a critical issue for most health entities. It is possible that some health entities have assets that are not easily liquidated. In those situations, specified stress tests may be useful in determining potential financial risk caused by a lack of

liquidity. There are numerous types of financial risks for a health entity. The NAIC *Troubled Insurance Company Handbook* Chapter 3 – Causes of Trouble, discusses causes of insolvency that are related to all types of insurers. The following discusses the most common causes of trouble that have most frequently been the source of problems for health entities in the past.

Causes of Solvency Risks

1. Premiums may be inadequate - premiums are to cover all current obligations of the health entity for the contracts to provide health insurance or services. They may prove to be inadequate if:

    a. Actual claims exceed expected levels (examples include but are not limited to):

        i. This may be due to more claims (frequency), higher value claims (severity), unexpected claims (new technology, alternative services, use of out-of-network facilities) or an underestimation of the combined effect of these factors when adjusting prices from recent periods to current or future periods (trend).

        ii. The demographics of the insured population are inconsistent with the expected values - where premiums cannot differentiate for demographic values (e.g., age, sex, marital status), the health entity must make assumptions as to the likely demographic composition of the actual insured population. When the actual is materially different from what was expected (e.g., more older insured, fewer males), the premiums may be inadequate.

        iii. Assumptions with regards to the effects of provider networks are not realized - savings may not be achieved if insureds do not utilize network providers to the level anticipated, if provider networks do not control costs to the level anticipated or if the failure of prepaid providers requires the health entity to incur additional costs.

        iv. The health status of the insured population is inconsistent with expected values - many health coverages do not allow the health entity to adequately reflect the actual potential for losses (e.g., a requirement to guarantee issue of health coverage may allow a level of self-selection by new insureds that was not anticipated and cannot be reflected in premiums).

    b. Actual expenses exceed expected levels - this may occur because less business is serviced than anticipated, additional services are required or the cost to provide the services exceeds expected costs, assumptions with regards to geographic diversity cannot be achieved, for example, through the potential for catastrophic natural disasters or geographic events.

    c. Assumptions with regards to persistency are not realized - when level premiums (generally issue age rating) are charged, the amount of contract reserves developed depends upon the lapse assumption to reflect release of reserves when lapse or death occurs. Lapse-supported products may not collect sufficient premiums if low lapse rates occur.

    d. Rate increases are not implemented on a timely basis due to delays in applying for or receiving rate increases for regulated products.

    When premiums are not sufficient to cover all current “costs”, the health entity will likely report a loss. This loss may be substantial if premiums cannot be adjusted immediately, and premium deficiency reserves need to be established or increased.

    Premiums are more likely to be inadequate in situations where claims costs are difficult to predict. Health entities monitor claim data closely to protect against undetected shifts in cost or utilization; the two components that determine health care claim costs. Claim reporting lags along with data process lags means that premiums must be set based on data that is several months old and shifts may be missed.

    Benefit designs are changing to shift more of the cost of health care back to the individual. Economists believe that this will reduce inappropriate utilization that resulted from individuals being unaware of the

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actual cost of services. Having the individual pay more of the cost of each service may reduce large jumps in costs when new services are introduced by lowering the demand, but there is little risk reduction.

Managed care techniques often make claims costs less variable and therefore easier to predict. The more services being provided that come from contracted providers, the more predictable claims costs are and the lower the risk of underestimating premiums.

- Capitations control for both cost and utilization variation and are the most effective way of reducing risk for the covered services.
- Fee-based contracts allow better prediction of the cost of services but do little to control utilization which may be increased by providers to make up for lower fees.
- The use of primary care physicians as gatekeepers as well as bonus and withhold incentives can be used to better influence utilization and make it more predictable. The effectiveness of these arrangements has been reduced recently with the influence of and the push back from providers and patients.

2. Reserves and liabilities may be inadequate – Assumptions used in the development of premiums often contribute to the determination of reserve levels. Thus, underestimation of claim costs often leads to under-reserving as well as underpricing. Reserves can be inadequate for other reasons as well. Changes in the processing of claims may not be appropriately recognized when using claim paid-to-incurred tables. New risks may not be reported and paid under the same time sequence as historical completion tables. New technology may create higher claim payments for the same medical need. New claims processing systems or higher than average turnover in claims processing personnel may increase claim backlogs. If increases in claim backlogs are not adequately taken into consideration, claim reserves will be underestimated. To reduce the risk of underestimates, health entities may increase monitoring of claims backlogs or attempt to pay claims more promptly in order to better predict reserves.

   Contract or policy reserves may become inadequate over time as actual experience deviates from what was assumed, (e.g., persistency of lapse-supported products). The actual cost of processing claims may require more expenses.

   Note that underestimated claim reserves will overstate income as well as capital.

   Converse to the above, there are cases where reserves may be considered too conservative and surplus too high. While this does not represent a risk to solvency, it may be indicative of other issues. Reserve margins that are significantly above the industry norm, or that are growing excessively may indicate that rate increases cannot be supported based on incurred claims experience. Unfortunately, there are no definitions of excess margins, appropriate increases in reserves or reserve margins, or appropriate levels of surplus. Regulators must use their judgment when financial statements show trends that are too dissimilar from those of similar health entities in the industry.

Other Solvency Risk Considerations

1. Transfer of Risk – The following are methods frequently used by health entities to reduce overall risk unique to the health industry:

   a. Risk sharing with insurers – Reinsurance is the most direct form of risk transfer. Reinsurance can be used to transfer specific risks such as transplant reinsurance. Reinsurance can also be used to keep risk below a certain level either per individual or on a block of business. For coverage of individuals, reinsurance pays over a specified amount (stop-loss) or it can pay a specified percentage of claims (quota share). On a block of insurance, reinsurance can also be written on a stop-loss or quota share basis. There are endless variations of agreements that combine these elements. For example, the reinsurance could cover a percentage of claims in a corridor and then cover all claims above the corridor. In this case the health entity is responsible for all claims until the corridor is reached and for a percentage on claims

until the upper end of the corridor is reached, at which time the health entity is not responsible for additional claims.

Reinsurance availability changes as the market changes. A health entity cannot depend on being able to purchase reinsurance in the future and, even if reinsurance is available, the cost increases may make it prohibitive in the future.

b. Risk sharing with employer/policyholders – Some large employer groups want to take on more of the insurance risk and thus reduce the risk premium that they are paying to the health entity. If the policyholder assumes all of the risk, the agreement is called either ASO or ASC. In both cases the employer is responsible for all claims payment and the health entity is responsible for the administration of the coverage. The employer also benefits from these arrangements in that they pay for health services using the contracted rates that the health entity has with providers. If an employer does not want all of the financial risk, they can purchase stop-loss reinsurance, which is generally available from health entities in the ASO market.

   Health entities also share risk with employers through experience rating contracts. Experience rated contracts contain settlement formulas that allow the health entity to collect more premium if health care costs are above the formula amount or require a refund if claims experience is lower than expected. These are effective risk transfer techniques but may not be totally effective if employers cancel contracts before claims can be recaptured or employers become insolvent and unable to pay.

c. Risk sharing with providers – Health entities have many risk sharing agreements with providers. Staff Model HMOs reduce their risk by hiring providers as employees. In this case, payroll costs make up a large share of the claims cost and are more predictable. More typical risk sharing with providers consists of paying for services on a PMPM or capitated basis. The more services that are covered by the capitated payment, the more risk is transferred. Physician groups are more willing to be responsible for outside services such as prescription drugs than individual physicians.

   Withholds and bonuses can be used to share risk with providers, as well as to provide incentives to keep utilization down. Withholds are amounts retained from fees or capitations that are paid if specific financial metrics are met. The amount of risk transferred to the providers equates to the amount of withhold retained by the health entity. Bonuses are additional payments that are made if specific financial metrics are met. Bonuses that are paid based on quality measures are becoming more common and are not considered risk transfer. (Withholds and bonus arrangements may also be based on non-financial metrics. In those cases, the influence on risk is much less direct—for example, arising from improvements in health care quality.)

   Risk is transferred to hospitals by the use of Diagnosis-Related Group (DRG) payments[6]. DRG payments are scheduled amounts to be paid for any admission in specific DRGs. If more care is needed than the scheduled amount, the hospital is still only paid the DRG payment. There is usually allowance for individuals that have complicated circumstances or extreme cases as “outliers”. Additional payments will then be approved for outlier cases. Risk may also be transferred to hospitals by the use of per diem payments, which pay a fixed amount per inpatient day.

d. Risk-sharing for specialties – Health entities may contract for the provision of care for certain portions of the coverage under broad medical insurance contracts on an exclusive basis with another entity – mental health or substance abuse care and drug benefits through a pharmacy benefits manager are frequently seen examples. In some cases, this risk-transfer may be to another health entity, but it may be to an organization that is not regulated for insurance purposes. The contract may provide for full transfer of risk or a sharing of favorable and unfavorable results.

[6] Diagnosis-Related Groups (DRGs) are categories of diagnosis use to determine the amount per admission paid to a hospital based on the anticipated severity of the typical patient having the assigned DRG.

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2. Capital (as measured by minimum capital or RBC calculations) may be inadequate to cover variations from expected values – assumptions about the value of assets may not be realized when the asset is sold, earnings may not increase at a rate higher than the increase in risk as determined by RBC, unusual or very infrequent levels of risk may occur, which are outside normal bounds (e.g., legal settlements, claim continuation patterns during slow economic times).

   Business plans that necessitate rapid growth or getting into new lines of business creates potential risks to capital from:

   - The "normal" level of statutory surplus strain from above average levels of new business;
   - The greater potential that aggressive assumptions used to produce very competitive premiums (including writing business at a small loss to grow rapidly) will not be achieved; and
   - The high probability that assumptions and practices in new lines can only be realized following seasoning of the line.

   Non-financial risks can impact financial results. Few can be restated into a financial value, but all are likely to have a financial impact:

   - The health entities rating by public rating agencies, if downgraded, may create difficulties for the company in meeting its business plan;
   - Relations with networks may deteriorate producing fewer benefit savings than assumed. If the problems become public, the ability to renew existing business at adequate premium levels, to maintain a sufficiently broad network and to satisfy contractual obligations with different network providers can all reduce earnings, make reserve estimation more tenuous, and/or require the focus of management on certain issues so others do not receive the normal, necessary review.
   - Legislation (both federal and state) and resulting regulation create changes that need to be reflected in contracts with policyholders, providers and other vendors.

   RBC Formula Risk Assessment – The NAIC models using the RBC approach seek to establish a level of capital related to the existing risks of an insurer or health entity such that the regulator will, when capital values fall into "RBC action levels," have sufficient time to rectify the causes of capital inadequacy and allow the insurer or health entity to remain in business meeting all of its obligations. In general, the NAIC has tried to establish this timeframe as three to five years. States generally also have minimum absolute dollar levels of capital required to maintain a license to write various types of insurance.

   For health entities, the underwriting risk or risk for underpricing health insurance contracts generally overwhelms all of the other risks. The RBC formula applies factors to premiums (adjusted by the loss ratio to translate premiums into incurred claims for most medical coverage), and allows for reductions for risks transferred to providers (e.g., the amount of RBC risk is reduced for the value of withholds, reduced more for capitation payments and reduced the most when salaried providers are used). Some ancillary coverages (e.g., stop loss) have factors applied to premiums without further adjustment. The RBC factors are developed using consistent risk-assessment models and historical information. The RBC formula recognizes that the health entity's risk is less than the sum of all independent risks (because these are not likely to occur simultaneously) through a "covariance" calculation.

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V. Domestic and Non-Lead State Analysis

A. Holding Company Analysis Procedures (Non-Lead State)

B. Form A Procedures

C. Form D Procedures

D. Form E (or Other Required Information) Procedures

E. Extraordinary Dividend/Distribution Procedures

F. Analyst Reference Guide

Legend of Abbreviations

Branded Risk Classifications		
Symbol	**Risk**	**Description**
CR	Credit	Amounts actually collected or collectible are less than those contractually due or payments are not remitted on a timely basis.
LG	Legal	Non-conformance with laws, rules and regulations, prescribed practices or ethical standards (in any jurisdiction in which the entity operates) will result in a disruption in business and financial loss.
LQ	Liquidity	Inability to meet contractual obligations as they become due because of an inability to liquidate assets and/or obtain adequate funding without incurring unacceptable losses.
MK	Market	Movement in market rates or prices (such as interest rates, foreign exchange rates or equity prices) adversely affect the reported and/or market value of the investments.
OP	Operational	The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events.
PR/UW	Pricing/ Underwriting	Pricing and underwriting practices are inadequate to provide for risks assumed.
RP	Reputation	Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.
RV	Reserving	Actual losses and/or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
ST	Strategic	Inability to implement appropriate business plan, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

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Special Notes: The following procedures are intended to be performed by non-lead domestic states to develop and document an analysis of the impact of the holding company system on the domestic insurer.

Form procedures do not supersede state regulation but are merely additional guidance an analyst may consider useful.

Name of Holding Company System _____ Name of Lead State _____

Compliance Assessment – Form B (and C)

1. Review the registration statement to determine if it was filed in accordance with the state's Insurance Holding Company System Regulatory Act[1] (#440) and if it included the required current information. The information provided should include a description of the transaction or agreement, including, at least, the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and the relationship of the affiliated parties to the registrant. (LG)

2. Did the domiciled registered insurers properly report dividends and other distributions to shareholders in accordance with the following Model #440 requirements? (LG)

3. If dividends and other distributions to shareholders were considered extraordinary, did the transaction receive proper regulatory approval? (LG)

4. Did the insurer receive proper prior regulatory approval for any transaction that occurred during the last calendar year involving the insurer and others in its holding company system that required such prior regulatory approval? (LG)

Assess the Impact of the Holding Company Group on the Domestic Insurer

Assessment of Group Profile Summary from the Lead State

5. Obtain a copy of the lead state's Group Profile Summary (GPS).

6. Consider the GPS's branded risk assessment in determining the impact of the holding company on the domestic insurer.

7. Review the conclusion and supervisory plan of the GPS. Did the lead state identify any holding company risks impacting the domestic insurers in the group and/or supervisory plans that impact your state's domestic insurer?

8. Consider the nature of the domestic insurer(s)' interdependence on the holding company group or affiliated entities for business operations or financial stability (e.g., employees, services provided, reinsurance and/or capital support in the near term). (OP, CR, ST)

9. Consider the level of reputational risk that the holding company (as a group) poses to the domestic insurer(s). (RP)

10. Determine if income of the domestic insurer(s) is being used to service holding company debt or other corporate initiatives (e.g., acquisitions). (OP, ST)

[1] The list provided is based on the NAIC *Insurance Holding Company System Regulatory Act* (#440). However, analysts should review the Form B compliance in relation to their own state's requirements.

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11. Review the information provided in the GPS regarding the Corporate Governance Annual Disclosure (CGAD) and other related corporate governance information provided by the lead state. Does it identify any risk or concerns that require questions or follow-up to the lead state? Does it highlight any issues that are only relevant to your state's domestic insurance entity? Do any material concerns exist regarding corporate governance that could impact the domestic insurer's financial condition (e.g., operations, policyholder surplus or capital position)?

12. Review the information provided in the GPS regarding risks or concerns noted in the Enterprise Risk Report (Form F) or any other related information provided by the lead state. Does it identify any risk or concerns that require questions or follow-up to the lead state? Do any material concerns regarding enterprise risk have the potential to impact the financial condition of the domestic insurer risks or pose an immediate material risk to the domestic insurer's policyholder surplus or risk- based capital position, insurance operations (e.g., changes in writings, licensure, and organizational structure), balance sheet, leverage, or liquidity?

Assessment of Form B (and C)

13. Based upon a review of the registration statement, were any significant and/or unusual items noted, such as, but not limited to, the following?

    a. Person(s) holding 10% or more of any class of voting security who also have a history of transacting business of any kind directly or indirectly with the insurer. (OP, ST)

    b. Biographical information about directors or officers, which may elevate concerns such as convictions of crimes. (OP, ST)

    c. Any litigation or administrative proceeding involving the ultimate controlling entity or any of its directors and officers, such as criminal prosecutions or proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company, such as bankruptcy, receivership, or other corporate reorganization. (LG)

    d. The absence of an affirmative statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions to avoid statutory threshold amounts. (OP, ST)

Assessment of Affiliated Risks on the Domestic Insurer

14. Were any material deficiencies or risks noted during the annual review of the domestic insurer's Notes to Financial Statements, Interrogatories, Schedule Y – Part 2, Holding Company Forms B & C, or recent examination reports with respect to affiliated transactions? (CR, LQ, OP, ST)

    a. Management agreements

    b. Third-party administrative agreements

    c. Managing general agent agreements

    d. Investment management pools

    e. Reinsurance agreements and pools

    f. Consolidated tax sharing agreements

    g. Other

15. If any of the following forms have been filed with the domestic regulator since the last review, indicate if risks or concerns were noted in any of the reviews of these forms.

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a. Form A (Acquisition of Control or Merger)

b. Form D (Prior Notice of a Transaction)

c. Form E (Pre-Acquisition Notification) or Other Required Information

d. Extraordinary Dividend/Distribution

Assessment of Own Risk and Solvency Assessment (ORSA), if applicable

16. Obtain the lead state's analysis of the ORSA Summary Report (See section VI.F-Own Risk and Solvency Assessment Procedures.)

17. Did the lead state document in its analysis any risks or concerns that in its opinion have an impact on the overall financial condition of the insurance holding company system? If so, do any of the risks or concerns identified pose a material risk to the domestic insurer?

Communication & Follow-Up with the Lead State

- ❑ Notify the lead state of any additional material events or concerns applicable to the domestic insurer, or the group as a whole, that the lead state may not otherwise be aware of, and that should be considered in the evaluation of the overall financial condition of the holding company system.
- ❑ If any material risks or events were identified during your holding company analysis that were not discussed in the lead state's holding company analysis, communicate those findings to the lead state.

Update the Insurer Profile Summary

Update the Insurer Profile Summary of the domestic insurer with the summary and conclusion of the impact of the holding company system on the domestic insurer based on the above analysis performed.

Analyst:	Date:
Supervisor Review:	Date:
Supervisor Comments:	

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Special Notes: The following procedures do not supersede state regulation but are merely additional guidance analysts may consider useful. The procedures may be completed in part, or in total, at the discretion of the analysts depending on the level of concern, and the area in which the risk was identified.

Form A – Statement of Acquisition of Control of or Merger with a Domestic Insurer

Model Act and Database Procedures

Form A is transaction-specific and is not part of the regular annual/quarterly analysis process. Every Form A review should be tailored to the risks associated with the proposed acquisition, including the target company, acquiring entity, and the complexity of the transaction. The review of these transactions may vary, as some states might have regulations that differ for Form A.

Initial Review

1. Determine if the filing is complete, note the missing items and promptly send a deficiency letter to the Applicant. A filing may not be considered complete and active until all relevant information has been received. Enter any changes to the status of the filing or other data elements into the NAIC Form A database within 10 days of receipt of Form A. Data and information should be entered by the state's designated person.
    a. Identify attorneys, party contacts (all stakeholders), and other insurance regulators reviewing the Form A, including the lead regulator.
    b. Assign appropriate analyst, legal, and other professional staff to conduct regulatory review.
    c. Carefully consider whether regulatory review can be completed by Applicant's target close date, including any interim deadlines and obtain deemer extension or waiver if appropriate.
    d. Schedule and notice hearing/consolidated hearing, if applicable, within statutory timeframes.
    e. Review the NAIC Form A database to determine whether the current Form A is pending or has been approved, denied, or withdrawn in another state. Assess any reasons noted for denial and document any risks or concerns.
2. Establish contacts with other states and regulators to discuss the status and/or disposition of the current and prior filings made with those states. Where multiple jurisdictions are involved, coordination of information between the states and functional regulators should be initiated by the lead states(s). Perform the following steps:
    a. The domestic state should notify the lead state regulator of the holding company group of any merger or acquisition of a domestic insurer in the group.
    b. The lead regulator should obtain key contact information from each state reviewing the Form A and consider organizing a regulator to regulator call to discuss concerns with the filing.
    c. Create a contact list of relevant persons and representatives.
    d. Separate confidential and public documents, information, and communications and maintain as appropriate.
    e. Contact and collaborate with other reviewing regulators involved in the review process, as appropriate, including the lead state regulator regarding ORSA and ERM reviews.
    f. As applicable, contact other regulators of noninsurance entities of the acquiring party or target.
    g. Based on the nature and materiality of the transaction, the lead state and domestic state(s) should regularly communicate with all states and other functional regulators, as necessary throughout the filing

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review process, to provide updates on the transaction, states' reviews, and to share feedback between regulators.

h. Where multi-jurisdictions are involved and based on the size and complexity of the acquisition/merger, the lead state should take responsibility for the coordination and facilitation of communication. Regulators should work jointly on the Form A review to maximize efficiency and promote coordinated communications with the insurers involved to reduce duplication of regulatory efforts, where possible.

Compliance Assessment and Review

Transaction Details

3. Review details provided on the transaction for compliance with application filing requirements by determining whether the Form A application provides the required content, which may include the following:

   a. Provides a brief description of how control is to be acquired.

   b. Contains the following information:

      - Name and address (legal residence for an individual or street address if not an individual) of the applicant.
      - States the nature of the applicant's business operations for the past five years, if the applicant is not an individual.
      - Describes the business to be performed by the applicant and its subsidiaries.
      - Identifies and states the relationship of every member of the insurance holding company system on the organizational chart.

   c. Contains the required signature and certification, and include copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and of additional soliciting material relating thereto.

   d. Contains any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by the Form A.

   e. Contains an agreement to provide the information required by Form F – Enterprise Risk Report within the required timeframe.

   f. Includes the number of each class of shares of the insurer's voting securities that the applicant, its affiliates, and any person that plans to acquire; 2) the terms of the offer, request, invitation, agreement, or acquisition; and 3) the method by which the fairness of the proposal was determined.

   g. States the amount of each class of any voting security of the insurer that is beneficially owned or concerning that there is a right to acquire beneficial ownership by the applicant, its affiliates, or any person.

   h. Gives a full description of any contracts, arrangements, or understandings with respect to any voting security of the insurer in which the applicant, its affiliates, or any person is involved. Discussion includes, but is not limited to, the transfer of any of the securities, joint ventures, loan or option agreements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies.

4. Perform analysis review considerations, in addition to the compliance review in #3 as necessary, to analyze the details of the transaction, which may include, but is not limited to the following:

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a. Document any risks or concerns by carefully reviewing transactional documents (e.g., merger, stock purchase, stock exchange).

   i. Consider disposition of all classes of target shares, including addressment of any beneficial owners.

   ii. Ascertain propriety of disposition of minority interests and concerns, if applicable.

b. Consider any affiliate or employee benefit as appropriate.

c. Has the applicant included information on the assignment of specialized personnel (such as an attorney, actuary, or CPA) to the transaction?

d. Determine how any ancillary regulatory reviews or other interim procedural steps will be completed, including Form E – Pre-Acquisition Notification Form, for other licensed states.

e. Obtain copies of shareholder communications or sole shareholder consent.

f. Consider obtaining copies of fairness and other contractually required opinions, if available.

g. Review relevant portions of board resolutions, power points and related board minutes pertinent to the Form A transaction, using care to keep documents confidential.

h. Determine if after the change of control:

   i. The insurer will be able to satisfy the requirements for the issuance of a license to write the classes of insurance for which it is presently licensed.

   ii. The insurer's surplus will be reasonable in relation to its outstanding liabilities and adequate for its financial needs.

i. Review financial projections for the applicant and the insurer to ensure that they are consistent with the description of the intended business plan of the insurer and other assertions and representations made in the Form A filing. Determine whether the projections are based on reasonable expectations.

   i. Determine the target's estimated post-acquisition financial condition and stability.

j. If not included in the Form A filing, request copies of all contracts between the applicant (or other entities for which it exhibits control) and the insurer. Review these contracts to ensure that the terms are at arm's-length, fair, and reasonable to the insurer.

k. Will the proposed merger or acquisition comply with the various provisions of the state's General Administrative Amendments or Business Corporation Law (e.g., board resolutions, plans of merger, draft articles of merger, etc.)?

l. Does the Form A describe any plans or proposals for which the applicant might have to declare an extraordinary dividend, to liquidate the insurer, to enter into material agreements (including affiliated agreements), to sell the insurer's assets, to merge the insurer with any person or persons, or to make any other material change in the insurer's business operations, corporate structure, or management?

m. Consider suitability of any new affiliated and non-affiliated material agreements, including managing general agents, third party administrators, any professional organizations and reinsurance arrangements.

n. Consider plans for technological interfacing with new affiliates and any potential adverse impact on operations including claims.

o. Require Form D filings for any affiliated material transactions, post-acquisition; consider including language in the approval order.

p. Consider with disfavor any plans to liquidate the target or sell its assets, consolidate or merge, that may be unfair, unreasonable, or hazardous to policyholders.

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q. Review required statutory deposits and authorized lines of business.

r. Has the insurance department identified any reasons or circumstances surrounding the transaction to warrant the hiring of outside experts or consultants?

Ultimate Controlling Person/Parent (UCP), Officers, and Directors

5. To identify the UCP, review the ownership documents/agreements and other information provided in the Form A application to understand its ownership structure, the terms of the documents/agreements, each parties' rights and responsibilities conveyed by the documents/agreements, who has responsibility for decisions and who controls the insurer.

6. Review the background information and financial statements provided in the application for the UCP.

   a. Does the Form A summarize the fully audited financial statements regarding the earnings and financial condition of the ultimate controlling party(ies)/person(s) for the preceding five years, and are exhibits and three-year financial projections of the insurer(s) attached to the filing?

      i. Identify the Audited Financial Statements (or CPA reviewed financial statements for individuals) of the ultimate controlling party(ies)/person(s).

      ii. Review holding company, and the UCP, 10K and 10Qs, and other current financial information for enterprise condition, potential debt service by the UCP and its ability to service such debt.

      iii. If fully audited financial information is not available, consider acceptability of unaudited financial statements regarding the earnings and financial condition, compiled personal financial or net worth statements and/or tax returns of the ultimate controlling party(ies)/person(s), as deemed acceptable to the commissioner.

      iv. Financial statements accompanied by a certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations.

      v. Management's assessment of internal controls accompanied by an independent public accountant's report to the effect that the applicant maintained effective internal controls.

7. Perform additional review considerations as necessary to analyze and identify potential risks concerning the UCP, Officers, and Directors which may include but not limited to the following:

   a. Perform a query of the NAIC Form A database on the name of the UCP, directors, executive officers, or owners of 10 percent or more of the voting securities of the applicant and perform the following step(s):

      i. Assess the feasibility of the acquiring person's holding company structure including location and control (direct/indirect) of the target company post acquisition.

      ii. Carefully scrutinize and understand complex organization and ownership structures.

         1. Whether a simple corporate structure, or a unique or complex structure such as trusts, limited partnerships (LP) and limited liability corporations (LLC), review the ownership documents and agreements to understand the terms of the structure, each parties' rights and responsibilities conveyed by the agreement, who has responsibility for decisions and who controls the insurer. For LPs, also identify who has controlling interest in an LP's general partner and who has the right to unilaterally replace the general partner (if anyone). For trusts, also identify who has the ability to modify a trust.

         2. For structures with complex or unique share classes and voting carefully review the voting and non-voting share classes rights and agreements to determine who has rights to control and vote to make decisions.

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3. Request and review corresponding investment, management or operational agreements as necessary to determine if any delegate control or decision making to another specific person or entity.

b. Review other external sources to gain a better understanding of the acquiring persons, its affiliates, and the UCP.

c. Identify and review all relevant parties to the proposed acquisition and the nature of other filings made in other states by similar individuals.

d. Consider suitability of UCP through background review and regulatory review of the prospective new owners, using UCAA biographical affidavits and third-party background reviews by NAIC listed independent third-party reviewing companies or fingerprinting criminal checks if applicable and note any risks or concerns regarding competence, experience, and integrity of the applicant, as well as the results of any background investigation.

e. Does the Form A provide adequate background information (e.g., biographical affidavits including third-party background checks) on the applicant (if an individual) or all persons who are directors, executive officers, or owners of 10% or more of the voting securities of the applicant (if the applicant is not an individual)?

f. Review the lead state's assessment of the acquiring UCP's most recent ORSA Summary Report and information in the Group Profile Summary (GPS) regarding Form F, if applicable; to better understand the impact on risk assessment, risk appetite and tolerances, and prospective solvency (capital and liquidity).

g. Cross check the UCP with source of funds and consider debt funding sources.

h. Review and assess the UCPs ability to provide future capital support to the insurer, if needed.

i. Consider acceptability of SEC disclosures by board members of publicly traded UCPs in suitability review.

j. Review rating agency reports and public news sources to identify and assess comments or concerns, have been expressed regarding the acquiring entity (or group).

k. For non-U.S. acquiring parties: Carefully evaluate Form A applications and supporting documentation received from non-U.S. acquiring entities to understand its ownership structure and identify the UCP. Consider the following steps:

i. Carefully consider the impact of varying accounting and auditing standards utilized in other countries when evaluating financial data and results.

ii. Identify and investigate the nature and extent of government control over or involvement with the acquiring entity.

iii. Ask the parties involved in the transaction for the results of the Committee on Foreign Investment in the U.S. (CFIUS) review (if applicable).

iv. Communicate and coordinate with the group-wide supervisor regarding each jurisdiction's review of affiliated entity acquisitions, requesting assistance to verify biographical affidavits and understanding the roles, responsibilities, and expectations for post-acquisition solvency monitoring.

Purchase Consideration

8. Analyze the source, nature, and amount of consideration used (or to be used) in effecting the merger or acquisition of control and assess the ability of the entity to fund the insurance company.

a. Determine fairness (equivalency) of total amount to be paid to total value to be received, including derivation of price and value of target under standard valuation methodologies or to book value.

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b. Consider quality of consideration, giving careful scrutiny to payments other than cash or cash equivalents which are disfavored particularly when any funds are being transferred to the target.

c. Consider fairness opinions and actuarial appraisals, if provided.

d. Consider source, type and valuation basis of funds to be used for consideration.

   i. If funds are from a regulated entity, confirm the existence and valuation of such assets with that entity's regulator.

e. Where the applicant issues or assumes debt obligations or is required to fulfill other future obligations as a result of the purchase or through existing agreements, review the holding company's cash flow projections to ensure that cash flows appear adequate to cover such obligations without relying heavily on cash flows from the insurer.

f. Review dividend expectations and projections, including amounts expected to be paid from the insurer to the owner.

   i. Will dividends from the insurer be required to support debt payments of the applicant or the applicant's subsidiaries?

g. If the Form A involves a parental guarantee agreement or capital maintenance agreement, the analyst should utilize the guidance and procedures noted in the Analyst Reference Guide chapter V.F. Domestic and/or Non-Lead State Analysis – Form A, to review the agreement.

9. If amounts will be borrowed, consider the following:

   a. Does the Form A describe the relationship between the borrower and lender, the amounts to be borrowed, and include copies of all agreements, promissory notes, and security arrangements relating thereto?

   b. Does the Form A describe the nature, source, and the amount of funds or other consideration (e.g., pledge of stock, other contributions, etc.) used or expected to be used in effecting the merger or acquisition of control?

   c. Does the Form A:

      i. Describe any purchases of any voting securities of the insurer by the applicant, its affiliates, or any person during the 12 calendar months preceding the filing of the Form A.

      ii. Describe any recommendations to purchase any voting securities of the insurer made by the applicant, its affiliates, or any person—or by anyone, based on interviews or the suggestion of the applicant, its affiliates or any person—during the 12 calendar months preceding the filing of the Form A.

      iii. Describe the terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions, or other compensation to be paid to broker-dealers.

   d. Perform additional review considerations as necessary to analyze the purchase conditions and implications of any debt financing, which may include, but is not limited to the following:

      i. The mechanics of any debt financing to be used to fund the transaction, whether funds are being borrowed in the ordinary course of business or on terms that are less favorable than generally commercial loans.

      ii. The percentage of debt versus non-debt funds to be used.

iii. The source of funds or stream of income to be used by the parent for repayment and the ability of the acquiring party to repay the debt from sources other than the target.

iv. Identity of the creditor(s) and creditors' financial condition.

v. How will debt be secured; consider prohibiting securing of debt on shares of target or target's assets if not already prohibited by state statute.

vi. Compare the time period of loan commitment with parent's income stream over the same time period, including the ability of the acquiring party to repay the debt from sources other than the target until loan is repaid/retired.

vii. Consider the long-term impact of parent's debt service on operations of the target company and group.

viii. Does the Form A explain the criteria used in determining the nature and amount of such consideration?

Market Impact

10. Is the acquisition of control likely to lessen competition substantially or likely to lead to a monopoly in insurance in the state? If "yes," has a Form E been filed?

11. Perform additional review considerations to analyze market impact, which may include, but is not limited to the following:

    a. Consider anticompetitive impact of acquisition on lines or products. Disapprove transaction if completion will create a monopoly.

    b. Consider Form E information and market concentration for combined lines and other appropriate information to assess market impact if warranted by nature of transaction, including coordination with other states where the target is admitted.

    c. Consider imposing tailored conditions subsequent or undertakings as necessary to address competitive market concerns.

Record Maintenance and Conclusion

12. Respond as appropriate to questions from third parties and interested regulators and keep the acquiring party representatives informed as to status of the review.

13. Receive and consider any information provided by external sources, including possible financial or other incentives or motivation of those commenting on a particular transaction.

    - File and maintain documents under state procedures

14. Has the application been publicized to all interested persons inside and outside of the insurance department, in accordance with the department's policy or applicable laws?

15. Perform any additional procedures, as deemed relevant, to evaluate the Form A application in accordance with the specific circumstances identified, which may include, but is not limited to, the following:

    - Contact the insurer seeking explanations or additional information
    - Obtain the insurer's business plan
    - Meet with the insurer's management

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16. Develop and document an overall summary and conclusion regarding the holding company Form A application.
    - If application approval is deemed appropriate, consider whether any conditions precedent, specific ongoing stipulations or conditions subsequent should be included with the approval.
17. Add any material items from the Form A review to the Insurer Profile Summary.

Post-Approval

Post-Approval Considerations (if applicable)

18. Receive notification of changes to effective closing date.
19. Confirm compliance with conditions precedent.
20. Receive waivers for market conduct or financial examination.
21. Receive notification if transaction does not close and consider withdrawal of approval.

Post-Acquisition Considerations

22. Receive confirmation of the transaction following the closing, per your state's statutory requirement timeframe.
23. Request written details of the final purchase price after all adjustments are complete on the transaction.
24. Request confirmation of any capital contribution contemplated in the transaction. Request the names and titles of those individuals who will be responsible for the filing of the amended Insurance Holding Company System Annual Registration Statement.
25. Request an amended Insurance Holding Company System Registration statement per your state's statutory timeframe within each applicable state's statutory required timeframe after the close of the proposed transaction.
26. Consider requesting for a period of two years, commencing six months from closing, a semiannual report under oath of its business operations in your state, including but not limited to, integration process; any changes to the business of the Domestic Insurers; changes to employment levels; changes in offices of the Domestic Insurers; any changes in location of its operations in your state; and notice of any statutory compliance or regulatory actions taken by other state regulatory authorities against the acquiring parties or the Domestic Insurers.
27. Consider prior approval of all dividends for a two-year period from the close date.
28. If concerns are identified during the post-acquisition review, consider the following actions:
    - Conduct a target financial and/or market conduct examination
    - Hold a meeting, conference call or requesting additional information from the insurer or applicant
    - Require additional interim reporting from the insurer
    - Obtain a corrective plan from the insurer

Post-Closing Monitoring:

Consider monitoring the following after the close of the acquisition.

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29. Confirm ongoing compliance or satisfaction with any other conditions subsequent, undertakings or other expectation and stipulations that were set as part of the Form A approval.

30. Monitor target's market performance to projections two years after transaction close date.

31. Ongoing commitments and capital support to the insurer from the new owner.

32. Review of subsequent Board minutes.

33. Specific to an international acquisition:
    a. Monitor the Board and the International UCP's involvement and influence over the U.S. operations
    b. Assess the implementation of how the U.S. business is incorporated into or decentralized from the non-U.S. operations
    c. Access to the Group ORSA (as opposed to the US ORSA)
    d. Actively participating in supervisory colleges and other international coordination efforts to evaluate the solvency position of the acquiring entity/group as appropriate.

34. Monitor the ongoing financial condition of the acquiring entity/group by:
    a. Comparing actual results to pre-transaction projections to determine whether results of the acquisition/merger are meeting expectations. If not, gain an understanding of why projections have not been achieved and the company's planned actions to address issues.
    b. Requesting and reviewing information on the integration of company processes and systems (if applicable), as well as steps taken to ensure that adequate cybersecurity precautions are taken during the integration process.
    c. Reviewing the impact of the acquisition on the risk profile of the insurer and assessing whether it has been incorporated into the group's ERM, ORSA and Form F reporting, including the overall assessment of group risk capital.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the review of the Form A.

Recommendations for further action, if any, based on the overall conclusion above:

- Contact the insurer seeking explanations or additional information
- Require additional interim reporting from the insurer
- Meet with the insurer's management
- Other (explain)

Analyst:	Date:
Supervisor Review:	Date:
Supervisor Comments:	

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Special Notes:

The following procedures do not supersede state regulation but are merely additional guidance analysts may consider useful only if the state has adopted the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions*, (#450).

Form D – Prior Notice of a Transaction

Form D is transaction specific and is not part of the regular annual/quarterly analysis process. The review of these transactions may vary as some states may have regulations that differ for Form D.

Compliance Assessment

1. If a material transaction has occurred, did the insurer file a Form D with its domestic state? (Section 5 of the NAIC *Insurance Holding Company System Regulatory Act* (#440) requires each insurer to give prior notice of certain proposed transactions).

2. Did Form D include the following information for each party to the transaction (Form D of *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions*, (#450):

   - Name
   - Home office address
   - Principal executive office address
   - The organizational structure
   - A description of the nature of the parties' business operations.
   - The relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.
   - The name(s) of the affiliate(s) that will receive, in whole or in substantial part, the proceeds of the transaction, when the transaction is with a non-affiliate.

3. Does Form D include the following information for each transaction for which notice is being given:

   - A statement as to the section of the holding company regulation Form D filing is being made.
   - A statement as to the nature of the transaction.
   - A statement of how the transaction meets the 'fair and reasonable' standard of the state's insurance holding company law or regulation; and
   - The proposed effective date of the transaction.

4. Does Form D provide a brief description of the following:

   - Amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment.
   - Whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice.
   - A description of the terms of any securities being received, if any.

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- A description of any other agreements relating to the transaction, such as contracts or agreements for services, consulting agreements and the like.

5. If the transaction involves consideration other than cash, does Form D provide a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation?

6. If the transaction involves a loan, extension of credit or a guarantee, does the Form D provide a description of the maximum amount that the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest?

7. If the transaction involves an investment, guarantee or other arrangement, has the time period been stated during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements? Does Form D provide a brief statement as to the effect of the transaction upon the insurer's surplus?

8. If the transaction involves a loan or extension of credit to any person who is not an affiliate, does the Form D include the following:

   - A description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extension of credit.
   - A specification regarding what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate.
   - A description of the amount and source of funds, securities, property or other consideration for the loan or extension of credit.
   - For transactions involving consideration other than cash, a description of its cost and its fair value and basis for evaluation.
   - A brief statement as to the effect of the transaction upon the insurer's surplus.

9. If the transaction is a reinsurance agreement or modification thereto or a reinsurance pooling agreement or modification, does Form D include the following:

   - A description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year.
   - The period of time during which the agreement will be in effect.
   - A statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more affiliates.
   - A brief description of the consideration involved in the transaction.
   - A brief statement as to the effect of the transaction upon the insurer's surplus.

10. Determine if the reinsurance agreement complies with the requirements for credit for reinsurance.

11. Determine whether the reinsurance agreement's right of offset limits the offset specifically to the reinsurance agreement(s) and not other balances that may accrue as a result of other transactions.

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12. For management and service agreements, does Form D include the following:
    - A brief description of the managerial responsibilities or services to be performed.
    - A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made (compensation bases other than actual cost should be closely evaluated).
13. For cost-sharing arrangements, determine whether the Form D includes the following:
    - A brief description of the purpose of the agreement.
    - A description of the period of time during which the agreement is to be in effect.
    - A brief description of each party's expenses or costs covered by the agreement.
    - A brief description of the accounting basis to be used in calculating each party's costs under the agreement.
    - A brief statement as to the effect of the transaction upon the insurer's surplus.
    - A statement regarding the cost allocation methods that specifies whether proposed charges are based on 'cost or other than cost.' If other than cost, include the rationale for not using cost, including justification for the company's determination that amounts are fair and reasonable.
    - A statement regarding compliance with the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) regarding expense allocation.
14. For management, service and cost-sharing agreements, in accordance with the NAIC Insurance Holding Company System Act #440 and NAIC Insurance Holding Company System Model Regulation #450, does the agreement[1]:
    - Identify the person providing services and the nature of such services.
    - Set forth the methods to allocate costs.
    - Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the AP&P Manual.
    - Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement.
    - State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance.
    - Define records and data of the insurer to include all records and data developed or maintained under or related to the agreement that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate.
    - Specify that all records and data of the insurer are and remain the property of the insurer, and:
        - Are subject to the control of the insurer.

[1] All underlined text in Procedure 14 represents amendments to Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (Model #450) Section 19 as adopted by the NAIC on Aug. 17, 2021. As state insurance departments are still in the process of adopting these amendments into state law, analysts should refer to their own state's holding company law or regulation regarding compliance with Form D filings of management, service and cost-sharing agreements.

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- Are identifiable.
- Are segregated from all other persons' records and data or are readily capable of segregation at no additional cost to the insurer[2]

- State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer.
- Include standards for termination of the agreement with and without cause.
- Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services and for any actions by the affiliate that violate provisions of the agreement required in Subsections 19B(11), 19B(12), 19B(13), 19B(14) and 19B(15) of this regulation.
- Specify that, if the insurer is placed in supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts]:
  - All of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by [law of the state].
  - All records and data of the insurer shall be identifiable and segregated from all other persons' records and data or readily capable of segregation at no additional cost to the receiver or the commissioner.
  - A complete set of records and data will immediately be made available to the receiver or the insurance commissioner, shall be made available in a usable format, and shall be turned over to the receiver or insurance commissioner immediately upon the receiver or the commissioner's request and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable[3].
  - The affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or commissioner.
- Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to the [supervision and receivership acts].
- Specify that the affiliate will provide the essential services for a minimum period of time [specified in the agreement] after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], as ordered or directed by the receiver or commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court.
- Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts] and will make them available to the receiver or commissioner as ordered or directed by the receiver or commissioner for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court.

[2] In Model #450, the "at no additional cost to the insurer" language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer, receiver or commissioner. Since records and data of the insurer are the property of the insurer, the insurer, receiver or commissioner should not pay a cost to segregate commingled records and data from other data of the affiliate.

[3] In Model #450, the fair and reasonable cost to transfer data to the receiver or commissioner refers to the cost associated with physically or electronically transferring records and data files to the receiver or commissioner. This cost does not include costs to separate comingled data and records that should have been segregated or readily capable of segregation.

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- Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver's authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], and portions of the insurer's policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate's commitments under Subsections 19B(11), 19B(12), 19B(13) and 19B(14) of this regulation will extend to such guaranty association(s).

15. For any Form D agreement with an affiliate, in accordance with the holding company regulation, processes and procedures of the state, review and consider compliance with any state-specific requirements.

16. In evaluating fairness and reasonableness of affiliated investment management agreements, consider whether the following elements are appropriately included in the agreement:
    a. **Selection of Investments –** It should be clear from the advisory agreement how the investment adviser will select investments. This should be detailed through clear investment guidelines documented in the investment management agreement, which are also in compliance with the insurer's investment strategy and applicable laws and regulations.
    b. **Authority for Transactions –** Advisory agreements should address the level of authority that will be given to the investment adviser in executing transactions.
    c. **Conflicts of Interest –** To the extent that any conflicts of interest may be known to the insurer, the advisory agreement should specifically indicate the manner in which such conflicts will be considered.
    d. **Fiduciary Responsibility –** Language provided in the investment management agreement should acknowledge the investment adviser's role as a fiduciary in advising the insurer and, if applicable, confirm the entity's registration as an investment advisor/manager with the SEC and/or State securities regulators.
    e. **Calculation of Fees –** It is important that the manner in which fees are calculated is well defined in the management agreement and that the structure of the fee is considered as management assesses the adviser's performance. Special attention should be paid to whether there are any performance or incentive fees over and above a base management fee.
    f. **Sub-Advisors –** Does the investment manager have the authority to engage sub-advisors and is consent by the insurer required? Who is responsible for the fees of the subadvisor?
    g. **Reporting –** Are expectations for the reporting of portfolio performance included in the agreement?
    h. **Termination –** Are there appropriate termination provisions, both with and without cause?
    i. **Review of Performance and Compliance –** Agreements should include consideration of information that will be provided to the company to permit the company to perform adequate review of the adviser's performance and execution of the investment strategy, including compliance with adopted investment guidelines.

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Assessment of Form D – Prior Notice of a Transaction

17. For affiliated capital or surplus notes, amendments or requests for payment of principal or interest, utilize the review procedures as outlined in this Handbook, IV.A. Supplemental Analysis Guidance, Section G. – Income Statement, Surplus and Capital and Surplus Notes.

18. Form D – Prior Notice and Application for Approval of Certain Transactions

    a. For a parental guarantee or capital maintenance agreement Form D filing, utilize the procedures and guidance in Chapter V.F – Form A, to complete the review, including a review of the time frame, maximum amount of the guarantee, and any provisions that may impact the guarantee.

19. Review Form D for any significant and/or unusual items or inconsistencies. Determine if the transaction is fair and reasonable as required under Section 5A(1)(a) of Model #440 by considering the following:

    a. For reinsurance agreements, are the general terms, settlement provision, and pricing consistent with those of agreements with non-affiliates?

    b. For management, service or cost-sharing agreement, are the charges or fees to be paid by/to the insurer reasonable in relation to the cost of such services?

    c. Are fees paid for related party transactions consistent with the applicable section of the state's Insurance Holding Company Act? (Note: Insurers should not use related-party transactions as a method for transferring profits of the insurance company to an affiliate or related party.)

    d. Will the insurer have adequate surplus upon completion of the transaction?

    e. Does the transaction comply with the NAIC AP&P Manual? Are expenses incurred and payment received allocated to the insurer in conformity with prescribed insurance accounting practices consistently applied?

    f. Are books, accounts and records of each party maintained clearly and accurately to disclose the nature and details of the transactions including such information as is necessary to support the reasonableness of charges or fees to the respective parties?

    g. Does the transaction comply with the state's requirements regarding the insurer's ownership of data and records that are held by an affiliate, and control of premium or other funds belonging to the insurer that are collected or held by an affiliate?[4]

    h. Do unusual circumstances, risks or concerns exist?

    i. Any other state-specific requirements for determining and reviewing fair and reasonableness.

20. Determine whether the transaction was accounted for properly, based on statutory accounting principles, with the NAIC AP&P Manual.

[4] Procedure 16.g represents amendments to Insurance Holding Company System Model Act (Model #440) Section 5A(1)(h) and 5A(1)(i) as adopted by the NAIC on Aug. 17, 2021. As state insurance departments are still in the process of adopting these amendments into state law, analysts should refer to their own state's holding company law or regulation regarding compliance with Form D filings of management, service and cost-sharing agreements.

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Assessment of Form D – Captive Reinsurance Transactions

Transactions Subject to AG48:

21. For all transactions proposed to be entered into on or after Jan. 1, 2015, perform the following (either directly or by reviewing the work of the captive state) initially upon presenting the transaction for approval:

    a. Require the insurer to submit a statement as to whether some or all of the risks ceded under the transaction qualify for an exemption from Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued Under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG48). If so, require the insurer to identify with specificity the basis for claiming the exemption.

    b. Require the insurer to submit five years of pro forma financial statements of the affiliated captive reinsurance entity (assets, liabilities, equity and income) including specifically projected statutorily required reserves.

    c. Require the insurer to list and value (in accordance with the valuations used in AG 48) all funds to be held by or on behalf of the insurer as security under the reinsurance contract. The insurer should identify any funds so listed that are: (1) Primary Security (as that term is defined in AG 48); and/or (2) held by or on behalf of the insurer on a funds withheld, trust, or modified coinsurance basis.

    d. If no exemption under AG 48 applies, require the insurer to submit current and five-year projected calculations, and support therefor, of: (1) the statutory reserves with respect to the XXX/AXXX business being ceded; and (2) the Required Level of Primary Security, as defined in AG 48.

    e. If no exemption under AG 48 applies, require the insurer to state whether, both at the inception of the transaction and thereafter: (1) funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, will be held by or on behalf of the insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis; and (2) funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (1) above, will be held by or on behalf of the insurer as security under the reinsurance contract.

    f. Consider the following in determining if the transaction should be approved:

        i. If no exemption under AG 48 applies, consider: (1) whether funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, will be held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust or modified coinsurance basis; and (2) whether funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (1) above, will be held by or on behalf of the ceding insurer as security under the reinsurance contract.

        ii. The extent of refinancing risk present within the transaction given they may involve financing of long duration reserve liabilities with short or medium duration assets. If the financing transaction is scheduled to mature when the best estimate amount that would need to be refinanced is a substantial percentage of statutory reserves, consider whether: (1) the terms of the transaction provide the insurer with flexibility to either refinance (with the same finance provider or a replacement finance provider) or to recapture without incurring a material reduction to the insurer's Total Adjusted Capital; or (2) the insurer otherwise has a contingency plan to manage its capital at transaction maturity.

        iii. Conditions imposed by the financing provider that require the assets available to satisfy policyholder claims be used before payment is made by the financing provider. Request information from the insurer as to whether assets supporting reserves contain conditions or "priority of payment"

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provisions that could make the asset unavailable to satisfy general account liabilities. If so, consider if such provisions are consistent with existing law.

iv. Contact the lead state to determine the financial position of the group as a whole and the group's ability to absorb material unexpected losses from the transaction given the specific terms of the financing transaction given the specific terms of the financing transaction. In determining the ability to absorb material unexpected losses, consider either reviewing the group's Own Risk and Solvency Assessment (ORSA) Summary Report or obtaining similar information that may demonstrate available capital above existing group capital.

v. Consider if there are high-quality assets supporting the surplus of the captive that provide additional cushion to absorb material unexpected losses.

vi. Determine if other provisions are in place within the captive transaction that may help to limit exposure to the group. This may include specific capital requirements on the captive, limitations on the ability of the captive to pay dividends to the parent, additional reinsurance to a third-party reinsurer or other risk-reduction strategies.

vii. Contact the lead state and every domiciliary state insurance regulator within the group to determine if they have any input in approving the transaction, although ultimately the decision must be made by the state of domicile.

viii. Consider if the captive will be retroceding business to other affiliates or non-affiliates.

Captive Reinsurance Transactions on Other Lines of Business Not Subject to AG 48:

ix. Utilize the information in Form D for affiliated captive transactions and other annual reporting (annual statement, actuarial reporting), and if necessary, ask the company, to gain an understanding of the purpose of the use of captive (non-traditional) reinsurance to better assess the insurer's overall reinsurance strategy.

x. Consider Handbook procedures similar to the procedures above for AG 48 captive reinsurance if any procedures are applicable to assessing transactions on other business types.

xi. Within the Form D affiliated reinsurance transaction filing, require the insurer provide RBC projections of the impact of the ceding insurers longevity risk charge based on a gross reserve basis for approved affiliated reinsurance transactions.

xii. Within the department's Form D analysis, document the assessment of how the affiliated reinsurance transaction affects the level playing field and competition in the marketplace, consideration of the impact to RBC for the affiliated reinsurance transaction and reserving, specifically, asset adequacy.

xiii. As part of the Form D review and approval process, if concerns are noted, consider including conditions on the approval of the Form D reinsurance transaction, such as:

1. All new affiliated business assumed under the agreement must be submitted to the Department for an assessment of fair and reasonableness and arms-length terms. Only business evaluated by the Department's actuary through the Form D review are permitted to be ceded.

2. On an annual basis, the ceding insurer will provide the following of the captive reinsurer:
    a. The audited GAAP financial statements and audited [international jurisdiction] statutory financial statements.
    b. Current business plan and any subsequent changes to this plan.
    c. Actuarial report.

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3. On an annual basis, the ceding insurer will prepare a separate asset adequacy analysis on business assumed by the captive reinsurer for the Department's evaluation, including cash flow testing and sensitivity tests. The sensitivity tests, at a minimum, must include: lapse test (stress the lapse rates); utilization test (stress the utilization rate); combined surrender/utilization test; and credit defaults tests. The results of this analysis will be referenced in the reinsurance section of the Actuarial Opinion and Memorandum. This asset adequacy analysis must be used to true-up the statutory sufficiency of the reserve credit taken on the related gross reserves. This true-up is regardless of any offsets from redundancies found within the gross reserves of other business.
4. Prepare and submit financial projections to the Department to demonstrate the impact on RBC as if the affiliated transaction with the captive reinsurer was not in place.

Summary and Conclusion

Following the review of previous procedures develop and document an overall summary and conclusion including items for follow up regarding the review of the holding company Form D.

Recommendations for further action, if any, based on the overall conclusion above could consider steps such as the following:

- Contact the insurer seeking explanations or additional information.
- Review support provided by management supporting its assessment that the agreement meets the standard of "fair and reasonable".
- Review the insurer's business plan on file or obtain a more current business plan if applicable.
- Require additional interim reporting information from the insurer including forecasted cash flows relating to the agreement (e.g., 1-3 years) to evaluate materiality of changes in year-to-year cash flows to the insurer, particularly if the agreement is other than cost-based or if there are other ongoing concerns noted.
- Compare cash flows relating to any prior agreements (if similar in services/scope, and whether those were with affiliates or non-affiliates) to the forecasted cash flows relating to the proposed transaction or amendment. The comparison should consider not just the fees/expenses, but also the impact on cash flows relating to the services provided (e.g., reduced claims cost, etc.)
- Consider the insurer's aggregate exposure to all agreements with affiliates, current and trending, absolute dollars and relative to base (e.g., capital and surplus, total expenses, etc.) and whether the terms and amounts meet the "fair and reasonable" standard.
- Determine if one or more agreements with affiliates trigger or increase concerns regarding related party risks or create financial solvency concerns.
- Refer concerns to the examination section for targeted examination or follow-up on the next full-scope examination. Consider suggesting specific procedures to be performed by placing them in the supervisory plan section of the IPS.
- Consider the need to engage external resources to assist in the review of complex agreements with affiliates (i.e., independent actuary or other reinsurance expert to review specific reinsurance contracts, investment expert to review investment management agreements with affiliates).
- Meet with the insurer's management.
- Other (explain)

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Notice to Insurer

In the notice to the insurer, state that approval of the agreement is based upon representations made in the filing, all of which are subject to verification on analysis or examination. In addition, state that the department reserves the right to review the charges and fees for fairness and reasonableness as part of future financial examinations or at any time validation is warranted. For issues found on exam, a correction would generally be required on a going forward basis.

Consider whether any additional stipulations or orders should be imposed on the agreement as a result of the review and communicated in the notice to the insurer, such as the interim reporting outlined above.

Analyst:	Date:
Supervisor Review:	Date:
Supervisor Comments:	

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Special Notes:

The following procedures do not supersede state regulation but are merely additional guidance analysts may consider useful. The following procedures are intended only for the review of compliance with filing requirements and are not specific to the decision process for approval of a transaction.

Form E (or Other Required Information) – Pre-Acquisition Notification Form Regarding the Potential Competitive Impact of a Proposed Merger or Acquisition by a Non-Domiciliary Insurer Doing Business in This State or by a Domestic Insurer

Form E or other required information is transaction specific and is not part of the regular annual/quarterly analysis process. The review of these transactions may vary, as some states may have regulations that differ from Form E.

1. Does Form E or other required information state the names and addresses of the individuals who are providing notice of their involvement in a pending acquisition or change in corporate control?

2. Does Form E or other required information contain the following information:
   - State the names and addresses of the individuals affiliated with the individuals listed in question 1
   - Describe their affiliations

3. Does Form E or other required information state the nature and purpose of the proposed merger or acquisition?

4. Does Form E or other required information state the nature of the business performed by each of the individuals listed in questions 1 and 2?

5. Does Form E or other required information provide the following information:
   - State the market and market share in each relevant insurance market the individuals identified in questions 1 and 2 currently benefit from in this state
   - Historical market and market share data for each individual identified in questions 1 and 2 for the past five years
   - Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of the state. If the proposed merger or acquisition would violate competitive standards, provide justification of why the acquisition or merger would not substantially lessen competition or create a monopoly in the state.
   - The sources of the above information

Assessment of Form E or Other Required Information

6. If the Form E or other required information identifies certain thresholds that are exceeded, indicating evidence of the transaction's violation of the competitive standards within the state, has the applicant provided appropriate information or arguments that support the transaction does not violate the competitive standard? If "no," explain.

7. In the department's review of the Form E or other required information, did the Department note any concerns or risks regarding the impact of the proposed merger or acquisition on the market share or competition within the state? Explain.

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Summary and Conclusion

Develop and document an overall summary and conclusion regarding the review of the holding company Form E or other required information.

Recommendations for further action, if any, based on the overall conclusion above:

- Contact the insurer seeking explanations or additional information
- Obtain the insurer's business plan
- Require additional interim reporting from the insurer
- Meet with the insurer's management
- Other (explain)

Analyst:	Date:
Supervisor Review:	Date:
Supervisor Comments:	

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Special Note: The following procedures do not supersede state regulation but are merely additional guidance analysts may consider useful. The following procedures are intended only for the review of compliance with filing requirements and are not specific to the decision process for approval of a transaction.

Extraordinary Dividend/Distribution

Extraordinary Dividend/Distributions are transaction-specific and are not part of the regular annual/quarterly analysis process. The review of these transactions may vary as some states may have regulations that differ.

1. Does the request for approval of the extraordinary dividend or distribution include the following?
    - The amount of the proposed dividend
    - The date established for the payment of the dividend
    - A statement as to whether the dividend is to be in cash or other form and, if in other form, a description, its cost, and its fair value together with an explanation of the basis for the valuation
    - A copy of the calculations determining that the proposed dividend is extraordinary
    - A balance sheet and statement of income for the period between the last annual statement filed and the end of the month prior to the month in which the request for dividend approval is submitted
    - A brief statement as to the effect of the proposed dividend on the insurer's surplus, the reasonableness of surplus in relation to the insurer's outstanding liabilities, and the adequacy of surplus relative to the insurer's financial needs
2. Does the notice include adequate information regarding the purpose of the dividend?
3. Does the purpose of the dividend/distribution appear reasonable?
4. Based on the information above, is the dividend or other distribution, in fact, extraordinary in nature?
5. Does the transaction comply with statutory accounting rules?
6. Will the insurer have adequate surplus?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company.

Recommendations for further action, if any, based on the overall conclusion above:

- Contact the insurer seeking explanations or additional information
- Obtain the insurer's business plan
- Meet with the insurer's management
- Other (explain)

Analyst:	Date:
Supervisor Review:	Date:
Supervisor Comments:	

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Special Note: This Handbook guidance does not supersede state law and regulation but is merely additional guidance and best practices that analysts may consider useful. This guidance and accompanying procedures may be used in part, or in total, at the discretion of the analysts depending on the level of concern, and the area in which the risk was identified.

Non-Lead State Holding Company System Analysis Procedures

Refer to section VI.C. Group-wide Supervision - Insurance Holding Company System Analysis Guidance (Lead State) for additional guidance on holding company analysis procedures.

Forms A, B, D, E (or Other Required Information), and Extraordinary Dividend/ Distribution

Forms A, D, E (or Other Required Information) and Extraordinary Dividends/Distributions are transaction specific and are not part of the regular annual/quarterly analysis process. The review of these transactions may vary, as some states may have regulations that differ from these forms.

Form A – Statement of Acquisition of Control of or Merger with a Domestic Insurer

The *Insurance Holding Company System Regulatory Act* (#440) outlines specific filing requirements for individuals wishing to acquire control of or merge with a domestic insurer. Form A is filed with the domestic state of each insurer in the group. Every attempt should be made to coordinate the analysis and review of holding company filings among all impacted states and other functional regulators to avoid duplicate processes. The domestic state or lead state should communicate the filing with all impacted states.

The period for review and action on proposed affiliations for transactions falling under the Gramm-Leach-Bliley Act (GLBA) is limited to 60 days prior to the effective date of the transaction. Under GLBA Section 104(c)(2), the states have a 60-day period preceding the effective date of the acquisition, change, or continuation of control in which to collect information and take action. Individual state statutes and regulations may or may not impose other time limitations on the review period.

Form B – Insurance Holding Company System Annual Registration Statement

Model #440 defines insurance holding companies and the related registration, disclosure, and approval requirements. Form B is the insurance holding company system annual registration statement. Model #440 requires every insurer, which is a member of an insurance holding company system, to register by filing a Form B within 15 days after it becomes subject to registration, and annually thereafter. Any non-domiciliary state may require any insurer that is authorized to do business in the state, which is a member of a holding company system, and which is not subject to registration in its state of domicile, to furnish a copy of the registration statement.

An insurance holding company system consists of two or more affiliated individuals, one or more of which is an insurer. An affiliate is an entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, another entity. Control is presumed to exist when an entity or person, directly or indirectly, owns, controls, holds the power to vote, or holds proxies, representing 10% or more of the voting securities. The review of Form B should be completed by Oct. 31st for analysis conducted by a lead state and by Dec. 31st for analysis conducted by a non-lead state.

Form D – Prior Notice of a Transaction

Model #440 requires each insurer to give notice of certain proposed transactions. Form D must be filed with the domestic state. Material transactions include but are not limited to sales, purchases, exchanges, loans, extensions of credit, guarantees, investments, reinsurance, management agreements, service agreements and cost-sharing agreements. The transaction is considered material if for non-life insurers, it is the lesser of 3% of the insurer's admitted assets or 25% of surplus, and for life insurers, 3% of the insurer's admitted assets, each as of the most recent prior Dec. 31. Some states have stricter definitions of materiality in their holding company regulations.

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Holding company regulations require that affiliated transactions be fair and reasonable to the interests of the insurer. Generally, affiliated management or service agreements should be based on actual cost in order to meet the fair and reasonable standard.

The appropriate Statement of Statutory Accounting Principle should be reviewed within the NAIC *Accounting Practices and Procedures Manual* to ensure proper accounting.

Form E (or Other Required Information) – Pre-Acquisition Notification Form Regarding the Potential Competitive Impact of a Proposed Merger or Acquisition by a Non-Domiciliary Insurer Doing Business in This State or by a Domestic Insurer

Model #440 mandates that any domestic insurer, together with any person controlling a domestic insurer, proposing a merger or acquisition to file a Form E (or Other Required Information), pre-acquisition notification form. Any differences between Model #440 and the applicable state regulations should be considered. As state requirements for Form E vary, in many states the Form E or other required information is filed to the non-domestic regulator. The insurer may also be required to file documents with the Federal Trade Commission under the Hart-Scott-Rodino Act.

The period for review and action on proposed affiliations for transactions falling under the GLBA is limited to 60 days prior to the effective date of the transaction. Under GLBA Section 104(c)(2), the states have a 60-day period preceding the effective date of the acquisition, change, or continuation of control in which to collect information and take action. It may not be mandatory for some states to approve or disapprove the Form E (or Other Required Information). These states may only have a certain period of time that an insurer's license to do business in the state is denied or a cease-and-desist order is put into effect.

Extraordinary Dividend/Distribution

Model #440 indicates that any domestic insurer planning to pay any extraordinary dividend or make any other extraordinary distribution to its shareholders receive proper prior regulatory approval. The insurer is required to wait 30 days after the commissioner has received notice of the declaration and has not, within that period, disapproved the payment or until the commissioner has approved the payment within the 30-day period.

Each state has its own definition of "extraordinary"; however, Model #440 defines an extraordinary dividend or distribution as any dividend or distribution of cash or other property, whose fair value, together with that of other dividends or distributions made within the preceding 12 months, exceeds the lesser of:

- 10% of the insurer's surplus as regards to policyholders as of Dec. 31 of the prior year; or
- For life insurers, net gain from operations and for non-life insurers, net income, excluding realized capital gains for the twelve months ending Dec. 31 of the prior year. This should not include pro-rata distributions of any class of the insurer's own securities.

Form A – Statement of Acquisition of Control of or Merger with a Domestic Insurer

Determination of the Ultimate Controlling Person (UCP)

For all ownership structures, when reviewing Form A applications, it is most important for the analyst to understand the terms of the ownership documents, whether traditional stock ownership or other unique or complex ownerships structures such as trusts, limited partnerships, limited liability corporations, international owners, or structures with unique share classes and voting rights. Certain agreements within the structure may convey control through unique share classes and voting rights, or through certain management or operational agreements that delegate decision making and control to a specific person or entity. For all of these structures and unique situations, it is important to identify an individual ultimate controlling person (UCP) at the top of the organizational structure, i.e., to trace ownership/control to the top person/entity. It is at the UCP level that financial statements and other insurance holding company filings will be required to be submitted to the

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department, although other controlling entities (e.g., minority owners) may also be asked to provide such information when appropriate.

The state insurance department should engage the state's legal staff and other necessary internal or external expertise early in the Form A review process to assist in the review of organizational documents and agreements and in the determination of the UCP.

Review Procedures

PROCEDURES #1-2 provide instructions for the initial review of Form A including determining if the filing is complete, establishing communication and coordination with other states and functional regulators, and updating the NAIC Form A database. States should enter the high-level information about Form A filings into the NAIC Form a Database as well as update the Form A Database with changes in status. The Form A Database allows regulators to communicate high-level information of a filing, as well as share contact information and comments on a filing. States are encouraged to use Personalized Information Capture System (PICS) alerts to notify them of Form A Database entries and updates. Such alerts would highlight any potential addition or deletion of any insurer to a Group. Contact information for the lead analyst/supervisor/chief, as applicable, responsible for the Form A review at each insurance department, as well as contact information for other functional regulators involved should be distributed to all regulators involved.

PROCEDURES #3-4 provide steps for reviewing the details of the transactions to ensure that the Form A filing is in compliance with application requirements. The procedures also suggest additional considerations and assessment of any risks and concerns regarding items such as future financial solvency of the insurer, its ability to continue to satisfy the requirements of its license, sufficiency of surplus, financial projections, debt support, suitability of affiliated agreements, technology interfacing, and dividends.

PROCEDURES #5-7 assist analysts in reviewing the background and financial information provided in the Form A application to identify the UCP, and to ensure that the Form A filing is in compliance with application requirements. Additionally, the procedures provide for review considerations of the UCP, Officers and Directors.

PROCEDURES #8-9 provide steps to ensure that information provided on purchase considerations in the Form A filing is in compliance with application requirements. In addition, the steps provide guidance for assessing the purchase considerations including source of funds & consideration, debt financing, and voting securities.

PROCEDURES #8g - Review of a Parental Guarantee or Capital Maintenance Agreement
Analysts should consider the following when reviewing a parental guarantee or capital maintenance agreement (CMA) that may be included with a Form A filing:

- The agreement should clearly outline:
  - The parties or insured covered under the agreement should be clearly outlined in the agreement.
  - The parents' obligation to provide capital in order to maintain an adequate level of capital or minimum RBC Ratio level (e.g., ##.#% of ACL).
- Review the terms of the agreement including the effective date, renewal terms and termination provisions. Determine whether the agreement has an expiration date or dollar limit threshold on capital, or if a pre-approved alternative funding method will be provided. Understand the minimum level of RBC % that is expected to be maintained under this agreement.
- Ensure that any modifications or demands under this agreement should be reviewed and approved by the domiciliary insurance department.
- If the parental guarantee or CMA specifically addresses the concerns identified and provides adequate support to the insurer.
- If concerns exist, consider requesting additional information, as necessary, to understand the level of commitment.

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- Evaluate the financial stability of the parent holding company (or other affiliated entity providing the guarantee such as an intermediate holding company), to determine if the parent is adequately capitalized to support/maintain the capital in the insurer above minimum thresholds. Evaluate the impact of providing a parental guarantee or CMA on any debt covenants of the parent, if applicable.

Situations when it may be appropriate to request an Insurer/Group develop and submit a parental guarantee or CMA to the state insurance regulator:

- When an applicant has submitted a new Form A application for change in control of an insurer, if deemed necessary.
- When the insurer has triggered Hazardous Financial Condition or an RBC action level.
- When an insurer has applied for either primary or foreign licensure in your state.
- When there are material concerns identified with other affiliated agreements within the group.

Reliance on a CMA or Parental Guarantee

- States should exercise caution in relying on a parental guarantee or CMA for regulator actions such as licensure approval.
- Domestic states should proactively communicate to other licensed state(s) when a parental guarantee or CMA has been approved (or denied), modified or terminated.

PROCEDURES #10-11 provide steps for assessing the impact of the acquisition on the insurance market, any concentrations/monopolies, anticompetitive impacts, and including consideration of the review of Form E-Pre-Acquisition Notification Form.

PROCEDURES #12-17 provides steps for completion of the approval or denial of the Form A application and developing an overall conclusion regarding the Form A.

POST-APPROVAL PROCEDURES #18-34 provide administrative steps for the conclusion of the Form A approval process as well as analytical steps for post-acquisition financial solvency analysis and compliance review. It is important for the department to conduct follow-up analysis and/or examination to ensure that stipulations or conditions of the acquisition approval have been met, that actual results are in line with the financial projections, business operations and strategy of the insurer that were provided with the Form A, and if not, to understand the reasons for variances.

General Statutory Standards and Risk Assessment for Form A Review

When performing the procedures listed above, it is appropriate to first consider the general statutory standards that regulators must apply in consideration of a Form A, namely that:

- The financial stability of the insurer would not be jeopardized
- Policyholders will not be prejudiced
- The acquiring party's future plans are not unfair and unreasonable to policyholders
- The transaction is not likely to be hazardous or prejudicial to the insurance-buying public

Although these are the general statutory standards that apply, analysts may need to think more broadly when considering whether these standards have been met. The point of this suggestion is to consider all aspects of the financial condition of the acquiring entity including the acquiring entity's group business model, its strategy in general and its specific strategy in purchasing the insurer, as well as any assumptions used by the acquiring entity in its evaluation of the benefits of the proposed transaction. Understanding these aspects of the proposed transaction should assist analysts in reaching a recommendation related to the proposed transaction.

Analysts are already required in other areas of this handbook to consider the prospective risks of any domiciled insurer as they perform their annual analysis and ongoing financial solvency oversight of the insurer. This also

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includes considering the financial condition of the entire holding company structure as defined within state law and discussed separately within this Section VI. Therefore, as analysts consider the application for change in control, it may be appropriate to consider the risks of the acquiring entity and the entire group of affiliated insurers and non-insurance affiliates under its control. In so doing, analysts should consider the group's exposure to branded risk classifications.

Branded Risks

In considering exposure to branded risk classifications, the issues of legal risk and reputational risk are generally well incorporated into the Form A application and its review. Many of the other risks (pricing and underwriting and reserving) tend to be most concentrated in the area of the insurers and therefore in these cases, it is reasonable that analysts initiate conversations with regulators of existing insurers in the applicant's group (domestic states or foreign jurisdictions) to determine if there are any concerns in these areas. However, the proposed transaction may put additional pressure on the insurer and the group from the standpoint that it may increase the leverage (operating or financial) which has the potential to increase the risks in each of these areas. The Form A application already contemplates obtaining proforma results for the insurer and the group. As analysts review proposed transaction, they may want to consider requesting additional information related to such proformas, such as how such results, and perhaps key ratios (e.g., operating or leverage) may look under certain feasible stress scenarios, particularly those that can be the most problematic for the group given its existing products or those included in its proposed business plan. However, stress scenarios should be evaluated in the context of how the company, as currently configured, would perform under the same stress scenarios. This may also be helpful in further assessing credit, market or liquidity risk. The results of such stresses should not be overemphasized but should be considered when evaluating whether the proposed transaction meets the previously mentioned criteria. Such an analysis may also be helpful in evaluating the strategic risk of the company and the group. However, strategic risk may be difficult to evaluate without additional information beyond the proforma financial statements. This is because the proforma financial statements may not reveal enough information to permit analysts to evaluate the ability of the group to execute its business plan.

Non-Insurance Affiliate Risks

More often, the risks that may be most difficult to discern are those that may exist within non-insurance affiliates because such entities may be unregulated, thereby eliminating the ability to obtain information from another regulator as can be done with insurers. Generally speaking, such non-insurance affiliates will not carry pricing and underwriting and reserving risks because those risks tend to be thought of as insurance risks. Those affiliates may however have other comparable risks, (or unrelated risks) that may be evident from a review of the proforma information. In particular, something that may not be captured in the proforma information is the other types of risks not already discussed which include or pertain to credit, market and liquidity. For some non-insurance affiliates, these risks can be more pronounced, or at least by comparison to the relative risk from the insurers within the group because state investment laws may serve as a deterrent to excessive amounts of such risks. Consequently, in addition to considering the information provided in proforma financial statements and even stressed proforma financial statements, analysts may need to obtain additional information in order to evaluate whether the proposed transaction meets the four previously identified general standards. In order to evaluate credit, market and liquidity risk, analysts should evaluate the potential enterprise risks posed to the insurer from other non-insurance affiliates and may need to request information regarding the investment portfolio of the entire group. In all cases where information is sought relating to non-insurance affiliates, controlling individuals and other equity holders, care should be taken to ensure that confidentiality of such information can be appropriately protected.

In some cases, this may require more detailed information regarding investments such as LLCs, equity and other fund holdings and other invested assets (BA for insurer). In cases where the investment portfolio appears to be complex, analysts may need to consider engaging an investment specialist and actuary to review the entire proposed transaction to determine if the investment strategy and related affiliated agreements are appropriate

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or not excessively risky for the backing of the insurance contracts from a risk and asset/liability matching perspective, respectively.

Such a review would consider the reasonableness of equity firm fees and other fee structures, if any, charged or to be charged to the insurance company, as well as any similar arrangements, proposed or existing, between the insurance company and affiliated broker-dealers. Unreasonable charges to the insurance company is a particular risk that can be common in many different types of holding company structures. Because of this risk, states may need to look to authority within their holding company laws to review and deny transactions that have the potential to excessively charge the insurer for certain services and transactions if the costs are not excessive in comparison to costs for a similar transaction with a non-affiliated entity. Prior to agreeing to the proposed Form A, it may be appropriate to consider whether such contracts exist and to review them.

Analysts should also consider reviewing arrangements with parties that may not be affiliates by definition but may be parties that appear to be engaging in a manner that is similar to an affiliate. The primary concern is whether these arrangements could be excessively charging the insurer for certain services. Another concern includes the creation of relationships that are used to prevent full disclosure of the entirety of activities within the holding company structure. Again, in many cases the primary concerns with a proposed transaction may be derived from the credit, market and liquidity risk of the non-insurance affiliates (or related strategic risks), and this type of analysis may be necessary in cases where these risks may pose enterprise risks to the insurer. Further analysis of these presumably unrelated party transactions may be necessary to determine if the risks of the non-insurance affiliates may pose enterprise risks that may affect the insurer.

In many cases, provided the application includes information on the overall investment portfolio, it may be unnecessary to seek more detailed information and to perform a more detailed review by an investment specialist. In many cases, providing a five-year plan of operation may be sufficient. This type of plan can also be helpful in mitigating the need for future detailed information on the group's investments when investments, reinsurance or other items are not a concern, or do not change materially.

Conditions and Stipulations for Form A Approval

After considering all of the risks of the proposed transaction, analysts and the states may determine that the proposed transaction either meets the general standards previously referred to or can be met with the addition of certain stipulations agreed to by the acquiring entity. These stipulations can include such things as those listed below:

Stipulations for limited period of time:

- Requiring RBC to be maintained at a specified amount above company action level/trend test level. Because capital serves as a buffer that insurers use to absorb unexpected losses and financial shocks, this would better protect policyholders.
- Requiring quarterly RBC reports rather than annual reports as otherwise required by state law.
- Prohibiting the insurer from paying any ordinary or extraordinary dividends or other distributions to shareholders unless approved by the Commissioner.
- Requiring a capital maintenance agreement from or establishment of a prefunded trust account by the acquiring entity or appropriate holding company within the group.
- Enhancing the scrutiny of operations, dividends, investments, and reinsurance by requiring material changes in plans of operation to be filed with the commissioner (including revised projections), which, at a minimum, would include affiliated/related party investments, dividends, or reinsurance transactions to be approved prior to such change.
- Requiring a plan to be submitted by the group that allows all affiliated agreements and affiliated investments to be reviewed, despite being below any materiality thresholds otherwise required by state law. A review of

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agreements between the insurer and affiliated entities may be particularly helpful to verify there are no cost-sharing agreements that are abusive to policyholder funds.

Continuing Stipulations

- Requiring prior Commissioner approval of material arms-length, non-affiliated reinsurance treaties or risk-sharing agreements.
- Requiring notification within 30 days of any change in directors, executive officers or managers, or individuals in similar capacities of controlling entities, and biographical affidavits and such other information as shall reasonably be required by the commissioner.
- Requiring the filing of additional information regarding the corporate structure, controlling individuals, and other operations of the company.
- Requiring the filing of any offering memoranda, private placement memoranda, any investor disclosure statements or any other investor solicitation materials that were used related to the acquisition of control or the funding of such acquisition.
- Requiring disclosure of equity holders (both economic and voting) in all intermediate holding companies from the insurance company up to the ultimate controlling person or individual, but considering the burden on the acquiring party against the benefit to be received by the disclosure.
- Requiring the filing of audit reports/financial statements of each equity holder of all intermediate holding companies but considering the burden on the acquiring party against the benefit to be received by the disclosure.
- Requiring the filing of personal financial statements for each controlling person or entity of the insurance company and the intermediate holding companies up to the ultimate controlling person or company. Controlling person could include, for example, a person who has a management agreement with an intermediate holding company.

With respect to the above, although each has its own limitations, they may provide additional assurances. For example, a capital maintenance agreement has a number of pros and cons, but, regardless it can simply raise awareness to the ultimate controlling party of the need to be a good corporate citizen.

Post Approval Review

Even after the proposed transaction has been approved, or approved with stipulations, it may be appropriate to use existing authority to perform either an annual or otherwise targeted examination of certain risks or use of ongoing (e.g., quarterly) conference calls or meetings to ascertain whether the proposed transaction and the business plan are being executed as anticipated. These are not things that would be done all the time, but only where necessary to give regulators the appropriate comfort level.

During such an examination or meeting, analysts may want to consider (as an example) any of the following procedures, using a specialist where deemed appropriate:

- Examining the insurer and its affiliates to ensure that the investment strategy provides a prudent approach for investing policyholder funds or does not create excessive contagion risk.
- Requiring ongoing annual stress testing of the insurer and the group in accordance with existing laws and regulations. This includes stress testing not only the investments but also the policyholder liabilities to ensure that the assets and liabilities continue to be properly matched.
- Conducting periodic and possible ongoing review of the investment management and other affiliated agreements, including a review of the equity firm fees and fee structure charged or to be charged to the insurer, if any, as well as arrangements with intercompany broker to ensure that they continue to be fair and reasonable. Also examine the flow of funds related to such agreements.

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- Coordinating a meeting with multiple regulators and even all states to the extent there is a need for all regulators to better understand the business plan and operations of the group.
- Coordinating an examination with another regulator of a non-affiliated insurer where the direct writer has ceded a material portion of its risk to a separately controlled insurer.

Lead State Role in Form A Reviews and Disclaimers of Control/Affiliation

The lead state(s) or designee should assume the role of the coordinator and communication facilitator in a Form A and disclaimers of control/affiliation review. The lead state(s) should serve as the facilitator and central point of contact for purposes of gathering and distributing information to all regulators involved. If the lead state(s) delegate this responsibility to another domestic state within the group, all regulators, domestics and licensed states should be informed.

In identifying the UCP, the lead state should lead a discussion among the domestic states regarding who should be identified as the UCP, and therefore the person/entity primarily responsible for making insurance holding company filings. The lead state and the domestic states should come to an agreement as to who is the UCP and who is disclaimed from control (if anyone).

Where disclaimers of control/affiliation have been filed in multiple domestic states for insurers in the group, the lead state should coordinate the communication of disclaimers received, each state's review and approval/denial of the disclaimer, as well as coordinate discussions on any conditions and stipulations being considered on disclaimer approvals. The lead state should lead a discussion among the domestic states regarding each states' decision on any disclaimers that are allowed and at what percentages of control those disclaimers were allowed.

The lead state(s) or designee should schedule regular conference calls or arrange for regular e-mail communications, as deemed necessary, to receive and share status updates from each regulator involved. As many states have strict timeframes within which to complete reviews and schedule hearings, the frequency of conference calls and other communication will depend on the timelines of the particular states involved and the sensitivity of the transaction. Additionally, regulators can share comments regarding a filing in the Form A Database. The lead state(s) or designee should compile questions and issues identified by all domestics, licensed states and functional regulators in an unbiased manner in order to coordinate the resolution of the answers to the applicable parties and reduce duplicative requests.

Review results, either internally prepared or work performed by hired consultants, or information collected by a state should be shared between the applicable regulators, where permissible. Collaborative sharing of information during the review process will reduce duplicative efforts and costs for both regulators and insurers. If the use of consultants is deemed necessary, regulators should consider coordinating the selection of the consultant and agree to share the work product of the consultant.

The lead state(s) or designee should coordinate a consolidated public hearing, if deemed necessary by the lead state as set forth in the *Model* #440Section 3(D)(3). Refer to the state's laws regarding public hearing requirements.

Merger(s) or consolidation of two or more insurers within the same Holding Company System (Section 3(E)(1))

To the extent that the merger or consolidation transaction is subject to prior approval filing under other laws of the states in which the merger/consolidation entities are licensed, the merger or consolidation is exempted from filing under the Holding Company Act.

Merger or consolidation of entities of an insurer with one or more non-insurers or insurance entities. The domestic regulator should have a clear understanding of the merger or consolidation with the following documentation requested from the insurer:

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- Nature of and the reason for merger/consolidation
- Evidence relating to why the merger/consolidation is fair and reasonable
- Operational and financial impact of the merger/consolidation transaction to the domestic insurer
- If subject to oversight by another functional regulator, seek material solvency concerns or regulatory concerns affecting the domestic insurer(s) or the holding company system
- If the non-insurer is subject to oversight by another functional regulator, evidence of communication and approval of the transaction by the functional regulator

Acquisitions of Control Exemption

The general premise of the exemption provision applicable under Section 3(E)(2) for acquisition of control of an insurer within the same Holding Company System assumes minimal impact upon the insurer on the acquisition. Such assumptions should include the considerations that:

- The ultimate controlling person of the insurer being acquired remains the same
- No debt, guarantee, or other liability incurred as related to the transaction
- No significant impact upon the financial position and operations of the insurer

However, there must be a need for the acquisition of control to take place. The emphasis may not be the insurer being acquired, but the entity that is acquiring the insurer. The holding company restructure may be related to strengthen the financial position of the acquiring entities by reallocation of the stock ownership of the insurer to the acquiring entity in lieu of any cash contributions. Or the holding company restructure is to realign companies in preparation for sale of the insurer.

The domestic regulator of the insurer being acquired should request the following documentation:

- Nature of the acquisition
- Consideration of the acquisition
- Organizational chart – pre- and post-acquisition
- Operational and financial impact of the acquisition of both entities
- 3-year financial projections for the insurer
- Most recent audited financial statements of the acquiring entity
- Discussion of any anticipated changes to affiliated agreements
- If the entity acquiring the insurer is subject to oversight by another functional regulator, evidence of communication and approval of the transaction by the functional regulator.
- Biographical affidavits of all officers and directors of the acquiring entity and any intermediary company(s), to help ascertain the competence, experience and integrity of these individuals.
- All the actual documents to be executed relate to the acquisition.

Standards of Management of an Insurer Within a Holding Company System

Form A Exemptions

The following are suggestions for additional oversight when considering an exemption under Model #440 Section 3E (2) of the Holding Company Act. Specifically, the following should be considered when reviewing an exemption

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pertaining to investment managers/advisors that hold proxies directly or indirectly which may have more than 10% control.

Reputational Risk – Market Disruption Regarding 10% Investor Limitation

An investor with a large percentage of Holding Company stock may be entitled to divest significant shares, therefore driving the stock price down. This may cause a drop in the confidence levels of investors and policyholders and may also lead to ratings downgrades (if in combination with other issues).

Best Practices

- Although an exemption from change in control of over 10% may be contemplated for a "fund manager," consideration should be given to limit the stock ownership by an individual or group of mutual funds or commonly managed companies to no greater than 9.9%.
- As part of the review process, obtain written confirmation of the percent limitation in individual mutual funds.
- The domestic insurer's awareness of the exemption request.
- The request does not violate the domestic insurer's bylaws.

Operational Risk – Ability to Influence Management and Policy Decisions

An investor with a large percentage of Holding Company stock may inherently have the ability to influence management and policy.

Best Practices

- Upon reviewing the exemption from change in control, the regulator should inquire not only about the ability of the investor to obtain a board seat, but also about the ability of the investor to become a "non-voting observer" on the board. Holding Company board controls should be firmly in place to assure that "influencing policy and management decisions" cannot occur.
- Board governance should be reviewed.

Financial Risk – The Financial Condition of Holding Company and Insurer Deteriorates

Reputational and operational risk (discussed above) can lead to financial risks.

Best Practice

The approval of the exemption from change in control should include a requirement that the State receive an attestation from the investor stating when there are changes in investing philosophy.

Disclaimer of Control/Affiliation

Model #440

Section 1C of Model #440, outlines the definition of control, which broadly includes "… the power to direct or cause the direction of management and policies of a person…" as follows. By this definition, control may include other situations beyond the presumed control of 10% ownership of voting securities.

> *Model #440 Section 1. Definitions. C. "Control." The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by*

Section 4K that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

Section 4K of Model #440 outlines specific requirements for filing a disclaimer of affiliation by the insurer or any member of the insurance holding company system.

"Disclaimer. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved."

Considerations

Consideration should be given to situations where a disclaiming party may directly or indirectly possess the power to direct or cause the direction of the management and policies of the insurer This may include situations such as:

- over management decisions, or the operations of the insurer; where there is a minority owner;
- where lending agreements may result in ownership of the insurer in the event of default;
- where non-voting shareholders have protective rights affording them the opportunity to acquire control in certain circumstances; any non-voting arrangement or contract that may convey an element of control (e.g., investment management, reinsurance, administrative service, employment); or
- passive investment companies with more than 10% ownership of voting shares within funds they manage, where the actions and activities do not support the investment company's assertion that it does not exert control. Actions asset managers take in the ordinary course of their advisory services, such as engagement with management and proxy voting, should not be viewed as actions and activities that indicate exerting influence or control for these purposes.

These are only a few examples of situations that may require additional inquiry and a deeper review of the disclaimer application to determine if control exists, if the disclaimer should be approved or denied, or if any conditions or stipulations should be placed on the approval. The burden of proof is on the applicant to demonstrate they do not have control or affiliation.

Passive Investors

Note that the purchase of equity securities or debt securities by passive investors, such as institutional investors, regulated funds and fund advisors, do not typically result in control of the insurer. These types of investors typically purchase equity securities on the open market or purchase debt securities through offerings where terms are standardized for all investors. It is only where evidence exists that a passive investor may be engaged in actions and activities beyond their ordinary course of business, when further inquiry and review by the state insurance department may be necessary.

Where these types of passive investors are regulated by the SEC, additional reporting is required to the SEC, such as proxy voting disclosures. Where the insurer's equity is registered with the SEC, the analyst should determine if the investor has filed a Schedule 13G[1] with the SEC. Institutional investors file publicly available beneficial ownership reports with the SEC on Schedule 13G when acquiring SEC registered securities exceeding 5% of a

[1] Refer to the Securities and Exchange Commission Act of 1934, Section 13G and Section 13D, for more detail.

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company's total stock issue in the ordinary course of business and not with the intent nor with the effect of influencing control of the issuer. However, note that SEC Schedule 13D is required to be filed where investors acquire more than 5% beneficial ownership of a class of registered equity securities and who have the purpose or effect of changing or influencing the control of the issuer, in which case additional and more timely reporting to the SEC is required. Additionally, for passive investors, analysts should consider if the investment includes prohibitions on board representation and prohibitions on proxy solicitations as further evidence the investment does not represent control.

Other Considerations

- Consider state laws that require limitations on investments, which could vary by state. It is recommended that domestic states communicate and collaborate to reach an agreement on the approval of the disclaimer and the percentage limitation.
- Monitor annual financial statements for minority ownership and disclaimer disclosures in Schedule Y, Part 3.
- If the disclaimer approval includes stipulations or conditions, consider the following:
    - In situations where ownership percentages may fluctuate, require a condition whereby the disclaiming party must reapply for the disclaimer if the percentage ownership exceeds a specified percentage.
    - Require that the domestic insurer is responsible for notifying the Department if any of the conditions/stipulations in the disclaimer approval are violated.
    - Include in the disclaimer approval letter what the consequences will be for violating the conditions/stipulations (e.g., the disclaimer would be rescinded).
    - If a disclaimer is requested for tax purposes and is relied upon by the tax authority (or similar situation where the Department has concerns that another regulatory authority may be unduly relying on the disclaimer), consider including a statement in the disclaimer approval letter that makes it clear that the approval is for state insurance law purposes only.
- In situations such as reinsurance side car or other similar arrangements where a third party appears to have influence through operational management, investment management or other agreements (e.g., the disclaimer is requested for tax purposes):
    - With regard to investment management agreements, consideration should be given to agreements with non-customary terms that extend beyond advisory services and into broader influence over the insurer's business such as termination provisions that would be onerous and implausible in practice, authority over the insurer's strategy and implementation for managing its assets, or an affiliated adviser becoming intertwined in the insurer's business operations.
    - As part of the approval of the disclaimer, if concerns are identified, consider requesting the service agreements between the domestic insurer and the third party be submitted for Department review (not including all holding company filings).

Inquiries to the Applicant

The following provides guidance on additional inquiries the regulator may make of the applicant(s) to gain a better understanding when reviewing disclaimers of control/affiliation.

1. Request any additional information needed to effectively evaluate the disclaimer application. Consider if sufficient information has been provided to understand the relationship of the disclaiming party.
2. Ensure the applicant addresses the Board of Director membership, management positions, covenants in lending agreements (including a copy of the lending agreement), organizational charts to understand relationships, and material relationships that are in place with the company (e.g., consulting).
3. Ask for information about commitments regarding voting stock.

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4. Ask the applicant(s) whether they have any agreements or understandings with any other individual or entity, written or verbal, limiting their control of the insurer.

Post-Disclaimer Considerations

The following are examples of considerations a state may deem appropriate after a disclaimer has been approved, dependent on the facts and circumstances of the approval.

- Additional disclosure requirements may be requested on an ongoing basis, which may be part of the disclaimer approval.
- Review and monitor the Financial Statement for minority owners and disclaimer disclosures to make sure they are reporting Schedule Y Part 3 correctly.
- Consider if the disclaimer has an impact on who is designated the lead state for the group and therefore which state will perform holding company analysis in the future.
- The disclaiming person/entity may be asked to:
    - Provide notice before taking action on any of the rights and privileges of the non-voting shares.
    - Provide notice before transferring non-voting shares.
    - Provide notice before taking any position at the insurer or its affiliates.
    - Notify the state insurance regulator if the facts and circumstances for which the approval of the disclaimer was based on change.
- Perform a review of annual statement related party disclosures (e.g., Schedule Y, Notes to the Financials, and the electronic column of the investment schedules) to ensure that despite the approval of a disclaimer of affiliation, the insurer is correctly reporting any disclaimed party as a related party for material transactions pursuant to SSAP No. 25.

Non-Lead State Holding Company System Analysis Procedures

Refer to section VI.C. Group-Wide Supervision - Insurance Holding Company System Analysis Guidance (Lead State) for guidance on the Lead State's holding company analysis procedures.

PROCEDURE #1 assists analysts in reviewing Form B for completeness. It guides analysts through each of the major items of information required by Form B.

While analysts should base this review on the domestic state's holding company law, according to Model #440, the following should be included in Form B.

- The capital structure, general financial condition, including the most recent Annual Financial Statement, ownership, and management of the insurer, and any person controlling the insurer.
- The identity and relationship of every member of the insurance holding company system.
- The following agreements in force and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:
    - Loans, other investments, purchases, sales, or exchanges of securities of the affiliates by the insurer or vice versa, involving 0.5% or more of the registrant's admitted assets as of Dec. 31 of the most recent prior year ended.
    - Purchases, sales, or exchange of assets involving 0.5% or more of registrant's admitted assets as of Dec. 31, of the most recent prior year ended.
    - Transactions not in the ordinary course of business.
    - Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, involving 0.5% or more of registrant's admitted assets as of Dec. 31 of the

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most recent prior year ended, other than insurance contracts entered into in the ordinary course of the insurer's business.

- All reinsurance or management agreements, service contracts, consolidated tax allocation agreements, and cost-sharing arrangements.
- Dividends and other distributions to shareholders.

- Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.
- Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the Commissioner.
- A summary outlining all items in the current registration statement representing changes from the prior registration statement (Form C).

PROCEDURES #2-3 assists analysts in determining whether dividends to shareholders were proper and in accordance with regulatory guidelines. Analysts should be particularly alert to extraordinary dividends, which require prior regulatory notification.

PROCEDURE #4 assists analysts in reviewing other types of transactions involving the insurer and other entities in its holding company system. It guides analysts through each type of transaction that requires prior regulatory notification/approval. Analysts should identify disclosures about the holding company that may potentially affect the insurer. Analysts should focus specifically on shareholders that may also have a relationship with the insurer, and on litigation or administrative proceedings involving the holding company that may affect the insurer, such as bankruptcy, receivership, or other corporate reorganizations. Analysts should also closely review the holding company financial statements for unusual items, such as heavy reliance on dividends from the insurer to fund debt service requirements. Analysts should also determine whether there are inconsistencies between evidence of affiliated transactions or agreements as indicated in the insurer's annual or quarterly statement, and the information presented by the insurer in its Form B filing that may merit further investigation.

While analysts should base this review on the domestic state's holding company law, according to Model#440, the following are types of transactions discussed in Form B.

- Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments where the transactions equal or exceed:
  - With respect to non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as of Dec. 31 of the most recent prior year ended.
  - With respect to life insurers, 3% of the insurer's admitted assets as of Dec. 31 of the most recent prior year ended.
- Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions are equal to or exceed:
  - With respect to non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as of Dec. 31 of the most recent prior year ended.
  - With respect to life insurers, 3% of the insurer's admitted assets as of Dec. 31 of the most recent prior year ended.
- Reinsurance agreements or modifications thereto, in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds 5% of the insurer's surplus as of Dec. 31 of the most recent prior year ended, including those agreements which may require, as consideration, the transfer of assets from an insurer

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to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of such assets will be transferred to one or more affiliates of the insurer.

- All management agreements, service contracts, and cost-sharing arrangements.
- Any material transactions specified by regulation, which the Commissioner determines may adversely affect the interest of the insurer's policyholders.

PROCEDURES #5-17 assist analysts in assessing the impact of the holding company system on the domestic insurer. This includes five primary segments of the analysis as follows.

- ***#5-12*** **ASSESSMENT OF THE GROUP PROFILE SUMMARY (GPS) FROM THE LEAD STATE**: If the Lead State is not your state, the Lead State should provide a GPS to the non-lead states in the group by Oct. 31. Using the GPS consider the risks identified and assessed by the Lead State to determine any material impacts on the branded risks of the domestic insurer, the interdependence of the holding company and its affiliated entities, including the domestic insurer, dividend obligations of the domestic insurer to service holding company debt or fund other holding company initiatives, the holding company's reputation, enterprise risk management and corporate governance.
- ***#13*** **ASSESSMENT OF FORM B (AND C):** Model #440 defines insurance holding companies and the related registration, disclosure, and approval requirements. Form B is the insurance holding company system annual registration statement. Model #440 requires every insurer, which is a member of an insurance holding company system, to register by filing a Form B within 15 days after it becomes subject to registration, and annually thereafter. Any non-domiciliary state may require any insurer that is authorized to do business in the state, which is a member of a holding company system, and which is not subject to registration in its state of domicile, to furnish a copy of the registration statement.

  An insurance holding company system consists of two or more affiliated individuals, one or more of which is an insurer. An affiliate is an entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, another entity. Control is presumed to exist when an entity or person, directly or indirectly, owns, controls, holds the power to vote, or holds proxies, representing 10 percent or more of the voting securities.
- ***#14-15*** **ASSESSMENT OF AFFILIATED RISKS ON THE DOMESTIC INSURER**: Affiliated risks may exist due to interdependence of the holding company and its affiliated entities through affiliated transactions. Consider also the guidance included in section III.B.5 Operational Risk Assessment as well as guidance in this section regarding supplemental form filings for review of affiliated agreements.
- ***#16-17*** **ASSESSMENT OF OWN RISK AND SOLVENCY ASSESSMENT (ORSA):** If the Holding Company files an ORSA Summary Report, it is the responsibility of the Lead State to review and perform analysis of the report. At the completion of this review, the lead state should prepare a thorough summary of its review, which would include an initial assessment of each of the three sections. The lead state should also consider and include key information to share with other domestic states that are expected to place significant reliance on the lead state's review. Non-lead states are not expected to perform an in-depth review of the ORSA, but instead rely on the review completed by the lead state. The non-lead state's review of the lead state's ORSA review should be performed only for the purpose of having a general understanding of the work performed by the lead state, and to understand the risks identified and monitored at the group-level so the non-lead state may better monitor and communicate to the lead state when its legal entity could affect the group. Any concerns or questions related to information in the ORSA or group risks should be directed to the lead state.

Form D – Prior Notice of a Transaction

PROCEDURES #1-19 assist analysts in reviewing the Form D filing for completeness and help guide analysts through major items of information required by Form D.

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PROCEDURE #17. Capital or surplus notes may be issued to either affiliated or non-affiliated entities. Where an affiliated capital or surplus note is requested, amended or a request for payment is made, refer to the review procedures as outlined in this Handbook, IV.A. Supplemental Analysis Guidance, Section G. – Income Statement, Surplus and Capital and Surplus Notes, for further guidance.

PROCEDURE #18. For a parental guarantee or capital maintenance agreement Form D, utilize the procedures and guidance in Chapter V.F - Form A, to complete the review.

PROCEDURES #20ix – 20xiii assist analyst in reviewing captive reinsurance transactions other than those subject to Actuarial Guideline 48. Refer to the guidance in chapter III.B.9. Strategic Risk – Assessment, for an explanation of potential risks. Where risks are noted at the time of the Form D review or if follow-up is recommended, consider requesting any follow-up be conducted as part of the next financial condition examination to review against expected results.

Best Practices for Agreements with Affiliates for Management and Services

Charges for Fees for Services

SSAPs 25 and 70 and Appendix A-440 discuss Transactions Involving Services, Allocation of Costs, and Other Management Requirements.

Pricing for agreements with affiliates may be negotiated between related parties on a variety of basis including cost and other than cost-based pricing. Regardless of the method utilized, it is the responsibility of management to appropriately evidence that the terms of the agreement satisfy the "fair and reasonable" standard. It is management's responsibility to provide documentation demonstrating that this standard has been met using any of a number of methods including but not limited to those described below. The Form D filing should thus include management's documented support for its assertion that the transaction meets the "fair and reasonable" standard.

Transactions at Cost

This is the simplest method to evaluate the basis on which entities are charged. Transactions between two or more affiliates can be deemed to be fair and reasonable, subject to further evaluation of the allocation basis, if the transactions are entered into at a value that is based on or reflects an allocation of actual costs.

The costs borne by the entity providing the agreed upon services are allocated to the entity receiving those services. As stated in the related SSAPs, cost allocation must be done in a manner that is fair and yields the most accurate results. Theoretically the service provider should not make a profit or incur a loss if the transaction is at cost. Other considerations may include that:

- Costs can be apportioned directly as if the entity incurring the expense had paid for it directly, or
- Allocated using pertinent factors or ratios such as studies of employee activities, salary ratios or similar analysis.

If cost is the method used by management to establish "fair and reasonable," simply identifying a "rate per unit" estimate on the amount of costs and number of units, does not in and of itself make the charge reasonable. This rate per unit should result in a reasonable approximation of the actual, realized costs. Where appropriate, using a rate per unit is a method for easily calculating interim payments that are due to the service provider. If a rate per unit is used to allocate costs, an expense "true-up" may be prepared and settled on a periodic (e.g., annual) basis to reconcile the estimated costs (payments) with the actual costs incurred. The expense "true up" would serve to replace the estimated costs with the actual costs and any difference between these two would be included in a subsequent settlement between the parties.

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Note: Transactions with alien parties may require additional deliberation due to potential conflicts between international tax laws and provision of services at cost vs. other than cost.

Transactions at Other than Cost

Management is responsible for its assertion that transactions at other than cost that are entered into between affiliates meet the standard of fair and reasonable both on the basis of the amount of charges being allocated and on the basis of the allocation. In the case of two or more affiliates, transactions can be deemed to be at arm's length (and therefore fair and reasonable) if the transactions are entered into at a value consistent with current market value.

Management may use various approaches to demonstrate that this standard has been met, which could be applied in the following manner:

- The entity providing the service performs a substantial portion of its business with non-affiliated entities and can establish a price for a transaction with an affiliate that is similar to the price charged to non-affiliates, since the non-affiliates are assumed to have negotiated at arm's length.
- The entity receiving the services analyzes and retains up-to-date documentation of localized market rates of services that could be provided to the entity by non-affiliated parties and demonstrate that the price paid to the affiliate for services is comparable to or within the range of prices charged by non-affiliated service providers. As each transaction or service can be unique and the overall terms of service agreements may vary considerably, determining a fair and reasonable charge can be difficult. Judgement is inherently required when constructing a reasonable range of comparable values using non-affiliated party information. The Form D filing should include management's documented support for its assertion that the transaction meets the "fair and reasonable" standard.
- The entities providing and receiving the service agree to a "cost-plus" arrangement whereby the rate charged under the agreement is based upon the cost to perform the service plus a negotiated fee/profit margin intended to recognize the risk of providing the service. In some cases, the overall "cost-plus" rate or the negotiated fee/profit margin component may be comparable to market rates for similar services as indicated in the bullets above. However, in other situations, the services provided may be unique and not comparable to prevailing market rates. In these situations, it is the responsibility of management to justify the use of a "cost-plus" approach and to provide adequate supporting rationale and documentation demonstrating its analysis supporting the profit margin selected under the approach. Transactions at "cost-plus" should be carefully reviewed to ensure that they meet the "fair and reasonable" standard.
    - These types of agreements may not be acceptable in all jurisdictions. As such, the review of a Form D using this method should confirm that cost-plus is required (i.e., by another regulator or jurisdiction) and/or that there is no acceptable alternative approach. The regulator should determine if the Company has provided documentation sufficient to support the cost-plus methodology or if another methodology should be suggested.

Transactions entered into at arm's length with unaffiliated parties who willingly and freely (not under compulsion) enter into a transaction and arrive by negotiation at an agreed upon price (value) are by definition fair and reasonable. That does not mean that otherwise identical transactions between various unaffiliated parties will all be valued identically because, among other reasons, parties will vary as to their degree of motivation to transact, their relative advantages in terms of scale, their skills in negotiating, their time horizon to complete the transaction, and their available resources. Value also varies among other things depending on whether transactions are more specialized (i.e., involve non-commoditized goods or services) as well as depending upon the liquidity of the market for the goods and services (i.e., many service providers entering into many similar transactions where the terms and pricing of transactions are transparent to the public). Thus, even for seemingly

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identical transactions, there will be a range of values at which the market will transact and, as such, a range of values that should be viewed as being fair and reasonable. Further, the fair and reasonable range of values will be wider or narrower for different types of transactions. In the case of two or more affiliates, transactions can be deemed to be at arm's length (and therefore fair and reasonable) if the transactions are entered into at rates equivalent to current market rates or on an allocation of actual costs. Some regulators consider transactions of an allocation of "costs plus a mark-up or discount" as neither at market nor at cost because these transactions may not be deemed to be an arm's length transaction and may require more analysis to determine if it is fair and reasonable.

When considering a particular transaction and the potential range of values that would satisfy the fair and reasonable standard, the following factors may be considered to the extent relevant:

- Whether the subject good or service was previously transacted with a non-affiliate, and if so, the reason or rationale behind the change to transact with an affiliate.
- Whether the service was previously provided internally at the insurer and the rationale and business purpose for moving it to an affiliate.
- Whether the transaction involves an existing affiliate with an established history of performance and involvement in similar transactions with non-affiliates.
- Whether and, if so, to what degree the value at which the parties transact compare with the value at which the prior arrangement with non-affiliates transacted.
- Whether there are other aspects of the prior and proposed transaction (e.g., other agreement terms and conditions) that should be considered in evaluating differences in the value which is being transacted.
- Whether the transaction is the result of a broader strategic corporate restructuring, such that what might appear to be a stand-alone transaction is only one part of the implementation of that restructuring and, if so, whether there are other aspects of the broader restructuring that should be considered.
- If the filing is to amend an existing agreement with an affiliate, the intended business purpose of the proposed change.
- Whether the entity receiving the services in an agreement with an affiliate utilized other observable market factors and/or entity-specific cost or margin information in addition to, or to supplement, internal or external pricing for a similar product or service including industry sales price averages, market conditions, profit objectives, margin achieved on similar products, etc.
- Whether financial information from insurers and their affiliates including operating ratios, profit margins, and similar data can inform what would be considered a fair and reasonable range of profit margins on cost-plus agreements.

Regulator Considerations

Items for initial filing review—the actual document(s) should be filed, not merely a summary (these apply regardless of the method – cost or other than cost – unless otherwise noted):

- Identify and document:
  - The specific services that will be provided.
    - The specific expenses and/or costs that are to be covered by each party (cost).
  - The entity(ies) providing and receiving each of those services.
    - Separate affiliate entities from non-affiliates.

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- Allocation method (cost or other than cost) of the agreement.
  - The charges or fees for the services indicated.
- The accounting basis used to apportion expenses (cost).
- Confirm that contract provisions will be accounted for in accordance with SSAPs.
- Invoicing and settlement terms (should allow for admittance under SSAP 96).
- The effective date and termination date.
- The records rights and policies of each entity that is a party in the contract.
- The governing law.
- Any unique and relevant clauses not covered above.
- Financial statements of the entity providing the services.

- Other Considerations for Review of the Agreement:
  - Determine the reasonableness of the allocation method and the charges or fees, considering such items highlighted in the "Transactions at Cost" and "Transactions at Other than Cost" sections above.
  - Assess if cash flows/activities relating to the agreement are in line with forecasted amounts provided in the initial Form D review and, if not, inquire about material or unexpected variations, their cause, and implications.
  - Consider if there have been significant changes in the market for the services subject to the agreement, whether management has considered them and, if so, whether changes to the agreement have been made or are anticipated (for other than cost-based agreements).
  - Inquire of management if the agreement continues to be fair and reasonable and their supporting rationale and whether it has changed since the initial filing.
  - Consider the insurer's aggregate exposure to all agreements with affiliates, current and trending, both in terms of absolute dollars as well as relative to a base (e.g., capital and surplus, total expenses, etc.)
  - Does the agreement trigger or increase related party transaction or financial /solvency concerns?
  - Determine the agreement does not divert funds that could be considered a dividend.
  - Determine the agreement does not result in the insurer's fair share of expenses being retained by or allocated to a parent/affiliate, thereby masking the true performance of insurance operations.
  - Summarize the business rationale for purpose and need of the agreement.
  - Summarize the financial impact of the agreement on the company's surplus or financial condition.
  - Summarize the impact the agreement would have on the priority status of the company.
  - Summarize the reasons to approve/disapprove the agreement.

Additional Considerations for Affiliated Investment Management Agreements

In addition to regulator considerations for filing review listed above, the following considerations are included to provide additional guidance for a review of affiliated investment management agreements. A critical consideration in assessing whether the terms of an affiliated investment management agreement are fair and reasonable is to assess the level of oversight provided to the affiliated asset manager, as outlined through the following criteria:

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- **Selection of Investments –** The insurer should provide guidance to its affiliated asset manager on investment selection by providing clear investment guidelines that are documented in the investment management agreement at a sufficient level of detail on (a) what are permitted investment types, (b) limitations and restrictions on exposures, (c) specific risk metrics (e.g., credit quality and duration). These guidelines should reflect the type of assets that the asset manager has experience in. The guidelines for unaffiliated asset managers are often more limiting than the insurer's investment guidelines but it is not uncommon that may be the same in the case of an affiliated asset manager given the nature of that relationship. Nonetheless this should be a separate and distinct document.
- **Authority for Transactions –** The investment management agreement should describe the level of discretion that the affiliated asset manager has, as opposed to transactions that require prior approval from the insurer. Total discretion for the affiliated asset manager may not be appropriate for investments that are very complex, illiquid or large exposures. It may be desirable in those situations for the insurer's investment committee to retain authority.
- **Conflicts of Interest –** This is an important protection against an investment adviser's biases due to business arrangements (e.g., referral relationships, affiliate product offerings, etc.) that may interfere with the proper execution of the investment strategy. For example, investment advisers often have affiliates that offer investment options that should be available to the insurer but should not be given preferential treatment if competitor products are determined to be a better fit for the selected investment strategy. This is somewhat less critical for affiliated asset managers, but it is still advisable to have appropriate recognition of the potential for concerns, especially when the affiliated asset manager may also have third party clients. The typical areas of focus are transactions such as cross trades (those not involving a broker) and investments that may be considered related party transactions. This goes in conjunction with the acknowledgement that the affiliated asset manager is acting in a fiduciary capacity.
- **Fiduciary Responsibility –** Asset managers, whether or not they are formally registered as such, are still subject to the Investment Advisers Act of 1940. As such it is critical that all asset managers, whether affiliated or unaffiliated, acknowledge that the standard of care is that of a fiduciary. The affiliated investment manager is a separate legal entity from the insurer and this recognition provides for a standard of care that is equivalent. This is an important legal distinction that may help protect the insurer's interests in the execution of the company's investment strategy. The fiduciary standard is generally implied when an asset manager is registered as an investment advisor, which may be required at the federal (SEC) or state level (state securities regulator) depending on the nature and extent of services provided. In reviewing an affiliated Investment Management Agreement, the department should consider confirming whether the advisor is formally registered in accordance with existing legal requirements and in good standing © 2024 National Association of Insurance Commissioners 15Attachment B with its securities regulators. If the advisor asserts that it is exempt from registration requirements, the department should consider verifying that the advisor continues to meet the exemption criteria.
- **Calculation of Fees –** Management fees should reflect the current market conditions and should reflect the kind of assets and type of asset management. More complex investments and investment strategies do warrant higher management fees. Management fees for more plain vanilla assets have declined significantly over the last few years. While not common, different kinds of performance or incentive fees may be included. If so, it is important that the language be extremely clear when such payments are due so that the calculation can be verified. In the case of affiliated asset managers, special attention should be paid to the total amounts paid by the insurer to guard against such fees becoming a way around dividend restrictions. For example, if the advisory fee is computed based on volume of transactions, it would be important for management to closely review the frequency of trades to help avoid excessive charges.
- **Sub-Advisors –** The insurer should retain the right to consent to any sub-advisors as well as the ability to cancel such an arrangement. It should also be clear who is responsible for paying the management fees of the sub-advisor. Either the sub-advisor's fees should be paid by the primary asset manager, or if paid

by the insurer, the assets managed by the sub-advisor should not be included in the calculation for the primary manager. The affiliated asset manager may make the argument that they are overseeing the activities of the sub-advisors. Oversight is much less resource intensive and does not warrant a significant fee, even if permitted.

- **Reporting –** When the asset manager is affiliated, this is also less of a concern. Nonetheless some clear language on responsibility is advisable. This should include at least quarterly, if not monthly, reporting of the portfolio including different risk metrics.
- **Termination –** The agreement should include clear termination provisions that allow for a timely transition of investment management services and protect the rights of the insurer upon termination of the agreement.
- **Review of Performance and Compliance –** Following on some of the points above, proper governance still requires regular performance review and tracking of compliance with investment guidelines.

The insurer should still maintain an adequate control framework over investments, including monitoring and managing transactions, and monitoring compliance by the affiliate. They should not rely solely on the affiliated investment manager for oversight in this area.

Examination Verification and Validation

Both analysts and examiners are involved in assessing whether an affiliated agreement complies with statutory requirements (financial and non-financial) and is implemented by the parties in a manner that is consistent with representations made in the Form D as approved by, and considering any conditions imposed by, the regulator. Because both the analysis and examination functions are involved, care should be taken by each to leverage the knowledge and capabilities of the other, to share findings and concerns, and to minimize redundant or unnecessary efforts as well as regulatory burden on the parties involved.

Because of the necessity of a regulated entity to file a Form D for approval (or non-disapproval), the analyst generally is the initial and primary point of contact and is involved throughout the Form D review process. The analyst would thus be most knowledgeable about the agreement from its outset, including how it was initially framed and presented in the Form D, what was learned during the review process, whether any changes were made or required for it to be approved (or not disapproved), any conditions or stipulations that may have been imposed by the regulator as part of that approval/non-disapproval process, as well as about any amendments that may have occurred or inquiries or concerns that may have been received from other states relating to the agreement.

Also, as part of the Form D review process the analyst may have identified issues for which, after implementation of the agreement and in the next examination, it would be appropriate for examiners to follow-up and provide feedback to the analyst. These follow-up procedures could be aimed at determining whether the agreement was implemented consistent with its own terms and its compliance with regulatory requirements, financial or risk impacts to the insurer, and whether the underlying economics of the transactions pursuant to the agreement are consistent with representations in the Form D as approved (or non-disapproved).

In determining which agreements with affiliates or aspects of such agreements are to be reviewed during an onsite examination, the analyst should consider the following criteria:

- Is the agreement new or significantly modified since the prior examination?
- What is the nature and extent of services provided under the agreement?
- What is the basis for pricing/consideration paid under the agreement and what support is provided for that basis (i.e., other than cost-based allocations with limited support would be of highest concern)?
- Does the ongoing performance of the agreement raise concerns (i.e., excessive profitability of affiliated service provider and/or high expense structure of insurer)?

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- Is there a change in business plan or operations that has, or could significantly impact risks or obligations of the parties or the cashflows between the parties to the agreement as compared to what was represented in the Form D or most recent amendment or since the prior examination?
- Whether there are any other concerns that the analyst might have related to the agreement, e.g., impact on rate filings, company compliance with filing requirements, the Company's financial performance, etc. Note that the financial aspects of an affiliated agreement may cause or exacerbate overall financial or even solvency concerns of a company on the one hand, and on the other hand, emerging financial or solvency concerns triggered by other causes unrelated to the affiliated agreement may impact the relative significance of transactions which are subject to the agreement.

Considering the potential significance of concerns noted based on these criteria, the analyst should consider recommending specific follow-up procedures to be performed during an onsite examination, as appropriate. For example, the examination team may be able to verify and validate assertions made by management in the Form D filing, as well as verify that the agreement has been implemented and is functioning as approved by the department. In addition, the examination team may be in a better position to assess the fairness and reasonableness of expense allocations after the agreement has been in place for a period of time. Suggested follow-up procedures can be included in the Supervisory Plan section of the IPS and/or covered in the examination planning meeting between the assigned analyst and the examination team.

Form D – Captive Reinsurance Transactions

PROCEDURE #17 assists analysts in identifying and analyzing specific types of captive reinsurance agreements specifically, those agreements where the underlying business ceded is term life and universal life with secondary guarantees (ULSG). For these specific products (commonly referred to as XXX/AXXX), there is a perception that the full amount of the required statutory reserves may not be needed to pay policyholder claims. As a result of this perception, many domestic regulators have allowed XXX/AXXX business to be reinsured through captives or special purpose vehicles in a manner that attempts to reduce the need for high-quality assets to support the portion of the statutory reserve that has a lower chance of being needed. The regulatory community has concluded that such XXX/AXXX transactions raise risks that should be reviewed by regulators pursuant to a regulatory framework using consistent review procedures. The procedures in this section are intended to serve this purpose. The primary goal of the procedures is to ensure that the reserves backing the XXX/AXXX business of the ceding insurer are backed by high-quality and accessible assets in amounts sufficient to pay policyholder claims as they come due.

The procedures refer to, and incorporate certain definitions used in, Actuarial Guideline *XLVIII – Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Section 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation* (AG 48). Analysts are encouraged to become familiar with the terms of AG 48 before conducting the procedures.

The procedures distinguish between reinsurance transactions that qualify for an exemption from AG 48 and reinsurance transactions that are subject to AG 48, although there is substantial overlap between the procedures used in, and the regulatory goals of, both cases. For transactions qualifying for an exemption under AG 48, the procedures call for a review based primarily on the procedures historically used by the NAIC Financial Analysis Working Group (FAWG) to review XXX/AXXX reinsurance transactions.

Analysts should review security standards for reinsurance of "grandfathered policies" to ensure that any credit for alternative reinsurance arrangements must be dependent on security that meets reserve valuation and asset quality requirements, as initially approved by the domiciliary regulator, that are at least as protective as those in place at the time the arrangement received its grandfathered status (12/31/14). The risk associated with grandfathered policies is that these policies are not subject to the primary security requirements established in AG 48 because the grandfathering provisions of the Framework reflect an agreement to honor the terms under which various regulators had approved existing captive reinsurance arrangements before the effective date of the

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Framework's uniform requirements. A potential risk could occur if ceding insurers replaced existing "hard asset" collateral with Other Security of lesser quality, and thus met the primary security requirements without providing any new collateral by draining the existing security from grandfathered business and reallocating it to new Covered Policy business.

For transactions that do not qualify for an exemption under AG 48, the procedures call for a review based primarily on the regulatory framework for XXX/AXXX reinsurance transactions adopted in concept by the NAIC in 2014 (the "Framework"). In general terms, the Framework requires (among other things) that:

- The ceding insurer establishes gross reserves, in full, using applicable reserving guidance (currently, the "formulaic" approach).
- The ceding insurer holds "Primary Security" (certain high-quality assets) in at least an amount equal to the "Required Level of Primary Security", and that such security be held on a funds-withheld, trust, or modified coinsurance basis.
- Portions of the statutory reserve exceeding the Primary Security Requirement are supported by security acceptable to the commissioner ("Other Security").

The procedures relating to transactions not qualifying for an exemption under AG 48 are designed to help analysts identify whether the terms of the Framework have been satisfied.

For all transactions (whether qualifying for an exemption under AG 48 or not), the procedures include (i) obtaining five years of pro forma financial statements relating to the ceded business; (ii) obtaining information regarding the nature and amount of all funds held by or on behalf of the ceding insurer as security for the reinsurance contract; and (iii) obtaining information necessary to assess the overall financial stability of the ceding insurer and the group as a whole. Because XXX/AXXX reinsurance transactions may be structured in a way that could have an impact on the holding company group as a whole, the state of domicile should contact the lead state and other domestic state regulators of the group to determine if they have any input in approving the transaction, although ultimately the decision must be made by the state of domicile.

Form E (or Other Required Information) – Pre-Acquisition Notification Form

PROCEDURES #1-2 provide analysts with names and addresses of all the parties involved with the proposed merger or acquisition.

PROCEDURES #3-7 assist analysts in gaining a clear understanding of the rationale and goals of the proposed merger or acquisition.

Extraordinary Dividend/Distribution

PROCEDURES #1-6 assist analysts in ensuring that any extraordinary dividend or distribution was approved by all the appropriate channels, was fair and reasonable, and did not result in inadequate surplus for the insurer.

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VI. Group-wide Supervision Procedures and Analyst Reference Guide

A. Framework

B. Roles and Responsibilities Lead State/Group-Wide Supervisor

C. Insurance Holding Company System Analysis Guidance (Lead State)

1. Group Profile Summary Example

2. Non-Insurance Company Grid Template

D. Corporate Governance Disclosure Procedures

E. Enterprise Risk Management Process Risks Guidance

F. Own Risk and Solvency Assessment (ORSA) Review Template

G. Form F – Enterprise Risk Report Procedures

H. Group Capital Calculation (Lead State) Procedures

I. Group Capital Calculation (Lead State) Analyst Reference Guide

J. Periodic Meeting with Group Guidance

K. Targeted Examination Procedures and Guidance

L. Supervisory Colleges Guidance

M. Group Code Assignment

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INTRODUCTION

The framework for group-wide supervision within the state-based system of regulation is set forth in the *Insurance Holding Company System Regulatory Act* (#440), the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450), the *Model Law on Examinations* (#390) and other NAIC tools. These NAIC models and tools, along with individual state laws and regulations establish the guidance for the analysis of insurance holding company systems. This includes a risk-focused approach to group supervision, where specific risks that are germane to most insurance holding company structures are addressed directly through regulation, while other more broad-based risks are addressed in the supervision review process.

Throughout this document, the term "regulation" is used to describe statutory provisions required under state laws, state regulations, or similar requirements. Also, throughout this document, the term "supervision" and "supervisory process" is used to describe the process(es) of monitoring the financial condition of the insurance group, or what is commonly referred to as the analysis process/function or examination process/function. This terminology is used to help clarify those risks addressed through statute or regulation versus those risks addressed through supervision.

State insurance regulators believe that group-wide supervision is key to helping fulfill the regulatory mission cited in the *United States Insurance Solvency Framework* (U.S. Solvency Framework), which states: "To protect the interests of the policyholder and those who rely on the insurance coverage provided to the policyholder first and foremost, while also facilitating an effective and efficient market-place for insurance products." The state-based system uses both regulation and supervision to fulfill this regulatory mission but is focused more on the supervision process for group-wide supervision as that lends itself to a more balanced approach between free markets and solvency protection. The supervision review process is flexible as to the nature, scale and complexity of the risks presented to the group. Plus, the supervision review process is flexible in dealing with risk exposure, risk concentration and the interrelationships of risks among entities within the group. However, there are situations where specific statutory authority and regulations are deemed more appropriate.

Internationally Active Insurance Group: For internationally active insurance groups (IAIGs) where a state insurance regulator is acting as the group-wide supervisor (see VI.B for criteria and definitions), it may be necessary to address additional areas regarding group-wide activities and risks. Such areas are largely consistent with the International Association of Insurance Supervisors' (IAIS's) Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and have been incorporated throughout this chapter, as deemed appropriate by state insurance regulators. While such considerations and procedures are applicable to insurance groups identified as IAIGs (see state adoption of Model #440 Section 7.1), similar procedures applicable under the state's adoption of Model #440 Section 6 may also be appropriate for use in the supervision of other large insurance groups that do not meet the IAIG criteria. In assessing any such application, analysts must not exceed their legal authority, and any supervisory measures should be risk-based and proportionate to the size and nature of the group.

Likewise, because the ComFrame is to be applied flexibly and proportionately, not every additional area of IAIG supervision will apply to each IAIG, in the same way, or to the same extent. Group-wide supervisors have the flexibility to tailor the implementation of supervisory requirements and the application of insurance supervision. The ComFrame is not a one-size-fits-all approach to IAIG supervision, as the goal is to achieve the intended outcomes set forth in the ComFrame. IAIGs have different models of governance (e.g., more centralized or more decentralized). The ComFrame does not favor any particular governance model, and it is intended to apply to all models. The organization of an IAIG can be structured in various ways as long as the intended outcomes are achieved. Proportionate application, which is called for in IAIS guidance, involves using a variety of supervisory techniques and practices tailored to the insurer. The techniques and practices applied should not go beyond what is necessary in order to achieve the intended outcomes of the IAIS's Insurance Core Principles (ICPs) and the ComFrame.

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The following are excerpts from the NAIC models that help set forth the authority for the group-wide supervision framework.

AUTHORITY RELATED TO THE SUPERVISION REVIEW PROCESS

Model #440

Supervision review Model #440: (bolding and underlining used for emphasis).

Section 6. Examination

A. Power of Commissioner…the commissioner shall have the **power to examine any insurer registered under Section 4 and its affiliates to ascertain the financial condition of the insurer,** including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

Section 1. Definitions

F. "Enterprise Risk." "Enterprise risk" shall mean any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, **is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole,** including, but not limited to, anything that would cause the insurer's Risk-Based Capital to fall into company action level as set forth in [insert cross reference to appropriate section of Risk-Based Capital (RBC) Model Act] or would cause the insurer to be in hazardous financial condition [insert cross reference to appropriate section of Model Regulation to define standards and commissioner's authority over companies deemed to be in hazardous financial condition].

Section 7.1. Group-Wide Supervision of Internationally Active Insurance Groups

A. If the commissioner is the group-wide supervisor for an IAIG, **the commissioner is authorized to engage in any of the following group-wide supervision activities**:

(1) Assess the enterprise risks within the IAIG to ensure that:

(a) The material financial condition and liquidity risks to the members of the IAIG that are engaged in the business of insurance are identified by management.

(b) Reasonable and effective mitigation measures are in place.

(2) **Request, from any member of an IAIG subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk**, including, but not limited to, information about the members of the IAIG regarding:

(a) Governance, risk assessment, and management.

(b) Capital adequacy.

(c) Material intercompany transactions.

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the IAIG are domiciled, **compel the development and implementation of reasonable measures designed to ensure that the IAIG is able to timely recognize and mitigate enterprise risks** to members of such IAIG that are engaged in the business of insurance.

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(4) Communicate with other state, federal, and international regulatory agencies for members within the IAIG and share relevant information subject to the confidentiality provisions of Section 8 through supervisory colleges as set forth in Section 7 or otherwise.

(5) Enter into agreements with or obtain documentation from any insurer registered under Section 4; any member of the IAIG; and any other state, federal, and international regulatory agencies for members of the IAIG, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state.

(6) Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the commissioner.

Model #390:

Section 1. Purpose

The purpose of this Act is to provide an effective and efficient system for examining the activities, operations, financial condition and affairs of all persons transacting the business of insurance in this state and all persons otherwise subject to the jurisdiction of the commissioner. **The provisions of the Act are intended to enable the commissioner to adopt a flexible system of examinations** that directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance related laws of this state.

Section 3. Authority, Scope and Scheduling of Examinations

A. The commissioner or any of the commissioner's examiners **may conduct an examination under this Act of any company as often as the commissioner in his or her sole discretion deems appropriate…**

SCOPE OF GROUP REGULATION

The Model #440 defines the scope of group-wide regulation through various means including defining specific important terms such as the insurance holding company system, an affiliate, and control. These are important terms as they are used to define the scope of the group being the ultimate controlling person or entity, and all of its direct and indirectly controlled subsidiaries, and therefore subject to the requirements of the Model #440. It is important to note that these definitions also consider the extent to which there is either direct or indirect participation in the group, influence and contractual obligations that suggest there is control or influence over the group. Consequently, group-wide regulation and supervision includes all insurers, all operating and non-operating holding companies, non-regulated entities and special-purpose entities. It also includes other regulated entities such as banks, utilities or securities companies. In all cases, the lead state would need to understand all such entities and the risks that such entities pose to the insurer or group as a whole. However, with respect to the other regulated entities, Section VI.C. – Insurance Holding Company System Analysis Guidance (Lead State) of this Handbook discusses that the lead state's role is to establish a plan for communicating and coordinating with the other regulators, as well as other supervisors (e.g., international insurance regulators), if significant events, material concerns, adverse financial condition or prospective risks are identified.

Multi-Jurisdictional/Functional Cooperation

The scope of group-wide regulation under Model #440 is clearly meant to apply to all entities within the controlled group; it also makes an equally important distinction regarding authority. Under the U.S. group supervision approach, the lead state is responsible for understanding all the risks posed by the regulated and non-regulated

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entities within the group, but it does not have authority over the other regulated entities within the group. For many years, state insurance regulators have developed different methods of cooperating with each other in an effort to maximize the effectiveness of regulation while respecting the authority that each state has to protect the policyholders in their state. The states have worked together in a multitude of ways to provide these benefits. One of the best examples of cooperation is state participation in the NAIC's Financial Analysis (E) Working Group (commonly referred to as "FAWG"). The Working Group's primary role is to identify insurance companies and groups of national significance that are, or may be, financially troubled, and determine whether appropriate regulatory action is being taken, and if not, what action should be taken. This group of state regulators meets and holds conference calls throughout the year. This peer review process is an essential part of the state-based system of insurance regulation in that it reinforces the communication and cooperation that is necessary to regulate insurers and insurance groups.

Internationally Active Insurance Group: In addition, Model #440 provides definitions for IAIG and group-wide supervisor, which allow state insurance regulators to fulfill roles consistent with the ComFrame for cooperation across international jurisdictions in supervising IAIGs. See additional information in VI.B.

SUPERVISION REVIEW PROCESS (RISK-FOCUSED FINANCIAL SURVEILLANCE PROCESS)

States use specific procedures in carrying out the risk-focused financial surveillance process. Many of these procedures are focused on monitoring of the insurance legal entity and group. The legal entity regulation is performed in order to have a bottom-up view of the group, whereas the holding company analysis uses the top-down approach.

Communication: All domestic states are encouraged to communicate any significant findings or concerns they have up to the lead state for consideration in the comprehensive holding company analysis. In addition, lead states of IAIGs are expected to communicate any significant findings or concerns to the group-wide supervisor, if different than the lead state, through the use of supervisory colleges, crisis management groups, or other means necessary to address any enterprise-wide concerns that arise. Domestic and lead states should not take regulatory action or place sanctions on an insurance legal entity or key individual within a broader holding company system without first communicating with the lead state and/or group-wide supervisor.

Financial Analysis Handbook and Role of the Analyst

As part of the risk-focused surveillance approach, the financial analyst role is to provide continuous off-site monitoring of a group's financial condition, monitor internal/external changes relating to all aspects of the insurer and work with examination staff to review specific risks through an on-site examination. The holding company analysis procedures are designed to determine what risks exist at the holding company. Every holding company system is reviewed in order to derive an overall assessment that highlights areas where a more detailed analysis may be necessary. The procedures are intended to be used at the discretion of analysts depending upon the sophistication, complexity and overall financial position of the holding company system, as well as the degree of interdependence and interconnectivity within the holding company system. Also, consistent with the risk-focused surveillance approach, analysts should have a firm understanding of the following branded risk categories for each group:

- **Credit (CR)—**Amounts actually collected or collectible are less than those contractually due or payments are not remitted on a timely basis.
- **Legal (LG)—**Non-conformance with laws, rules, regulations, prescribed practices or ethical standards in any jurisdiction in which the entity operates will result in a disruption in business and financial loss.

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- **Liquidity (LQ)—**Inability to meet contractual obligations as they become due because of an inability to liquidate assets or obtain adequate funding without incurring unacceptable losses.
- **Market (MK)—**Movement in market rates or prices, such as interest rates, foreign exchange rates or equity prices adversely affects the reported and/or market value of investments.
- **Operational (OP)—**The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events.
- **Pricing/Underwriting (PR/UW)—**Pricing and underwriting practices are inadequate to provide for risks assumed.
- **Reputational (RP)—**Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.
- **Reserving (RV)—**Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
- **Strategic (ST)—**Inability to implement appropriate business plans, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

Analysts should also consider any prospective risk to the group. A prospective risk is a residual risk that affects future operations or conditions for the group. These prospective risks can be identified through assessments of company management and/or operations or risks associated with future business plans. Common types of such risks for insurers may include underwriting strategy, investment strategy, and reinsurance strategy and diversification/concentration. However, other risks from non-insurers can also include off-balance sheet exposures and other risks driven by the business model of that non-insurer. The analyst's understanding of the above nine risk classifications includes an assessment of the level of that risk and the ability of the entity to appropriately manage the risk during the current period and prospectively. The assessment of these nine risk classifications both currently and prospectively should be part of the quantitative and qualitative analysis completed within the holding company analysis.

The overall risk-focused surveillance process requires a significant amount of communication and coordination between the analysis and examination function to be effective. Analysts should identify and document all material current and prospective solvency risks and communicate those risks to the respective examiners for periodic on-site inspection.

Communication across functions is also discussed in more detail below (see Coordination in Risk-Focused Surveillance), as well as in Section I.A Department Organization and Communication of this Handbook.

At the conclusion of the basic holding company analysis performed on all groups, the lead state is required to document an overall summary and conclusion regarding the financial condition of the group, including its strengths and weaknesses and any risks identified. This summary and conclusion should be provided in the Group Profile Summary (GPS) that is maintained and updated on a regular basis. See the VI.B. for discussion of the GPS.

Financial Examination Assessment

Communication and/or coordination with other regulators are crucial when considering the financial condition of a group. There are various risks that the lead state may want to examine more closely through an on-site examination. The most common of such risks, or potential risk mitigators, is that which is derived from the group's governance and risk management practices. Both of these are reviewed during a full-scope examination. This information is then communicated and shared with analysts, the lead state and other regulators as necessary. The lead state should also consider whether these areas, or components of each, should be examined more periodically. There may be several other areas where the lead state may want to consider a targeted exam with

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respect to the group. In considering such a targeted review, it is important to consider both the flexibility envisioned within Model #390 for such reviews, as well as the work conducted during a full-scope examination.

The fundamental purposes of a full-scope financial condition examination report are: 1) to assess the financial condition of the company; and 2) to set forth findings of fact (together with citations of pertinent laws, regulations and rules) with regard to any material adverse findings disclosed by the examination. The report on examination is structured and written to communicate to regulatory officials' examination findings of regulatory importance. Management letter comments are considered to be examination work papers and can be used to present results and observations noted during the examination. As it relates to groups, most of the examination work completed on a group basis is not expected to result in a report of examination, but rather is intended to communicate any concerns noted internally. In most cases, the work completed will merely inform analysts and other state regulators as it pertains to a particular area. However, to the extent the examiner witnesses practices that are noteworthy, and for which there is a need to pursue a change in such practices, a management letter may be produced. Such a management letter provides an opportunity to alert management that, if left uncorrected, could ultimately lead to financial concerns.

Management letter comments generally contain the following information:

- A concise statement of the problem found
- The factors that caused or created the problem
- The materiality of the problem and its effect or potential effect on the financial statements
- The financial condition of the group
- The examiner's recommendation to the group regarding what should be done to correct the problem.

The effectiveness of the financial examination process is enhanced if effective follow-up procedures have been established by the lead state. Periodically, after a financial examination report or management letter comment has been issued, inquiries should be made to the group to determine the extent to which corrective actions have been taken on report recommendations and findings. Because the examiners have usually moved on to another examination, many states use the financial analysts to perform this function. A lack of satisfactory corrective action by the group may be cause for further action.

The concept of risk in the risk-focused examination encompasses not only risk as of the examination date, but risks that extend or commence during the time in which the examination was conducted, and risks that are anticipated to arise or extend past the point of completion of the examination.

The risk-focused examination anticipates that risk assessment may extend through all seven phases of the examination.

- **Phase 1** – Understand the Company and Identify Key Functional Activities to be reviewed—This involves researching key business processes and business units.
- **Phase 2** – Identify and Assess Inherent Risk in Activities—These risks include credit, market, pricing/underwriting, reserving, liquidity, operational, legal, strategic, and reputational.
- **Phase 3** – Identify and Evaluate Risk Mitigation Strategies/Controls—These strategies/controls include management oversight, policies and procedures, risk measurement, control monitoring, and compliance with laws.
- **Phase 4** – Determine Residual Risk—Once this risk is determined, the examiner can determine where to focus resources most effectively.
- **Phase 5** – Establish/Conduct Detail Examination Procedures—Upon completion of risk assessment, determine nature and extent of detail examination procedures to be performed.

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- **Phase 6** – Update Prioritization and Supervisory Plan—Incorporate the material findings of the risk assessment and examination in the determination of the prioritization and supervisory plan.
- **Phase 7** – Draft Examination Report and Management Letter—Incorporate into the examination report and management letter the results and observations noted during the examination.

The goals of the risk-focused examinations can also apply to group-wide supervision and are as follows:

- Assessing the quality and reliability of corporate governance to identify, assess and manage the risk environment facing the insurer in order to identify current or prospective solvency risk areas. By understanding the corporate governance structure and assessing the "tone at the top," the examiner will obtain information on the quality of guidance and oversight provided by the board of directors and the effectiveness of management, including the code of conduct established in cooperation with the board.
- Assessing the risks that a company's surplus is materially misstated.

The procedures above are performed for the purpose of completing a full-scope examination on an insurance legal entity. However, procedures related to governance and risk management can be performed at the group level when appropriate (See Section VI.B. for further discussion). In addition, for all other procedures, the states coordinate the examination of multiple insurance legal entities wherever possible. This typically involves identifying the systems that are common among members of the insurance group and only subjecting those common systems to one examination. This requires coordination among all domestic states and then further coordination in actually testing the particular system so that all domestic states can rely upon such work for their legal entity examinations.

Communication between analysts and examiners in preparation of an examination should include a thorough discussion of key risks, current and prospective. This communication and coordination may be best accomplished not only through written documentation but through face-to-face interaction. For example, the examiners and analysts should meet for pre-examination planning, conduct follow-up meetings/calls to discuss analysis of subsequent filings and finally meet at the end of the examination whereby examiners can communicate examination findings to analysts that in turn may help analysts focus on their next review.

Internationally Active Insurance Group: In addition to the general governance and risk management considerations and the targeted procedures related to specific concerns incorporated into financial examinations, there are additional considerations highlighted in the ComFrame that may be appropriate for incorporation into ongoing IAIG financial exams led by the group-wide supervisor. These considerations generally relate to ComFrame elements that are more effectively evaluated through on-site examination activities, such as the effectiveness of corporate governance, risk management, and internal control frameworks in place at the head of the IAIG. For more information on IAIG examination considerations, please see Section 1.I.F of the NAIC's *Financial Condition Examiners Handbook*.

Coordination in Risk-Focused Surveillance

Most, but not all state insurance departments follow a staffing model whereby separate units are responsible for off-site financial analysis and on-site financial examination activities. Such a staffing model can lead to challenges in supervising insurance groups if state departments do not emphasize the importance of communication and coordination across units. In some cases, financial examination activities are outsourced to third parties, which can lead to additional complications. To encourage effective coordination and communication across units, state insurance departments use the common language of branded risk classifications (see discussion above) to identify and assess insurance company risk exposures and incorporate this language into meetings and reports shared across units, i.e., GPS, Own Risk and Solvency Assessment (ORSA) Lead State Summary, Exam Summary Review Memorandum. In addition, formal meetings and ongoing communication between the two units, if separate, are

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required during the planning, fieldwork, and wrap-up stages of each financial examination to ensure effective coordination. Similar requirements are also in place to promote communication and coordination between analysis/examination staff and any subject matter experts (SMEs)—i.e., actuaries, investment specialists, information technology (IT) specialists, reinsurance specialists—that are supporting financial surveillance efforts.

Internationally Active Insurance Group: Given the level of complexity of many IAIGs and the critical need to ensure effective coordination in supervision, state insurance departments are encouraged to consider the benefits of customized approaches to financial surveillance staffing for IAIGs. For example, in some jurisdictions, both domestically and internationally, group-wide supervisors utilize a team-based approach to IAIG supervision whereby financial analysts; financial examiners; department supervisors; and specialists, both internal or external, are integrated into a single unit for the purposes of group supervision. Such an approach can promote the use of a more well-rounded and integrated team of supervisors with different backgrounds and skillsets in reviewing group regulatory reporting, holding periodic meetings with the group, conducting group risk assessments, performing on-site inspections of group functions, and leading ongoing supervisory college sessions. However, there may be other approaches to financial surveillance staffing that can be applied to address the nature and complexity of IAIGs. As such, state insurance departments acting as group-wide supervisors for IAIGs are encouraged to consider the benefits of more customized approaches to staffing in this area.

OTHER HOLDING COMPANY SPECIFIC RISKS ADDRESSED DIRECTLY IN REGULATION

State insurance regulators have consistently reviewed and monitored groups through the Form B, Form D required filings, required dividend distributions and Form A acquisition. Insurers are required to submit Form D filings for management agreements, service contracts, tax allocation agreements, guarantees, loans and all cost-sharing arrangements. All such contracts must be submitted for regulatory approval to avoid the possibility of management moving cash out of the regulated entity, which is a risk that the business model for the insurance industry is susceptible to. It also includes reinsurance agreements, where there are similar opportunities and where there must be a regulatory review of such agreements to ascertain that risk transfer has occurred within the contract. The fact is that intragroup transactions and exposures are subject to potential abuse and state insurance regulators have addressed these risks directly in this way. Also, subject to review under Model #440 are "extraordinary dividends" and change in control, since again these transactions have the potential to pose risk to the insurance group and the insurer and its policyholders.

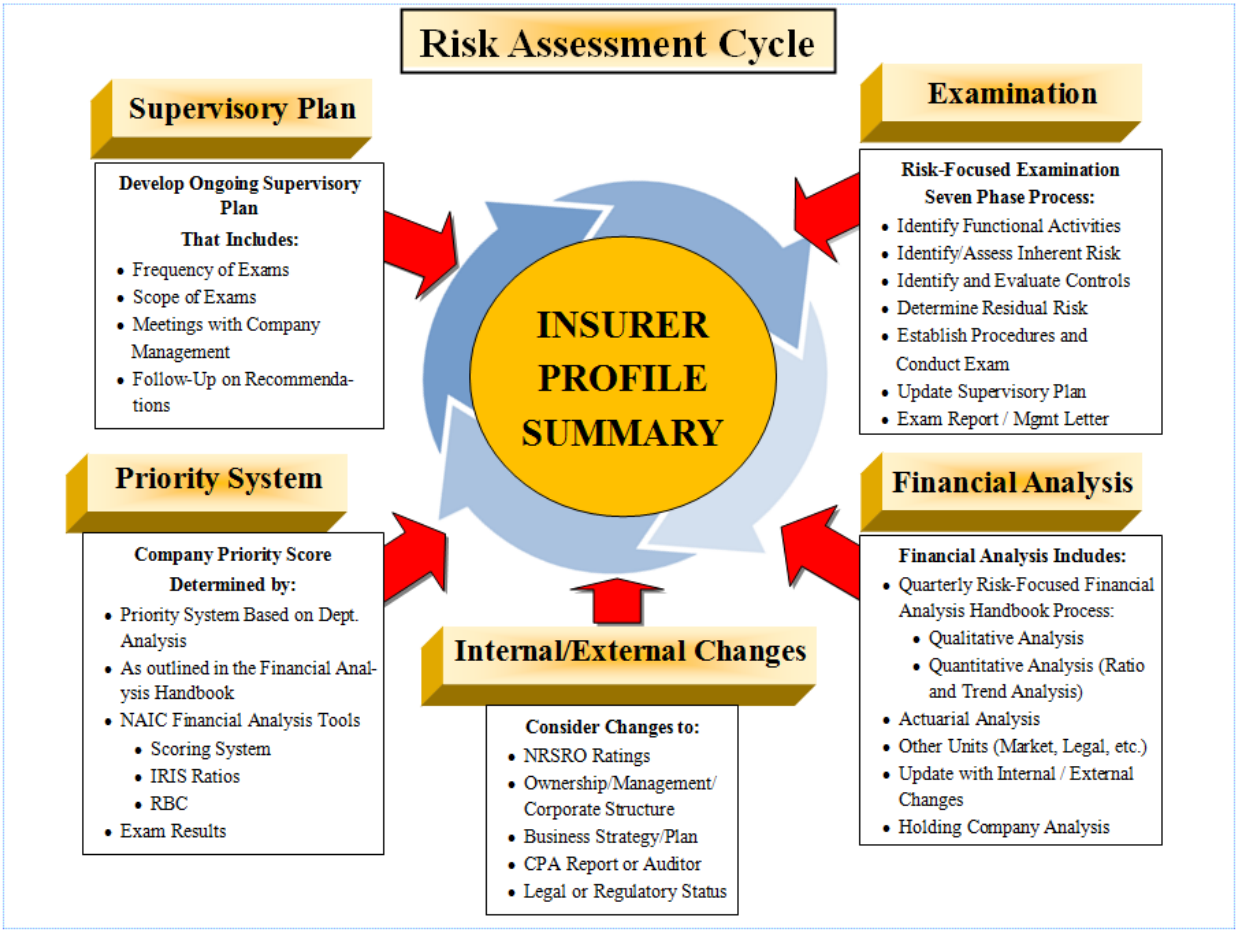
Lead State Summary

The Lead State Summary Report is located in iSite+, within Summary Reports, and provides a listing of all insurance groups and the companies within each group. The purpose of the report is to improve communication between regulators regarding group examinations. It can be sorted on a particular group code or group name to determine the lead state for that group or by state to view all of the insurance groups for which that state is the lead. The report also contains contact information for the department's analyst and chief analyst for a particular insurance group and other information such as premiums, assets and latest exam information. States should actively update its contact information throughout the year as changes occur.

Within the Lead State Summary Report the user can view the Domestic Report, which displays each group that includes an insurer domiciled in the state selected by the user. The Consolidated Domicile Data report displays consolidated data (direct and gross premiums written and percentage distribution and net admitted assets) by state within each group. For more information on the lead state refer to VI.B.

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The following diagram illustrates the risk assessment cycle:



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INTRODUCTION AND OVERVIEW

The previous section introduced the U.S. group supervision framework. This included references to the NAIC model laws, including respective state laws and regulations that help set forth the framework, followed by a discussion of the supervision review process. As previously discussed, in the U.S., the supervisory review process consists primarily of off-site and on-site monitoring activities. This section will discuss the roles and responsibilities of the group-wide supervisor/lead state.

For purpose of this Handbook, the terms "group-wide supervisor" and "lead state" are used somewhat interchangeable, but with greater use of the term lead state. This is due to the fact that the states have used the term lead state for years, however there are some instances where both would exist, and therefore it is important to understand that distinction. The lead state is generally considered to be the one state that "takes the lead" with respect to conducting group-wide supervision within the U.S. solvency system. The concept of the lead state and determining the lead state is discussed more in the following section. A U.S.-based company that only conducts business in the U.S., unless the group also has banking or similar functions, would result in the lead state being the group-wide supervisor. In the case of an international-based company, the group-wide supervisor would typically be a foreign-based regulator. (See Section VI.J. Supervisory Colleges Guidance, regarding international supervisory colleges). Ideally, when a foreign-based group-wide supervisor is involved, the U.S. lead state regulator should be able to defer some of his or her responsibilities to the foreign-based group-wide supervisor. However, it is possible that the U.S. lead state may not be able to obtain group-wide information from the foreign-based group-wide supervisor, and, therefore, the U.S. lead state regulator may need to complete a portion of the group-wide analysis.

Before discussing the roles and responsibilities of the lead state/group-wide supervisor further, the following is defined:

> **Group-wide supervision** – The process of promoting effective and coordinated supervision of an insurance group on a group-wide basis, including coordinating the input of insurance legal entity supervisors, as a supplement to insurance legal entity supervision.

The process for monitoring the financial condition of a group is similar to monitoring a specific insurer in that it requires the use of basic financial information, coupled with the ability to gather additional information produced by management. The information produced by the group's management that is generally considered to be the most helpful is that which is associated with managing the group's risks, or more specifically those risks that may ultimately have financial implications on the financial condition of the group, including prospective risks. During this supervision review process, the regulators role is to understand the various risks faced by the group and how the group is managing such risks.

One of the primary reasons for determining a lead state/group-wide supervisor is to increase the efficiencies and effectiveness of group supervision. The state-based system framework for group supervision is centered on the *Insurance Holding Company System Regulatory Act* (#440), which provides, among other things, that every domestic state within the insurance group should have the ability to evaluate the group and its potential impact on the domestic insurer. The use of a lead state or group-wide supervisor has the benefit of retaining this authority but sets up a system in which states regularly defer this authority to a key regulator. However, even if domestic regulators are not technically required to defer this authority, this deferral is considered a best practice that should be used in virtually all cases, with few exceptions. This has the effect of increasing efficiency and effectiveness of group regulation.

Lead State/Group-Wide Supervision Concept

The operations of an insurance company often are not limited to one state. When multiple states are involved in monitoring the activities or approving the transactions of a company or insurance holding company system, it is prudent to coordinate regulatory efforts.

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These coordinated activities should include:

- The establishment of procedures to communicate information regarding troubled insurers with other state insurance departments.
- The participation on joint examinations of insurers, when appropriate.
- The assignment of specific regulatory tasks to respective state insurance departments and/or other jurisdictions in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise.
- In the case of troubled or potentially troubled insurance groups, the establishment of a task force or crisis management group consisting of personnel from various state insurance departments and/or international jurisdictions to carry out coordinated activities.
- Coordination and communication of insurance holding company system analysis.

If significant concerns are identified related to the internationally active insurance group's (IAIG's) current or prospective solvency, whether due to legal entity or group-wide risks, the group-wide supervisor should determine whether additional supervisory measures, as outlined in Model #440, should be implemented. Model #440 provides the group-wide supervisor the authority to obtain the information necessary and appropriate to assess enterprise risk. In addition, Model #440 provides for coordination, through the authority of the regulatory officials of the jurisdictions where members of the IAIG are domiciled, to compel the development and implementation of reasonable measures designed to ensure that the IAIG is able to timely recognize and mitigate enterprise risks to members of the IAIG that are engaged in the business of insurance.

The concept of lead state/group-wide supervision is not intended to relinquish the authority of any state or jurisdiction, nor is it intended to increase any state or jurisdiction's statutory authority or to put any state or jurisdiction at a disadvantage. It is intended to facilitate efficiencies when one state coordinates the regulatory processes of all states and/or jurisdictions involved. Nevertheless, the lead state/group-wide supervisor should coordinate with non-lead states and/or other jurisdictions on all regulatory items that affect the group, or multiple legal entities contained in the group, to make it clear which state is responsible for activities and reduce regulatory duplication.

Procedures for Determining the Lead State

Insurance holding company systems with more than one U.S. insurance legal entity are deemed U.S. insurance groups and assigned NAIC group codes (see Section VI.K for more information on group code assignment). For U.S. insurance groups with insurance entities domiciled in more than one U.S. state/jurisdiction, a lead state is selected to oversee the group. The ultimate decision of who should function as the lead state is up to the domestic state insurance regulators of the group where a majority of such domestic states must agree to the decision. However, in practice, it has generally occurred through a consensus decision. The determination of a lead state is affected by the following factors:

- The state with the insurer/affiliate with largest direct written premiums
- Domiciliary state/country of top-tiered insurance company in an insurance holding company system
- Physical location of the main corporate offices or largest operational offices of the group
- Knowledge in distinct areas of various business attributes and structures
- Affiliated arrangements or reinsurance agreements
- Lead state must be accredited by the NAIC

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The Lead State Report is located in iSite+, within Summary Reports, and provides an up-to-date listing of all insurance groups and the companies within each group. The purpose of the report is to improve coordination and communication between regulators. The report also contains current contact information for the state's assigned insurance company analyst and the state's chief analyst which is maintained by state department staff. Within the Lead State Report the user can view the Domestic Report which displays each group that includes an insurer domiciled in the state selected by the user. The Consolidated Domicile Data Report displays consolidated data (direct and gross premiums written and percentage distribution and net admitted assets) by state within each group.

Procedures for Identifying an Internationally Active Insurance Group

U.S.-based insurance holding company systems that operate internationally are designated IAIGs if they meet the following criteria included in Model #440:

1. Premiums written in at least three countries.
2. The percentage of gross premiums written outside the U.S. is at least 10% of the insurance holding company system's total gross written premiums.
3. Based on a three-year rolling average, the total assets of the insurance holding company system are at least $50 billion or the total gross written premiums of the insurance holding company system are at least $10 billion.

Any involved supervisor of an insurance group operating internationally may prompt the process of identifying an IAIG. If no group-wide supervisor has been determined (see discussion on determination below), the supervisor most demonstrating the characteristics of a group-wide supervisor should lead the identification process and invite other involved supervisors to participate. The scope of an insurance group should be determined before considering whether the criteria for determining whether the group is an IAIG are met. If there is already a supervisory college for a group, it should be used to facilitate the determination as to whether the group is an IAIG.

In addition to the primary criteria for use in identifying an IAIG, although not explicitly addressed in Model #440, in limited circumstances, it may be appropriate for the group-wide supervisor to utilize discretion to determine that a group is not an IAIG even if it meets the criteria or that a group is an IAIG even if it does not meet the criteria, if permitted under state law. If discretion is used, then the reasons for exercising such discretion should be based on verifiable and documented quantitative and qualitative information. Examples of situations where it may be appropriate to determine that a group is an IAIG, even if it does not currently meet the criteria, include, but are not limited to:

- Growth/expansion or acquisition plans of the group.
- Significant off-balance sheet assets.
- Situations where a temporary event or fluctuation causes the group to fall below thresholds.

Examples of situations where it may be appropriate to determine that a group is not an IAIG, even though it currently meets the criteria, include, but are not limited to:

- Planned contraction or disposal of business.
- Situations where an unusual event or fluctuation causes the group to temporarily exceed thresholds.
- Situations where the group's business outside the U.S. exceeds 10% in aggregate, but its business in any one foreign jurisdiction is negligible.

The group-wide supervisor should regularly review its decision to determine whether the group continues to meet the criteria and invite other involved supervisors to participate in that process. At a minimum, the group-

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wide supervisor should review its decision once every three years and whenever a significant change or event occurs that affects the group.

Model #440 states that prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision, the commissioner shall notify the insurer and the ultimate controlling person within the IAIG providing reasons for that decision. The IAIG shall have not less than thirty (30) days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish on the state's website the identity of IAIGs that the commissioner has determined are subject to group-wide supervision.

Procedures for Determining the Group-Wide Supervisor

Model #440 defines group-wide supervisor as the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities, who is determined or acknowledged by the commissioner to have sufficient significant contacts with the IAIG. Model #440 requires a single group-wide supervisor to be identified for any IAIGs operating in the U.S., which could either be a state insurance regulator—i.e., most likely the lead state in the case of a U.S.-based insurance group—or a regulatory official from another jurisdiction, based on individual facts and circumstances. The following factors are considered when making the group-wide supervisor determination:

1. The jurisdiction of domicile of the insurers within the IAIG that hold the largest share of the group's written premiums, assets, or liabilities.
2. The jurisdiction of domicile of the top-tiered insurer(s) in the insurance holding company system of the IAIG.
3. The location of the executive offices or largest operational offices of the IAIG.
4. Whether another regulatory official is acting or seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:
    a. Substantially similar to the system of regulation provided under the laws of this state.
    b. Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials.
5. Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

Procedures for Identifying the Scope and Head of the Internationally Active Insurance Group

In conducting group-wide supervision of an IAIG, it is important for the group-wide supervisor to work with other involved supervisors to identify all the legal entities that are part of the insurance group.

The determination of both the scope and head of the IAIG is significant to group supervision, as review procedures and risk assessments are conducted at this level. Therefore, the group-wide supervisor should carefully consider this guidance, as well as additional best practice considerations outlined in Insurance Core Principle (ICP) 23 – Group-Wide Supervision, in making determinations regarding the scope and the head of the IAIG. However, International Association of Insurance Supervisors (IAIS) materials are not deemed authoritative and should not be viewed as official NAIC guidance if they are not directly incorporated into this chapter. The group-wide supervisor should provide the supervisory college with the main reasons and judgments it made when identifying the head of the IAIG and obtain concurrence from other college members, when possible.

To determine the scope and head of an insurance group, supervisors should:

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- First, identify all insurance legal entities within the corporate structure. Model #440 provides the authority to collect all information necessary to determine the scope and head of the IAIG.
- Second, identify all entities that have control over those insurance legal entities, as defined in Model #440. As noted in Model #440, control is generally presumed to exist based on 10% or more ownership, direct or indirect, of voting securities, but it can also take operational control factors into consideration.
    - If this results in only one entity being identified with control over all the insurance legal entities, this entity is the head of the insurance group.
    - However, if there is more than one entity with control over all the insurance legal entities, supervisors should identify the head of the insurance group, such as the entity that has the greatest level of control over the insurance business, by considering the following factors:
        - The proportion of the insurance business relative to other businesses it controls.
        - The degree of operational control.
        - The degree of shareholder control.

Head of the Internationally Active Insurance Group versus Ultimate Controlling Person: The head of the IAIG is not necessarily synonymous with the Ultimate Controlling Person (UCP) of the holding company system, which is the top-tier company or individual with control over and responsibility for all entities within the holding company system that is not controlled by any other person. As holding company systems may include various business segments and intermediate holding companies, it is the responsibility of the group-wide supervisor, in consultation with other involved supervisors, to identify the entity most responsible for the direct management/control of the insurance operations of the group.

Non-insurance Legal Entities: In determining the scope and head of the IAIG, the group-wide supervisor should consider whether noninsurance legal entities within the group pose risk to the insurance operations. In making this determination, the group-wide supervisor should evaluate whether there is a linkage between the insurance operations and the noninsurance legal entity, other than an investment in or from the noninsurance legal entities, that could adversely affect the insurance operations; and a lack of adequate safeguards, including additional capital, to mitigate risks arising from any such linkages. If so, such noninsurance entities should be included within the scope of the IAIG, and the group-wide supervisor should take this into consideration in identifying the head of the IAIG.

Subsidiary as Head of the Internationally Active Insurance Group: Where a legal entity controls all insurance legal entities within the group and noninsurance legal entities, which pose risks to the insurance operations, the group-wide supervisor has the discretion to identify a subsidiary of that entity as the head of the IAIG if: 1) prudential supervision is exercised by another financial sector supervisor over that entity; and 2) the group-wide supervisor can rely on the other financial sector supervisor to provide sufficient information concerning the risks that this entity and the legal entities it controls pose to the insurance operations.

LEAD STATE OR GROUP-WIDE SUPERVISOR ROLES AND RESPONSIBILITIES

The following identifies the roles and responsibilities, or procedures that should be performed by the lead state or group-wide supervisor as it relates to supervision of insurance groups. It also includes a short summary of the purpose of each of these duties. Most of these are further detailed in the remaining parts of this section of this Handbook.

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Communication and Coordination

Two of the main responsibilities of the lead state are: 1) to establish communication with other identified states, federal regulators and international regulators, including establishing points of contact and 2) to determine the amount of interest in participating in the multi-jurisdictional coordination. It also includes establishing lines of communication and serving as the regulatory contact with top management of the group.

The most important role of the lead state is to act as a communicator of group risk assessment information to other domestic states and then acts as a coordinator with the other states in determining what, if any, further action is appropriate regarding the domestic insurers in the group or the group as a whole. By serving in this role, the lead state can coordinate and add efficiency to the states' requests for group-level information. This approach helps to prevent regulatory gaps and, more importantly, efficiently detect problems earlier. In addition, this approach also helps to reduce duplication of regulatory requests with non-lead states only making additional regulatory requests of an insurer's domestic entity(ies) located in that non-lead state. Inquiries seeking group-level information or information concerning entities domiciled in another state or jurisdiction should be coordinated by, and made by, the lead state. Non-lead states should generally not pursue such inquiries directly with the group parent or indirectly through queries channeled via a domestic. To increase the effectiveness of this concept, it may be helpful for the lead state to find a means to make sure that each group for which it is the lead is aware that it is, in fact, the lead state for that group. This may include directing it to certain information or through some other communication.

Confidentiality of Information: Maintaining confidentiality of all information is of utmost importance and as such implementing confidentiality agreements with all regulators is imperative. The lead state is responsible for communicating and coordinating the procedures as to how information will be shared among each other. Verbal or written briefings that are arranged by the lead state, in conjunction with company management, have been the most effective.

Other Responsibilities: The lead state will have many procedures assigned to it, which include determining and documenting: 1) the depth of and approach to the insurance holding company analysis; 2) the assessment of the group's governance and enterprise risk; 3) questions addressed in a periodic meeting with the group; 4) targeted examination procedures; and 5) the extent to which there are any market conduct risks.

Participating States: In addition to the importance of lead state or group-wide supervisor communication and coordination, it is also important for domestic, or non-lead, states to communicate and coordinate effectively regarding the group. Of particular importance is that a domestic state notifies the lead state and/or group-wide supervisor prior to taking any regulatory action or placing sanctions on an insurance legal entity or key individual within a broader holding company system. This type of proactive communication can ensure that state insurance regulators are effectively coordinating and not undermining each other's efforts in conducting group/legal entity supervision.

Holding Company Analysis and the Group Profile Summary

NAIC Model #440, which has been adopted by all the states, establishes the platform for holding company analysis. One of the most important aspects of the holding company analysis is the requirement for the lead state to understand the entire insurance holding company system. As previously noted, the holding company system includes the ultimate controlling person or entity, as well as all of its direct and indirectly controlled subsidiaries. There are various things that must be considered in gaining this understanding, including documenting the nature and function of all non-insurance legal entities within the holding company system. The primary purpose of gaining such an understanding is determining the risks and risk concentrations that each entity may pose to the insurer and the group as a whole.

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Another important aspect of the holding company analysis is the analysis of the financial condition of the insurance holding company system. This specifically includes evaluating and assessing how four different areas i.e., profitability, leverage, liquidity, and overall financial condition - impact its exposure to the nine branded risk classifications. Although much of this analysis can be driven by aggregating risks identified in the legal entity analysis (including a review of the Insurer Profile Summary (IPS)) and by reviewing the group's financial statements submitted as part of the registration statement or filed with the U.S. Securities and Exchange Commission (SEC), the analysis may also require further discussion with management of the group. See Section VI.H. – Periodic Meeting with the Group Procedures for further guidance.

Completing the holding company analysis as detailed in Section VI.C. Insurance Holding Company System Analysis Guidance (Lead State) is one of the roles of the lead state. This analysis is intended to be completed by the lead state only. However, as discussed elsewhere in this Handbook, all domestic states are responsible for documenting the impact that the holding company group could have on the domestic insurer, which requires a basic level of understanding of the group's risks.

Group Profile Summary: All results of holding company analysis are to be documented in the GPS for purposes of presenting a comprehensive view of the current and prospective risks facing the holding company group as well as the ongoing regulatory plan (or supervisory plan) to ensure effective supervision. A separate supervisory plan document may also be utilized to outline more detailed steps to ensure effective supervision for high-priority or potentially troubled insurers within the group, as necessary. The purpose of the GPS also is to serve as the primary communication tool between the lead state and other regulators that provides consistency between the states. The GPS is intended to serve as a "living document" to "house" summaries of information from legal entity IPSs that are material to the group, such as coordinated risk-focused examinations, financial analysis, internal and external changes, supervisory plans, and other group information. Completing and distributing the GPS to other regulators on a timely basis is the sole responsibility of the lead state.

Analysts are involved in all phases of the risk-focused surveillance approach. There should be a continuous exchange of information between examiners and analysts to ensure that all members of the department are properly informed of solvency issues related to the group. Analysts should work with the examination staff to update the GPS.

Internationally Active Insurance Group: In performing holding company analysis and maintaining a GPS for IAIGs, the group-wide supervisor should ensure that both the scope and head of the IAIG are clearly defined and described within the analysis documentation. In addition, key considerations relevant to IAIGs are highlighted throughout to ensure that they are adequately addressed and incorporated, as appropriate, into holding company analysis processes and the GPS to meet the expectations of other involved international supervisors.

Corporate Governance Risks

The *Model Regulation to Define Standards and Commissioners Authority for Companies Deemed to be in Hazardous Financial Condition* (#385) specifically indicates that if an officer, director, or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position, the insurer can be deemed to be a company that is in a hazardous financial condition. Clearly, this inclusion recognizes that such a situation is a risk to a policyholder. For this reason, Model #385 specifically provides the supervisor with the authority to issue and order that insurer to correct corporate governance practice deficiencies, and adopt and use governance practices acceptable to the commissioner.

The NAIC has incorporated into its *Annual Financial Reporting Model Regulation* (#205) specific governance requirements as it pertains to insurers audit committees. Most notably, the regulation requires an increasing amount of independent audit committee members as the premium increases. The calculation of this independence requirement may be provided to the audit committee on an aggregate basis for insurers in the

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insurance holding company system. However, specific reporting is limited and instead governance is assessed with information gathered during the examination and analysis process.

The *Corporate Governance Annual Disclosure Model Act* (#305) and the *Corporate Governance Annual Disclosure Model Regulation* (#306) provide the analyst with annual reporting from insurers on their corporate governance practices. While there is flexibility in determining the level at which governance information is reported in the annual filing, the insurer or insurance group is encouraged to make the Corporate Governance Annual Disclosure (CGAD) disclosures at the level at which the risk appetite is determined; the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively; the supervision of those factors are coordinated and exercised; or the legal liability for failure of general corporate governance duties would be placed.

Assessing the corporate governance of the group is one of the roles of the lead state and group-wide supervisor, and conclusions regarding this assessment should be incorporated in holding company analysis documentation and the GPS. Certain elements of governance that should be reviewed and assessed at the head of the IAIG level are discussed in more detail in Section VI.D.

Enterprise Risk Management (ERM) Risks

As part of the risk-focused surveillance system, analysts and examiners identify and assess the inherent risk in the branded risk categories using their authority under the *Model Law on Examinations* (#390) and specific state laws and regulations. Analysts, although more commonly the examiner, also identifies and evaluates risk mitigation strategies/controls to assess the risk management environment of the group and will consider that in determining the overall supervisory plan. Larger scale insurers and insurance groups are subject to all of the requirements of the *Risk Management and Own Risk and Solvency Assessment Model Act* (#505). This model requires among other things, the maintenance of a risk management framework to assist with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. It also requires the completion of an Own Risk and Solvency Assessment (ORSA) no less than annually, but also at any time when there are significant changes to the risk profile of the insurer or the insurance group. The ORSA is the insurer/group's internal assessment appropriate to its nature, scale and complexity addressing the material and relevant risks associated with an insurer's current business plan and the sufficiency of capital resources to support those risks. Any follow-up associated with this risk assessment should be coordinated through the lead state to improve regulatory effectiveness and reduce the level of regulatory duplication.

The ORSA has two primary goals:

1. To foster an effective level of ERM, through which each insurer or insurance group identifies, assesses, monitors and reports on its material and relevant risks, using techniques that are appropriate to the nature, scale, and complexity of the insurer's risks, in a manner that is adequate to support risk and capital decisions.
2. To provide a group-level perspective on risk and capital, as a supplement to the existing legal entity view.

If a U.S. state insurance commissioner is the global group-wide supervisor of an IAIG, the U.S. state insurance commissioner should receive the ORSA Summary Report covering all material group-wide insurance operations. In addition, the insurer should work with the U.S. global group-wide supervisor to identify the head of the IAIG and determine which noninsurance operations, if any, within the group should be included within the scope of the ORSA Summary Report. However, for all ORSA filers, the noninsurance operations that present material and relevant risks to the insurer should be included in the scope of the ORSA Summary Report.

Otherwise, the insurer may file ORSA Summary Reports encompassing, at a minimum, the U.S. insurance operations, as long as the lead state receives ORSA Summary Reports encompassing the non-U.S. insurance operations. The lead state commissioner should discuss with the global group-wide supervisor from the relevant

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foreign jurisdiction(s) the report received to inquire about any concerns and either confirm that the report was compliant with the foreign jurisdictions' requirements or consistent with the applicable principles outlined in the IAIS ICP 16: Enterprise Risk Management for Solvency Purposes, as well as the *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual), to determine if additional information is needed. The commissioner will, where possible, avoid creating duplicative regulatory requirements for internationally active insurers.

Any follow-up associated with this risk assessment should be coordinated through the lead state to improve regulatory effectiveness and reduce the level of regulatory duplication. Assessing the enterprise risk management (ERM) process risks of the group as detailed in Section VI.E. Enterprise Risk Management Process Risks Guidance is one of the roles of the lead state.

Market Conduct Risks

This Handbook discusses within Section I.A. Department Organization and Communication the need for communication with other divisions of the insurance department. This Handbook also discusses within Section I.B. Interstate Communication and Cooperation, and specifically discusses regulatory actions taken relative to market conduct issues. The Risk Assessment worksheet within this Handbook also list market conduct actions/findings and documenting in the IPS. The IPS is a tool used for sharing information between states that also encompasses group information. Refer to the *Market Regulation Handbook* for further discussion of these types of risks.

Periodic Meeting with Group

As previously discussed, Model #440 and respective state laws and regulations give state regulators the authority to obtain and examine any information related to the group in order to determine the financial condition impact on the insurer. In addition, there is generally a need to meet periodically with group management in order to ascertain that the regulator has all relevant information he or she needs to have a current understanding of the financial condition of the group and insurer.

How often such a meeting takes place, or the depth of discussion, will vary considerably from group to group. However, an in-person meeting is recommended in the year of an examination. For example, if an examination is as of December 31, 2014, then meet early in 2014. The lead state regulator will use its judgment in making decisions on whether to meet or not, based on what it already knows about the group and insurer. Every holding company situation is different, and for that reason, the lead state should use its judgment in determining how best to gather additional information that can come from this type of process.

With the general objective of better understanding the financial condition of the group, the lead state should tailor any questions or discussion points to most accurately fit what the regulator knows about the group and its financial position and what could be projected into the future without the benefit of understanding what the group is doing to address such items. Therefore, considering what type of questions should be developed, or the focus of such a discussion, either through an in person meeting or a conference call, is one of the roles of the lead state. See Section VI.H. Periodic Meeting with the Group procedures for possible questions to consider for such a meeting.

Targeted Examination Procedures

The need for target examinations should be driven by the results of the risk-focused surveillance process. Therefore, because the general purpose of a targeted on-site examination is to focus resources on a particular risk, such procedures would generally be driven by any change in risks or any weaknesses or concerns given that on-site inspection can provide assurances that cannot be provided through off-site monitoring.

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Targeted examinations on groups would generally not need to focus on risks that are already addressed within individual company examinations, unless there appears to have been a change in that risk since the last examination and that particular risk is one that is shared among several insurance legal entities within the group. It may be appropriate for the lead state to involve other domestic states in order to determine if resources for addressing such potential issue can be shared, thus preventing the extraordinary strain on the lead state resources. The targeted group examinations are generally expected to occur on those risks that are either outside the insurance legal entity or risks that are common to all entities within the group. Targeted examinations on changes in governance, risk management and internal controls are the more common areas where such procedures may be expected. Also expected, although not expected to be commonly performed, is targeted examination on particular non-insurance entities within the group. Considering if any targeted examination procedures should be completed is one of the roles of the lead state, and it should consider the guidance in Section V.I. Targeted Examination Procedures and Guidance in making such a determination. Non-lead states should defer to the lead state with regard to whether a targeted group examination is necessary.

Internationally Active Insurance Groups: For IAIGs, in certain circumstances, targeted exam procedures may include the group-wide supervisor joining on-site inspections of an insurance legal entity in another jurisdiction to address specific issues of concern coordinated by the relevant involved supervisor, with prior consent from that supervisor. In addition, it may be appropriate for the group-wide supervisor or other involved supervisors to conduct targeted exam procedures in response to concerns and risks identified during supervisory college discussions and report the results back to the supervisory college. Finally, in addition to targeted exam procedures to address concerns identified through holding company analysis and supervisory colleges, the *Financial Condition Examiners Handbook* outlines additional examination considerations relevant to IAIGs that are more effectively conducted during an on-site examination.

Supervisory Colleges

The NAIC through the state regulators has defined a supervisory college as a regulatory tool that is incorporated into the existing risk-focused surveillance approach when a holding company system contains internationally active legal entities with material levels of activity and is designed to work in conjunction with a regulatory agency's analytical, examination and legal efforts. The supervisory college creates a more unified approach to addressing global financial supervision issues. Effective and efficient regulatory scrutiny of group-wide issues should occur in the context of an organized global approach and involve all significant regulatory parties, including regulatory agencies from countries outside of the U.S., and other state and federal agencies within the states. In rare cases (e.g., certain large health insurance groups), the use of a supervisory college for U.S.-only insurance groups (no insurance business outside the U.S.) may be beneficial to increasing the efficiency and effectiveness of group regulation. This type of supervisory college is referred to as a regional supervisory college.

A supervisory college establishes a routine communication channel with appropriate company personnel and all regulators, which can be beneficial in identifying the appropriate contacts quickly in the event of a crisis.

The above description of supervisory college is largely consistent with the lead state concept that has been used for years by state insurance regulators. In such situations, one jurisdiction takes the lead in terms of being primarily responsible for the coordination and communication between the insurance group and the other states, as well as other potential responsibilities. But ultimately each jurisdiction may have to do what it believes is necessary, and that is in the best interests of the policyholders in its jurisdiction. In addition, the supervisory college acts as a peer review process similar to how the NAICs Financial Analysis € Working Group acts as a peer review process of troubled or potentially troubled insurers or insurance groups. This peer review process has the effect of allowing other jurisdictions to defer some of their authority. To the extent issues arise, the collective group makes them known to all jurisdictions so that the group-wide supervisor and the other jurisdictions can discuss how best to deal with the issues. Alternatively, the collective group can make the jurisdiction aware that more may need to be done. State insurance regulators have been dealing with these types of multi-jurisdictional

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issues for years. Both state insurance regulators and the IAIS are aware that these situations demand mutual cooperation in order to build the relationship and trust needed.

Internationally Active Insurance Group: For IAIGs, the group-wide supervisor establishes a supervisory college, which is expected to meet at least annually. In addition, the members of the IAIG's supervisory college are expected to communicate and exchange relevant information on an ongoing basis, including information on group capital prepared by the group-wide supervisor, as well as a summary of any additional reporting related to group capital that has been reported at the option of the group-wide supervisor. Furthermore, through the supervisory college process, the group-wide supervisor should establish a crisis management group (CMG) for the IAIG, with the objective of enhancing preparedness for, and facilitating the recovery and resolution of, the IAIG. To facilitate this, the group-wide supervisor should put in place a written coordination agreement between the members of the IAIG CMG. The structure, participation in, and role of an IAIG supervisory college or CMG is ultimately the responsibility of the group-wide supervisor.

Guidance for use in conducting supervisory colleges and related activities is included in Section VI.J. Supervisory Colleges are one of the roles of the lead state.

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The following information is intended to provide a narrative description of the issues/considerations for analysts when performing insurance holding company analysis as well as procedures and processes for developing a Group Profile Summary (GPS). As discussed in Section VI.B Roles and Responsibilities of the Lead State/Group-wide Supervisor, the Group-wide Supervisor/Lead State is not intended to eliminate any authority that any jurisdiction has over a legal entity insurer. Rather, group-wide supervision is intended to increase the efficiencies and effectiveness for each insurance group by emphasizing that one state is responsible for completing certain duties that allow all other domestic states to focus their efforts in other areas.

STATES' ROLES IN PERFORMING INSURANCE HOLDING COMPANY ANALYSIS

It is important for analysts to understand the concept that the lead state has certain responsibilities pertaining to insurance holding company analysis and understanding that many of these responsibilities focus on increasing communication and coordination. There are several other coordination activities involved with group-wide supervision, particularly if the result of the group analysis identifies areas that targeted examination procedures are warranted within the insurance operations and as a result involve other states. The following table lists the possible scenarios and actions for lead and domestic states completing an insurance holding company system analysis:

When your state is the lead state and another state has a domestic in the group:	**When your state is sharing duties with a lead state:**	**When your state is the lead state and all insurers within the group are domestics of your state:**	**When there is no group code, but your state's domestic is a multi-state writer and part of a holding company system (i.e., you receive a Form B):**	***When your state domestic has a group code, but your state is NOT the lead state:**
• Complete an insurance holding company analysis that considers procedures similar to those contained within the *Financial Analysis* Handbook Insurance Holding Company Analysis guidance and document results in the GPS. • The insurance holding company analysis chapter represents guidance that the accreditation team will use to evaluate the sufficiency of depth and documentation considerations. • Complete before October 31st.	• Coordinate the completion of holding company analysis and preparing a GPS. • The *Financial Analysis Handbook* Insurance Holding Company analysis chapter represents guidance that the accreditation team will use to evaluate the sufficiency of depth and documentation considerations. • Complete before October 31st.	• Complete an insurance holding company analysis that considers procedures similar to those contained within the *Financial Analysis* Handbook Insurance Holding Company Analysis guidance and document the analysis results in the GPS. • Complete before December 31st.	• Complete an insurance holding company analysis that considers procedures similar to those contained within the *Financial Analysis Handbook* Insurance Holding Company Analysis guidance and document the analysis results in GPS. • Complete before December 31st.	• Offer a copy of the "legal entity IPS" or other applicable information to the lead state to assist in the completion of the insurance holding company analysis. • Obtain and review the GPS from the lead state and update the impact of the holding company on the insurer section of the domestic Insurer Profile Summary (IPS). • If a copy of the analysis has not been received from the lead state by November, contact the lead state and consider completing your evaluation of the impact of the insurance holding company system on the domestic insurer without the benefit of a detailed insurance holding company analysis.

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Special Note: Each state should still review Form B for its domestic companies (See also chapter V.A. Holding Company Procedures (Non-Lead State) and V.F. Holding Company Procedures (Non-Lead State) Analyst Reference Guide for possible Form B and C compliance and assessment procedures and guidance).

RESPONSIBILITIES OF THE LEAD STATE

Insurance Holding Company System Analysis

The lead state or an agreed upon other designated state(s) is responsible for completing the insurance holding company analysis. The domestic state is responsible for completing and documenting an evaluation/analysis of the impact of the insurance holding company system on the domestic insurer. The distinction of these responsibilities is set forth in the following.

The depth and frequency of the insurance holding company analysis will depend on the characteristics (i.e., sophistication, complexity, financial strength) of the insurance holding company system (or parts thereof), availability of information (e.g., SEC Form 10K or Form 10Q) and the existing or potential issues and problems found during review of the insurance holding company filings. Analysts are required to document the results of the insurance holding company system analysis once annually but will update it periodically as needed. The Form B, Form C and any other holding company filings should be analyzed by October 31st for analysis conducted by the lead state. (See also chapter V.A. and V.F. for possible Form B and C compliance and assessment procedures and guidance.)

Documentation and Communication of Insurance Holding Company System Analysis

Documentation in the GPS of the analysis work performed by the lead state (or the domestic state for those groups with only one multi-state insurer or with multi-state insurers domiciled in only one state) should include sufficient evidence of a review of the insurance holding company system. The GPS should be updated and shared with other domestic states within the group prior to October 31 each year. If the GPS includes information from the analyst's summary of the Own Risk and Solvency Assessment (ORSA) analysis, analysts are reminded of the sensitivity of the information in the ORSA Summary Report and that it includes proprietary and trade secret information. Before sharing the GPS with another domestic state or other impacted regulator, the lead state should verify the ability of each regulator to keep the shared information confidential, consistent with state law. Analysts may consider consulting with the state's legal counsel before sharing with another regulator.

The lead state may choose to rely on the analysis work performed by an international insurance supervisor (e.g., work products from a supervisory college) or another functional regulator. If such reliance takes place, the lead state is still responsible for documenting and distributing to other domestic states an analysis of the overall financial condition of the group, significant events, and any material strengths and weaknesses of the holding company group. Additionally, if the lead state has material concerns with respect to the overall financial condition of the holding company group, it is responsible for notifying all other domestic states.

RESPONSIBILITIES OF EACH DOMESTIC STATE

Evaluation of the Impact of Holding Company System

The domestic state is responsible for completing an evaluation of the impact of the insurance holding company system on the domestic insurer. In doing so, the domestic state is responsible for identifying and understanding the affiliated risks within the insurance holding company system. This information and understanding can be

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obtained from several sources, including the supplemental filings (i.e., Form A, Form B, Form D, and Form E). The Form B, Form C and any other holding company filings should be analyzed, to at least some extent, by December 31st for analysis conducted by the domestic state (See also chapter V.A. and V.F. for possible Form B and C compliance and assessment procedures and guidance.) Additionally, the domestic state should obtain a GPS from the lead state containing the risk assessment of the group that is necessary to evaluate the impact that the insurance holding company system could have on the domestic insurer. The domestic state is responsible for summarizing a conclusion regarding this evaluation. This should be included in either the annual or quarterly financial analysis work papers and summarized in the Insurer Profile Summary (IPS) of the respective domestic insurer on a yearly basis.

Communication of Holding Company System Analysis

Communication with the lead state should be documented in order to substantiate the domestic department's understanding of the insurance holding company analysis that was performed and included in the financial analysis work papers of the respective domestic insurer on a yearly basis. Such documentation should include the bulleted items in the section above included in the GPS. If a state relies on the insurance holding company analysis of another regulator, communication of such by the lead state should be completed by October 31.

HOLDING COMPANY SYSTEM ANALYSIS CONSIDERATION AND GUIDANCE

Overview of Insurance Holding Company System Structures

It is important for analysts to gain a thorough understanding of the organizational structure in order to properly analyze how each subsidiary/affiliate in the holding company operates. Organizational structures can vary significantly between insurance holding company systems. Larger holding company systems will often include lower-tier holding companies that manage both non-insurance and insurance subsidiaries independently of the ultimate holding company. Others may be partially held by different individuals and companies or have indirect ownership relationships.

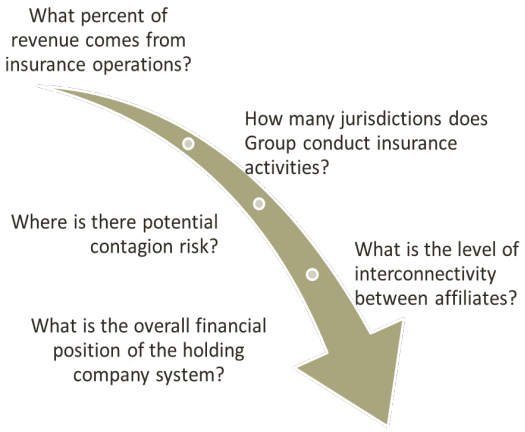
An insurance holding company system may consist of one company that directly or indirectly controls one or more other companies. Control may exist through ownership of the voting shares of a company's common stock or, particularly in the case of a mutual insurer where ownership lies with the policyholders, control may exist or be strengthened through contractual relationships and/or common management. The controlling entity often delegates operational functions to subsidiaries so that it can focus on the management of the overall insurance holding company system. Some insurance holding company structures are established to hold only insurance operations, while others may be more complex and engage in multiple types of businesses. Understanding the insurance holding company system structure and the various types of operations and obligations that the entities within the structure create is critical in performing insurance holding company analysis.

A sophisticated/complex insurance holding company system may include, but not be limited to, the following:

- Insurance and non-insurance operations
- International operations
- Multiple or diverse lines of business

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- Numerous entities or segments



This first step in understanding the insurance holding company structure is obtaining an organizational chart. Organizational charts are included in: 1) initial applications for licensure; 2) holding company registration statements (Form B); and 3) the Annual Financial Statement Schedule Y, which is also required to be updated and reported to regulators quarterly if there any changes from the prior year-end. The first step in understanding the organizational chart is identifying all the insurance subsidiaries and non-insurance affiliates in addition to identifying all the states and other jurisdictions responsible for regulating those subsidiaries.

There can be variations as to how an insurance holding company is classified. The most common types of insurance holding company structures are described below, each of which has different implications for understanding the impact that the structure may have on the financial condition of the group.

Public Holding Company

A public holding company is an entity that controls various other affiliates, including financial intermediaries, such as insurance companies, banking institutions, security firms, etc. The shares in a public holding company are open to investors (thus making them shareholders), which can be purchased via a public securities exchange market, giving such entities greater abilities to access additional capital. Transactions that result from the public holding company are approved by the board of directors. A public holding company may be obligated to pay dividends in order to maintain expectations of their shareholders. No two groups are the same and, only through conversations with management and/or reviewing external historical actions can these things be properly evaluated.

Private Holding Company

A private holding company is a separate legal entity designed to hold either investments or operating assets. The shares in a private holding company are held by or on behalf of the beneficial owners. All transactions regarding the holding company must be approved by or on behalf of the beneficial owners. A private company has some of the same characteristics as a public company in terms of expectations, but usually such expectations differ from a public company. A private company may have some access to capital that mutual insurers do not have, but it also may be just as limited.

Mutual Insurance Company

A mutual insurance company is formed and bound by its policyholders. A mutual insurer does not issue stock and, therefore, does not have stockholders. The initial net worth of a mutual insurer is limited to surplus paid-in by the original policyholders or by a third-party contributor. A mutual insurer can create or acquire subsidiaries, thus becoming the controlling affiliate of an insurance holding company system. It may also create a subsidiary to act as a holding company for downstream affiliates. Although a mutual insurer may be subject to some pressure from its policyholders, such pressure is usually much different from what is experienced by a public company. However, a mutual insurer is limited in terms of its access to capital because it cannot issue new stock. Again, no two groups are alike and understanding these issues usually can only be obtained through conversations with management and/or reviewing historical actions.

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Mutual Holding Company

In most states, a mutual insurer may be permitted to restructure by converting from a mutual to a stock insurer, with a new upstream mutual holding company owning a majority of the voting stock. The mutual policyholders' ownership rights are transferred to the mutual holding company. This structure gives the insurer more options to raise funds, through the issuance of stock. Such a conversion is subject to the approval of the policyholders and the domiciliary state's commissioner. Because mutual holding companies have characteristics of both public companies and mutual companies, there are implications of how such a structure affects its operations.

Non-profit Health Company

The term non-profit organization is generally most associated with the treatment of organizations under the Internal Revenue Code. The Internal Revenue Service (IRS) generally associates not for profits with charitable organizations, churches and religious organizations, political organizations and private foundations. Insurers that are non-profits are generally charitable organizations and it is not uncommon that some types of insurers, particularly those that provide health insurance, to have some history as a non-profit. It may be helpful to understand these types of dynamics when considering a particular insurance holding company structure.

Fraternal Associations

State insurance departments have authority over fraternal benefit society insurers, and although each state may define them slightly differently, such definitions usually provide that they are a corporation, society, order, supreme lodge or voluntary association, without capital stock, conducted solely for the benefit of its members and their beneficiaries. Because of this structure, regulators often find similarities between a fraternal benefit society and a mutual insurer because both can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the insurance holding company system, there is generally much more that must be understood before coming to this conclusion because in some cases, the fraternal may be able to assess its members or take other actions that can serve a similar purpose as raising capital.

Reciprocal Exchanges

State insurance departments have authority over reciprocal insurance exchanges and although each state may define them slightly differently, such definitions are generally centered on the notion of a group of persons who agree to share each other's insurance losses. The IRS provides that a reciprocal is an organization or group of subscribers, including individuals, partnerships and corporations, who may insure each other by "exchanging" insurance contracts through their commonly appointed attorney-in-fact. All such insurance contracts are executed on behalf of all the subscribers by their designated attorney-in-fact. Because of this structure, regulators often find similarities between reciprocal exchanges and fraternal benefit societies and mutual insurers because they can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the insurance holding company system, there is generally much more that must be understood before coming to this conclusion because in some cases, the reciprocal may be able to assess policies that can serve a similar purpose as raising capital.

Sources of Insurance Holding Company Information

Statutorily Required Filings: The most readily available source for gaining an understanding of an insurance holding company structure is through the statutory filings submitted by insurers. Analysts may use the statutory filings to gain an understanding of: 1) the entities included in the insurance holding company system; 2) where revenue comes from; 3) how many jurisdictions the insurance holding company system writes in along with the percentage of U.S. versus foreign revenues; and 4) contagion risks. Insurers are required to submit an organizational chart and details of affiliated transactions in Schedule Y—Part 1, Part 1A, and Part 2. Part 1A includes the relationships within the insurance holding company system to the ultimate controlling person(s) or entity. This schedule provides valuable insight into the ownership structure, insurance holdings, locale and

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affiliated relationships within the insurance holding company system. To understand the different levels of interconnectivity and impact within the insurance holding company system, analysts should review Form D which includes the management service agreements, tax sharing agreements and affiliated reinsurance. Analysts should also review Form B to assess the overall financial condition of the insurance holding company system as Form B includes the holding company's profitability, debt, equity and assets. Review and consider the impact any holding company debt reported by the holding company and whether the insurers fund this debt through upstream dividend payments (See also chapter V.A. and V.F. for possible Form B and C compliance and assessment procedures and guidance).

Form B - Insurance Holding Company System Annual Registration Statement: Form B is filed annually on June 1 and contains information on identity and control of the registrant, organizational structure, ultimate controlling person(s), biographical information on directors and officers, transactions, relationships and agreements, litigation, statement regarding plans or service transactions, and financial statements and exhibits.

Note #10: Under guidance from *Statement of Statutory Accounting Principles (SSAP) No. 25 - Affiliates and Other Related Parties*, insurers are also required to provide detailed information on related party transactions and relationships in Note #10. Refer to Section IV.B. Analysis of Notes to Financials for more information.

MD&A and Audited Financial Statement: These filings also contain information on the insurance holding company structure. These reports are filed with the NAIC by April 1 and June 1, respectively, of the year following the annual reporting period. Specifically, the MD&A provides background information on organizational structure, product lines, marketing systems, and actions such as corporate restructuring, acquisitions, and dispositions. It is a narrative that provides information to regulators that enhances understanding of the insurer's financial position, results of operations, changes in capital and surplus, and cash flows. The report often explains transactions or events that have occurred during the year that affect the financial condition of the insurer. It may also contain information about affiliated relationships or changes in those relationships.

Audited Financial Statement: This statement provides an overview of the background, operations, affiliated transactions, mergers and subsidiary holdings regarding a holding company. Several of the footnotes (Related Party Information, Reinsurance and Other Insurance Transactions, Reorganization, Acquisitions and Dispositions, and Summary of Ownership Relationships of Significant Affiliated Companies) also provide valuable insight into organizational structure and affiliated transactions. These footnotes provide disclosures on such issues as affiliated transactions, agreements, guarantees, reinsurance transactions, capital contributions, and organizational structure, which allow analysts to gain an understanding of how the different entities within the holding company operate together.

SEC Filings: Disclosures on non-insurance entities found within the holding company may be limited. For publicly traded companies, analysts can reference reports filed with the U.S. Securities and Exchange Commission (SEC) to gain insight on the insurance holding company structure. The SEC filings provide significant background information about the holding company and its subsidiaries. Form 10-K is used to report the entities' annual financial data. An example of sections within the Form 10-K that may provide valuable background information includes:

- Business**:** This section includes a general discussion of the entity's business, financial information, and industry segments. The industry segment section allows analysts to assess the organization by its major operating business segments.
- Directors and Executive Officers: This section helps analysts identify key officers, owners, and family relationships.
- Security Ownership of Certain Beneficial Owners and Management: This section identifies certain beneficial owners of the filer's securities and possible subsequent changes in control.

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- Certain Relationships and Related Transactions: This section discusses affiliated transactions and business relationships.

Form 10-Q is used to report quarterly financial data and is much more limited in scope than Form 10-K, but it does require condensed financials as well as some background information. Form 8-K is required after certain significant changes in business occur, including change in control, bankruptcy or receivership, and resignation of directors.

Combined Statutory Financial Statements: These statements are required for property/casualty insurers only. These statements have been adjusted for intercompany transactions and affiliated investments.

Shareholders' Reports: These are generally available on a holding company's website. The scope of the shareholder's report may vary between companies but is generally reported on a consolidated generally accepted accounting principles (GAAP) basis and may contain segment information. An insurance holding company system's Web page may contain additional information such as current stock price information, company history, descriptions of products or business segments, and recent press releases. The insurer's website can be obtained from the Jurat page of the insurer's annual and quarterly statutory financial statements. Links to company websites can also be obtained from the rating agency websites, as well as other financial websites or through tools such as Bloomberg Financial.

Rating Agency Reports: Credit rating providers, each with their own unique methodology for assigning ratings, often provide financial data and/or analysis of an insurer or insurance group. This information is available through purchase or subscription. Some of the organizations include: A.M. Best; Fitch Ratings; Moody's Investor's Service; Standard and Poor's (S&P); Dominion Bond Rating Service; RealPoint, LLC (for CMBS only); Kroll Bond Rating Agency (KBRA); and TheStreet.com Ratings.

NAIC database and iSite+ Reports: These iSite+ applications provide information primarily on the insurance companies, rather than the insurance holding company system, with the exception of the property and casualty combined annual financial statement. However, other information or resources on iSite+ may be helpful when reviewing collectively the insurance companies within an insurance holding company system. In addition to the financial statement and financial analysis solvency tools, other reports exist such as summary reports, the Lead State Summary Report and market analysis information. Line reports may be useful in collecting selected lines of data from the financial statements for all insurers within an insurance holding company system.

Internet/Websites: The Internet offers a variety of websites that contain information on the financial background of publicly traded companies. Some financial websites provide a comparison of the company's own financial results to that of their closest competitors and to industry averages. Some of these sites may provide information such as the buying and selling activities of company stock by senior level employees of the company. Additionally, links to news articles concerning the company and the industry are available.

Other Information Sources: These may include prior analysis performed on the insurance holding company system, financial and market examination reports, target examinations or special studies, discussions and other communications with other lead states or foreign regulators, and discussions with company management. The last point to make is that discussions with company management should not be minimized. This may be necessary particularly in those insurance holding company systems where the structure is more complicated, and more difficult to understand. The group should be willing to explain its structure and the purpose of such a structure to its regulators, including more in-depth discussions with the lead state or group wide supervisor. If the lead state or other regulators believe the structure is opaque, or difficult to understand, it should raise the issue with management. In rare cases, the lead state and/or other regulators may want to suggest that management consider some changes to either eliminate such confusion or determine if some additional disclosure could be made to in the public financial statements to reduce such confusion. The domestic regulator may initiate discussions to suggest dissolving, merging, de-stacking or other such transactions with legal entities within the insurance holding company system to facilitate corporate efficiencies and minimize complicated structuring.

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International Data Sources: When an insurance holding company system is domiciled in a foreign country, it is necessary to determine the supervisory authority in that country and the filing requirements. Some countries have an agency that functions similar to the SEC, and financial statements may be available through that agency. For example, The System for Electronic Document Analysis and Retrieval is the official site for the filing of documents by public companies as required by securities laws in Canada. This website can provide the annual report for publicly traded insurance companies domiciled in Canada. When information is not readily available through a government source, the company's shareholder's report or other information may be available on the company's website or through regulator request.

For foreign holding companies, certain sources of information may require conversion of financial data to U.S. currency. Conversion rates can be found on a variety of different Internet websites.

Recent News and Rating Information

Analysts should research recent news relevant to the insurance holding company system. Press releases and publications may provide valuable insight about important events and management decisions. These items may include significant transaction activity, changes in the company's stock price, legal or regulatory issues, employee layoffs, losses of key personnel, and issues with customers or providers.

Review current financial strength and debt ratings of the group. Rating agencies often issue separate ratings and analyses on the credit and claims-paying ability of insurers or the holding company. Reports of rating agencies provide a quick overview of a company. Such reports should be scanned for background information about the company's operations, management, and significant changes. If a report of the entire insurance group is available, it may be useful as an early step in understanding the relationships of each entity within the insurance group.

Rating agencies focus on liquidity available at the holding company, so much of a subsidiary's cash may be pushed up to the holding company through dividends, management fees, or other intercompany arrangements to gain a better rating. A rating downgrade may have a material effect on the ability of the company to sell its products (particularly in the commercial property/casualty and annuity lines of business), to obtain reinsurance, or to compete in the marketplace in general. Events such as these may place a greater strain on the insurance companies, which may already be coping with various financial issues such as high debt servicing requirements.

Stock Price Evaluation/Debt Prices/Credit Default Swaps

If the stock of the intermediate or ultimate holding company is publicly traded, monitor the stock price and volume. Compare the trends of price and volume of the holding company with peer organizations. Analysts should strive to determine the factors affecting stock prices, which extend well beyond the financial status of the insurer. The use of professional securities analyst reports may provide additional insight regarding the fluctuation of stock prices. In some cases, the intermediate or ultimate holding company debt may also be publicly traded, in which case similar to stocks; analysts should monitor the price and volume. Analysts should strive to determine the factors impacting the change in bond prices. Finally, some intermediate or ultimate holding companies may have credit default swaps issued on them. These should also be monitored where they exist. The NAIC Capital Markets Bureau monitors such information and summarizes the changes in the weekly reports available to state insurance regulators.

International Holding Company Considerations

Many insurance companies domiciled in the U.S. are owned by holding companies that are located in foreign countries. Depending on the country of domicile, for some, financial information is not readily available through a government-sponsored source similar to the SEC. Analysts may find that the investor's page of publicly held international holding companies' websites will provide the best source of financial information.

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The regulation of international holding companies varies according to the laws of its country of origin. For most European Union organizations, accounting treatment and reporting is somewhat consistent and is improving due to the efforts of many groups working with the standards developed by the International Accounting Standards Board (IASB). However, for many organizations domiciled in offshore countries, such as Ireland, those located in the Caribbean, and others, the regulation around public financial reporting may be less robust.

Analysts should understand the contact structure of the organization. For example, a German-based holding company may have advisory boards established to communicate with U.S. regulators. Analysts should direct any regulatory concerns to the proper organization contact to ensure a prompt reply or resolution.

Many transactions between a foreign holding company and U.S. companies, including the holding company's U.S. subsidiaries, are governed by special requirements. Transactions such as reinsurance, servicing, investment, the handling of pooling taxes, etc., are controlled by requirements that are in many cases quite different from similar transactions between two domestic entities.

Foreign holding companies invest in their U.S. subsidiaries to nurture profitable operations, to complement existing operations or to add to existing capacity. Some foreign holding companies may consider their U.S. enterprises non-core and consequently show weaker commitment to their ongoing business operations or financial support. In recent years, after sustaining continued losses from U.S. subsidiaries, several prominent foreign holding companies decided to cease their U.S. operations and liquidate their assets.

Analysts should be aware of a holding company's stated commitment to ensure the continued stability of U.S. operations. This commitment may include a written or verbal parental guarantee.

Some points to consider when assessing a holding company's commitment regarding continued U.S. operations include:

- The importance of the U.S. operations in the insurance holding company structure
- The holding company's historical involvement in supporting its subsidiaries
- Parental guarantees or commitments of financial support, or failures to act on these commitments

FORMS A, B, D, E, AND EXTRAORDINARY DIVIDEND/DISTRIBUTION

Forms A, D, E and Extraordinary Dividend/Distribution are transaction-specific and are not part of the regular annual/quarterly analysis process. The review of these transactions may vary as some states may have regulations that differ from the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). See section V. procedures for holding company considerations for domestic and non-lead states.

LIQUIDITY STRESS TEST

In 2021 the NAIC Executive (EX) Committee and Plenary adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) that introduced a new filing requirement for a Liquidity Stress Test (LST). While insurer and insurer groups within the scope of the LST will submit required filings in 2021 under states' examination authority, states are beginning the process of adopting Model #440 amendments into state laws. Additional lead state and non-lead state guidance will be developed in future years as regulators gain experience reviewing the LST filing.

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Scope Criteria and LST Framework

- The Scope Criteria for insurers or insurance groups required to perform and file the LST and the instructions for the filings are outlined in the *NAIC 2020 Liquidity Stress Test Framework* which is located on the Financial Stability (E) Task Force web page of the NAIC's at: https://content.naic.org/cmte_e_financial_stability_tf.htm. Once an insurance group with two or more life insurers triggers the Scope Criteria for a specific year, then the LST is performed at the legal entity insurer level within the group. Results are aggregated at the group level.
- Property/Casualty (P/C) and Health: Although the P/C and health insurers are not subject to the Scope Criteria in 2021, if a P/C or health legal entity insurer is deemed, by the insurer group, to pose material liquidity risk to a U.S. group that triggered the Scope Criteria in a future year, then the P/C and health legal entity insurer within the group will perform the LST.

Regulatory Goals of the LST per the NAIC 2020 Liquidity Stress Test Framework

The primary goal of the LST, and the specific stress scenarios utilized, are:

- First, for macroprudential uses, the goal is – to allow the Financial Stability (E) Task Force to identify amounts of asset sales by insurers that could impact the markets under stressed environments. Thus, the selected stress scenarios are consciously focused on industry-wide stresses – those that can impact many insurers within a similar timeframe.
- Second, the LST is also meant to assist regulators in their micro prudential supervision, in the context of being helpful for domiciliary and lead state regulators to better understand LST programs at those legal entities' insurers and insurance groups. The LST requires filing of reporting templates and other narrative disclosures referenced in the LST Framework to be submitted to the lead state by Sept. 30.

Non-Lead State Reliance on the Lead State Analysis of LST

- The LST must be reviewed by the lead state and significant findings should be incorporated into the GPS branded risk assessments.
- To reduce duplication, non-lead domestic states may rely on the analysis work performed by the lead state.
- Because the LST is performed at a legal entity insurer level and aggregated on an insurance group level, if material risks and concerns are identified for a legal entity insurer, the lead state should communicate those concerns to the non-lead domestic state.
- While the LST filing may provide good insights into a legal entity insurer's assumptions, processes and worst-case stress scenario results; a domestic state's assessment of liquidity risk for the legal entity insurer should not rely solely on the LST. It is acceptable that a legal entity insurer may have its own LST scenarios and manage liquidity differently from what is reported for the LST.

LEAD STATE HOLDING COMPANY ANALYSIS – PROCESS AND PROCEDURES

In completing the process of holding company analysis and developing a GPS, analysts are encouraged to customize the work performed and documented at a level commensurate with the nature and complexity of the group. Analysts may elect to limit the amount of analysis and supporting documentation performed outside of the GPS and/or eliminate certain sections of the GPS to promote efficiencies in conducting analysis work. Conversely, analysts working on very complex groups may elect to perform additional analysis (including those listed in the Additional Procedures on Key Risk Areas – Insurance Holding Company System) as well as provide additional documentation within the GPS and/or in supporting analysis workpapers. Keep in mind, the GPS should provide sufficient information about the group and its risks to enable other state, federal and international regulators to understand the group risks that may be relevant to their regulated legal entities.

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If the domestic insurers in a holding company system consist of only run-off companies, the domestic regulator, at its discretion, should determine the value, if any of performing a holding company system analysis. If it is determined that a holding company system analysis would be of no added value, this determination should be documented.

As the lead state, the department should coordinate the ongoing surveillance of companies within the group with input from other affected states (with the understanding that the domestic state has the ultimate authority over the regulation of the domestic insurer under its jurisdiction). The documentation contained in the GPS is considered to be part of the workpapers, and represents proprietary, confidential information that is not intended to be distributed to individuals other than state regulators.

Confidentiality of Information: Financial analysts are reminded that information collected from the group, generally under the authority of their holding company statutes or their more specific statutes dealing with the ORSA Summary Report may be confidential by law. Accordingly, before sharing statutorily confidential information with other jurisdictions, regulators will need to review their own statutory authority to do so, which generally requires that the receiving jurisdiction is able to maintain also the confidentiality of such information.

UCP is an Insurer: If the ultimate controlling person (UCP) of the holding company is a U.S. domiciled insurance company with a cocode, analysts may consider preparing one document that includes all the elements of the IPS and the GPS, in order to promote efficiency in the overall analysis. For example, in addition to the standard elements of the IPS, the document may also include sections such as corporate governance, ERM/ORSA, non-insurance affiliates/subsidiaries, etc. In addition, depending on the nature and extent of risks, analysts should consider whether it is more appropriate to assess and document certain risk exposures from a group or legal entity perspective (or both) in the IPS/GPS. In all cases, analysts are expected to document and complete both the legal entity and holding company analysis work in accordance with timeliness expectations. Therefore, the analyst and supervisor should demonstrate that the combined IPS/GPS is updated for both the results of legal entity analysis and holding company analysis through separate signoffs at different dates, as necessary.

SPECIFIC PROCEDURES FOR COMPLETING THE INSURANCE HOLDING COMPANY ANALYSIS

The following procedures are intended to assist analysts completing a holding company analysis documented in the GPS. The following procedures do not represent additional documentation requirements.

Understand the Insurance Holding Company System

1. Evaluate and document an understanding of the insurance holding company system. Consider using the following if available and/or applicable: statutory Schedule Y, Form B Registration Statement, Enterprise Risk Report (Form F), Corporate Governance Annual Disclosure (CGAD), ORSA Summary Report, and financial filings of the insurance holding company system and/or person. Summarize the understanding of the holding company in the GPS. If necessary, analysts may also document further details below.
    a. Ultimate controlling entity(ies) or person(s).
    b. Nature and level of complexity of structure (e.g., public, non-public, mutual, complex, simple, etc.) including the level of interdependence within the group structure (e.g., pooling, guarantees, risk structure, etc.).
    c. Business segments and percent of overall revenue per segment (use segments as defined in the most current 10-K or financial statement, if available), including how the group sells and distributes its primary products and whether they expose the group to risk concentrations (geographic or product related).

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d. Number of insurers and respective jurisdictions, including the level of international insurance activities (including branches) within the group. Where are the largest concentrations of international business and which regulatory authorities are charged with oversight?

e. The existence of captive insurance vehicles within the insurance holding company system as well as their specific purpose and domicile. What type of financial reporting is available/provided to the state of domicile for the entities? What risks do these captives pose to the insurance holding company system?

f. Nature and function of material non-insurance legal entities that pose a material risk to the insurance holding company system. Are there material risks presented by these non-insurance entities? (Note: It is recommended that the insurer supply information via the non-insurance company grid provided [Excel] to assist with this determination. See also procedure 2 to be completed in conjunction with Procedure 1, to determine how to tailor this grid to the risks of the group and therefore the focus of the remaining analysis)

g. Recent news, press releases or other information received from the group that identify changes in the holding company system or financial results.

h. Obtain and review information to consider whether high-level management of the insurance holding company system is suitable for the respective positions held (e.g., does the individual have the appropriate background and experience to perform the duties expected of him/her?). Any suitability and other governance-related concerns identified should be communicated in writing to other relevant regulators both domestically and internationally. Follow-up on any previously-identified corporate governance issues of the insurance holding company system.

PROCEDURES #1 - 2 are intended to be completed simultaneously, as each is anticipated to be informative to the other. In many cases, information obtained from prior years may not have changed**.** That prior information can also be helpful in determining the extent of information regarding individual companies (non-insurance and insurance) that needs to be collected from the group in accordance with Procedure #1f and Procedure #2. Analysts should use such prior analysis and prior knowledge, as well as updated financial and nonfinancial information on the group, or members of the group, to help determine what information update is requested from the group and its affiliates. The information requested is intended to be focused on the primary risks of the group, and changes in the group or economic environment which require additional information to evaluate. For example, a lead state that has previously identified possible concerns with the overall profitability of the group will commonly track measures of profits against some measure, and individual company by company information would be used by the lead state to monitor and better understand and continue to evaluate that risk. Another example may be a group for which the lead state has seen a substantial increase in business written without a corresponding increase in group capital. The lead state should use information from other filings (e.g., ORSA Summary Report and/or Form F) in understanding the business change, but may require further detail on the specific products and legal entities for which the business is written to fully understand and evaluate the change in risk. The exclusion or inclusion of entities from the focus of the group-supervision should be re-assessed annually.

PROCEDURE #1 assists analysts in documenting his or her understanding of the insurance holding company system. Various documents are available as a resource in helping to understand the insurance holding company system and its business purpose, but it is also anticipated that much of this information will be accumulated and updated by analysts through inquiries to the group.

As part of this review, analysts should also consider on a regular basis whether high-level management of the insurance holding company system is suitable for the respective positions held. Suitability includes considering whether the individual has the appropriate background and experience to perform the duties expected of his/her position. Any suitability and other governance-related concerns identified should be communicated to other relevant state insurance departments (and also possibly with international regulators). Analysts should

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also follow-up on any previously identified corporate governance issues of the insurance holding company system.

Complete Lead State Analysis Considerations

After gaining an understanding of the holding company system, complete the following considerations to assist in determining the detailed analysis procedures to be performed.

2. Based upon the information obtained in Procedure 1, and in combination of prior year analysis or prior knowledge of the group, determine the focus of this year's annual holding company analysis. Specifically consider the information obtained regarding both insurance and non-insurance entities and their impact on the entire group. Additionally, include a summary within this analysis that discusses the focus areas and why.
3. Using the Lead State Report on iSite+, identify the primary contact of other involved domestic states. Based on the analysis of the overall holding company structure and the state's preference, analysts may consider whether there is a need to request the confidential IPS report(s) from the applicable U.S. domestic states for insurers within the holding company system, pursuant to the NAIC's Insurer Profile Summary Sharing Best Practices. (E.g., A state may consider using the NAIC Prioritization Summary Report to assess the need to request such reports.) If the IPSs are requested, identify and document any material concerns or risks that were not covered elsewhere in this analysis.
4. Identify and document any other regulated entities within the holding company system and the respective involved supervisor. (Note: Consider using Annual Financial Statement, General Interrogatories – Part 1, #8.1 through #8.4). Consider the following:
    a. Does the size, complexity and/or interconnectivity of the entity with the holding company system warrant communication with the respective regulator/supervisor? If "yes," describe any communication between state, federal and international regulators that has been planned or initiated.
    b. If there is international insurance activity, document which jurisdiction(s) is considered the group-wide supervisor(s) of the insurance holding company system.
    c. Does the size, complexity and/or interconnectivity of the entity with the holding company system warrant a potential supervisory college? If "yes," describe any communication between state, federal and international regulators that has been planned or initiated.
    d. Does the department and/or other domestic state(s) within the group have a MoU to share confidential information with the involved supervisor(s)?
    e. Have any state, federal and/or international regulatory action(s) been taken? If "yes," describe.
    f. Determine and document whether it is necessary to develop an overall understanding of the relevant regulatory and supervisory requirements of the authority and document accordingly.
5. If applicable, identify and document contact information for federal or international involved supervisor(s).
6. Establish a plan for communicating and coordinating with the domestic state(s) and other involved supervisors if significant events, material concerns, adverse financial condition or prospective risks are identified.
7. If your state is leading or participating in a supervisory college of the holding company system, review the most recent information obtained as part of the supervisory college to determine if there are any areas of risk that require follow-up or additional analysis.

PROCEDURE #2 assists analysts in determining the focus of this year's annual holding company analysis. A practical method of determining the entities to focus on may begin with some type of internal unaudited

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consolidating financial statements prepared by the group, if applicable although other more simple methods could be used once the lead state had a better recognition of the size and risks of the individual legal entities. Alternatively, if internal unaudited consolidating financial statements are not prepared by the group, analysts may be able to obtain some information from the ORSA Summary Report. However, in many cases, that report will not contain legal entity information, therefore analysts may instead choose to request the insurer supply information via the non-insurance company grid provided. Analysts should also consider if there are other entities that pose a risk to the group, and for which the lead state analyst can only obtain qualitative information from the group in better evaluating such risks (such entities and these situations are presumed to be rare but can occur under some unique situations). The purpose of this step is to consider if there are any individual legal entities that can be excluded from the scope of group-wide supervision, because individual legal entities that are negligible to the group should be excluded. This procedure also assists analysts in putting together the Holding Company System Summary section of the GPS to indicate which entities have been subject to review and to be used as a starting point in ensuring there are no gaps or duplication in regulatory oversight between all of the states. Such process would conclude when the GPS is distributed and reviewed by the other domestic states and the lead state receives no feedback which would suggest otherwise. Although duplication is expected to be rare, obtaining input from other domestic states regarding the focus of the analysis is considered appropriate because the group can have an impact on each of the domestic insurance entities.

PROCEDURES #3 - 7 assist analysts with regulator/supervisor communication and coordination and supervisory college considerations. See Section VI.J. Supervisory Colleges Guidance for a more detailed discussion of supervisory colleges utilized for internationally active insurance groups.

Conduct Detailed Analysis of the Insurance Holding Company System

Conduct detailed analysis by evaluating the overall financial condition of the holding company system through an assessment of the group's exposure to each of the nine branded risk classifications. Consider both the financial review of insurance and non-insurance entities within the insurance holding company system. In certain cases, the review of non-insurance entities may be mitigated by the lack of interdependence of the entities. Conduct the assessment by using quantitative and qualitative information. Consider utilizing the following, if available and/or applicable: legal entity IPSs; Form B and Form F; ORSA; shareholders' report; combined financial statements; quarterly and annual SEC filings; International Financial Reporting Standards (IFRS) filings; personal net worth statements; audited financial statements; management's assessment of internal controls; auditor's assessment of management's assessment of internal controls; press releases; confidential information from other regulatory/supervisory bodies; and any other available sources.

The following are key areas of review of financial solvency. Below each are examples of the branded risks that may be identified through the analyst's review. The examples of related risks shown below do not represent a complete list; therefore, analysts should use professional judgment in categorizing issues identified during analysis into the risk categories. Summarize the overall analysis of the holding company in the branded risk assessment section of the GPS. If necessary, analysts may also document further details below.

8. Profitability: Evaluate the insurance holding company system's operating and net income over the past three years, as well as return on equity (ROE) and document any trends as well as the primary drivers of those trends.

    - Pricing and Underwriting Risk—e.g., volume/growth; new product lines; geographic concentrations; pricing policies; price adequacy as identified through quantitative metrics; segment information identifying profitable vs. non-profitable product lines; impact of insurance vs. non-insurance operations on the profitability of the insurer: etc.

    - Reserving Risk—e.g., reserve development & trends; reserve adjustments; crediting rates; shifts in exposures to product lines: etc.

- Market Risk—e.g., impact of market changes on investment income/yields; impact of/exposure to interest rate changes; impact of/exposure to changes in foreign exchange rates: etc.
- Strategic Risk—e.g., planned growth/decline in writings; management expertise; variance to business plans and ability for group to adequately project future profitability; investment strategy and the adherence to it: etc.
- Operational Risk—e.g., risk of events impacting the overall financial results, such as catastrophe events impacting P/C lines of business, issues with IT systems, cyber-security risks; degree of variability in profitability; high expense structures; TPA/MGA relationships; risks associated with distribution/sales channels; risks associated with unprofitable segments or lines of business: etc.

9. Financial Position**:** Evaluate the insurance holding company system's shareholder's equity (or equivalent), and document any negative deterioration.
   a. If publicly traded, review the holding company's stock price history. Has the value of common stock declined significantly over the past year? If "yes," explain the reasons for the negative trend.
   b. Assess the holding company's sources of capital.
      - Reputational Risk—e.g., sharp fluctuations and/or drops in stock prices or changes in financial strength and credit ratings that may impact market perceptions, sales growth and access to capital markets, etc.
      - Credit Risk—e.g., concentrations in investments; materiality of high risk or low quality investments; credit risks concentrated within certain segments of the group that impact the overall group financial position, etc.
      - Market Risk—e.g., stress test results, concentrations in certain investment market segments, changes in asset valuation due to market shifts, etc.
      - Operational Risk—e.g., impact of overall financial results; have sufficient profits been generated to meet business model needs and to generate capital, etc.
      - Strategic Risk—e.g., capital position; capital plans as may be outlined in ORSA or ERM planning; impact of changes in corporate structure, etc.
      - Legal Risk - e.g., litigation resulting in material contingent liabilities, etc.

10. Leverage: Review the insurance holding company system's leverage positions and document any negative trends and/or deteriorating ranges. In addition to traditional measures of financing leverage (debt to equity, interest coverage, etc.) and operating leverage (e.g., writings to surplus, surplus aid from reinsurance, etc.), evaluate the group's use of derivatives and their purpose including collateral held/required, trends, etc.
    - Market Risk – e.g., use of derivatives to mitigate economic conditions, generate profit, etc.
    - Credit Risk—e.g., asset leverage risk in the insurance vs. non-insurance investment portfolios, extensive use of reinsurance, etc.
    - Reserving Risk—e.g., level of operating leverage created by premium growth, etc.
    - Strategic Risk—e.g., effectiveness of risk mitigation strategies as may be outlined in ORSA, ERM filings or business plans; risks posed by the use of captive insurance vehicles, etc. Financing leverage as indicated through measurements such as interest coverage ratio and debt-to-equity ratio; amount/type/trend in debt issuance and ability to meet payment schedules, etc.
    - Reputational Risk—e.g., impact of reputational risk changes, such as ratings, on debt covenants, sales, etc.

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11. Liquidity: Evaluate the insurance holding company's liquidity and document any negative trends and overall strength.

    Liquidity risk—e.g., assessment of cash flow trends; cash and short-term investments held; indications of liquidity shortfalls reflected in quantitative ratios (i.e. liquidity ratio); liquidity needs for high surrender activity impacted by economic changes; liquidity needs created by catastrophic events; liquidity requirements for future debt payments; available lines of credit; and stress testing.

12. Liquidity Stress Test (LST):

    a. If the insurance group is subject to the requirements to perform and file an LST, review and determine if any concerns or material risks exist regarding the liquidity of the insurance group or any of its insurance legal entities performing the LST.

    b. If concerns or material risks are identified, consider requesting further explanation from the insurance group about its liquidity risk management framework and internal LST.

13. If applicable, review the insurance holding company system's independent public audit report. Comment on the following:

    - Auditor's Opinion
    - Notes to Financial Statements
    - Management's Assessment of Internal Controls
    - Auditor's Assessment of Management's Assessment of Internal Controls

14. Document in this analysis any concerns that arose during the lead state's evaluation of its domestic insurer(s) that in the opinion of the lead state have an impact on the evaluation of the overall financial condition of the insurance holding company system.

15. During the holding company analysis process, identify and document any material concerns or conditions within the group that may have a material impact on the lead state's domestic companies. Update the IPS of the state's domestic insurer(s) in the group for the impact of the Holding Company on that insurer(s).

PROCEDURES #8 - 14 assists analysts in determining and understanding the overall financial condition of the insurance holding company system which includes understanding profitability, financial position, leverage, liquidity and the organization's use of derivatives (if applicable). These procedures, and any additional/supplemental procedures that are chosen from the list below, are generally the most critical aspect of the insurance holding company analysis and contribute significantly to the identification and assessment of branded risk exposures as presented in the GPS. The following summarizes some approaches/issues for analysts to consider when completing these procedures. In most cases, analysts will require further information from the group in order to complete his or her evaluation of these key areas. Such information is necessary in part because no two groups are the same, and no two groups manage themselves in the same way. For example, in the area of profitability, it may be necessary to request more detail information at a particular legal entity or even product level to determine the cause of the changing trend and its impact on branded risk assessments. Another example is that the group may appear to have a greater than average amount of operating leverage and it may be necessary to gather more legal entity information to understand the source of this leverage. Although this may be discussed in the ORSA Summary Report, in many cases it may not. This approach of requesting further information to further isolate the causes of the profitability, leverage and liquidity trends is consistent with general techniques used in financial analysis. This use of general financial analysis techniques is the primary reason the states approach to group reporting requires only limited information. Consequently, much of the information that should be requested is centered more on the way the group manages itself and its risks.

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PROCEDURE #8 assists analysts in evaluating the profitability of the group and the impact of profitability issues on the group's exposure to branded risks. The first step in making such an evaluation would typically begin with analyzing the group's experience over a sufficient period of time so as to draw some conclusions. Although no two groups are the same, a good starting point for evaluating profitability would be looking at the group's operating and net income, as well as return on equity (ROE) (i.e., net income/stockholders equity) over a five-year period. The use of ROE is a common measure because it considers the perspective that the most common stakeholder, a shareholder, may use. Shareholders, or at least potential investors, commonly use ROE since it provides a measurement of the benefit that the company is generating for the potential use of shareholders. The measurement, although simple, can be effective because investors may make a decision to invest, or continue to invest, based on the value that the group can bring to the investors. Although return on equity does not indicate specifically how much value a group has generated for an investor, it provides a good starting point. It is suggested that it be measured over a five-year period, because such a time period is usually likely to show the results of the group under different economic conditions and therefore stresses, and can help to establish a normal expectation along with an expectation as to variables in the group's business plan.

As discussed in other areas, public company investors have different expectations than private investors, and stakeholders of mutual companies and mutual holding companies have even different expectations. Consequently, analysts should use caution in assuming certain things about the group only because its ROE is higher or lower than some of its peers. It is suggested that the information be used instead as a starting point to better understand the specific group. Analysts should use the information in connection with the latest business plan to better understand how the profits compare to what the group expected, and what its investors expect, on a short-term and long-term basis. The group may use other measures to track their experience (e.g., return on assets, return on revenue) but what is important is to understand how well the group is performing compared to its business plan, and how well that business plan allows them to continue to meet all of the demands of being part of a regulated insurance group. The measurement of profitability should not be minimized because, in virtually every single business sector, it is a major driver of strategic actions. The inability to generate sufficient profits can prevent the ability to generate additional capital. Consequently, although the regulator is primarily concerned about the ability of the insurance company, and therefore the group, to have sufficient capital/equity to absorb certain events or situations, a group that is unable to generate sufficient profits may have no ability to generate any new capital. As history has shown, in most cases, groups with insurance operations do not simply raise additional capital in time of stress, but rather find ways to reduce risk. This must be well understood in evaluating the financial condition of a group, and generally speaking, the starting point is the inability to generate the appropriate amount of profits to meet the business model needs. However, because this is a starting point for analyzing the group, and although most group analysis would be done using consolidated GAAP, that is currently not a requirement and therefore insurers may use different accounting basis that can skew such results. In such situations, analysts should consider asking for input from the group itself on the effect that such an issue has on the analysis and again, consistent with previous comments, ask the group to discuss the measures its stakeholders use to measure profitability.

In addition to measuring, tracking and monitoring profitability, analysts will need to obtain an understanding of what activities drive the profitability (or lack thereof) of the holding company system. As the group may be involved in various business activities across a number of segments, profitability may need to be reviewed and considered at the business segment level. Profitability challenges experienced by the group may indicate, or result from, any one of a number of branded risk exposures (e.g., pricing and underwriting risk, reserving risk, market risk, strategic risk and/or operational risk). Therefore, analysts will need to investigate the cause of profitability challenges to determine the extent of the group's exposure to branded risks in these areas.

PROCEDURE #9 assists analysts in evaluating the overall financial condition of the group and its impact on the group's exposure to branded risks. When performing this procedure, it is necessary for analysts to consider the requirement to obtain and understand the nature and function of all non-insurance entities within the group. This is needed in order to evaluate the potential risk associated with each entity. In connection with obtaining five years of historical profitability figures and obtaining an understanding of the risks of the non-regulated

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entity, analysts may want to consider requesting consolidating information from those groups that either have a higher degree of variability in their profitability over a five-year period or those groups that have non-insurance entities that have higher potential risk. These are factors that can drive the capital that a group may need to operate its business plan in addition to the capital that is needed for the insurance operations itself, which can be determined at a more granular level at an insurance legal entity and then accumulated up to the group level. Alternatively, or in addition, for those entities that prepare an ORSA, the latter can be easily determined through such a report and can be used as a better starting point for discussing the same issues because they are from the perspective of how the group is managing such risk. (See section VI.E. Enterprise Risk Management Process Risks Guidance for discussion of procedures related to ORSA reports). For those entities that do not, the regulator should use the information from Form F, as well as all of the regulated entities required capital levels, in connection with any additional consolidating information to determine if existing equity levels within non-insurance entities are sufficient to address the needs of the group. However, bear in mind that the ORSA is a report of internal management processes and company business plans and strategies involve management judgment and flexible elements. A deeper discussion with management can provide input to understand management's view of the adequacy of the capital for its business and help analysts better make an appropriate assessment in this area.

In addition to evaluating the group's and individual entity's equity/surplus position, analysts may choose to evaluate the group's stock price and recent trading activity (if publicly traded) and access to additional sources of capital. If the group has been exposed to significant shifts in its stock price, this may be indicative of market concerns regarding the group's financial position. In addition, the sources of capital for the group may provide insight to sources of strength that can be accessed in a troubled company situation and provide greater stability for the group. However, if the sources of additional capital are questionable, this may indicate broader concerns regarding the group's strategy and prospective solvency.

Concerns regarding the group's financial position may indicate, or result from, any one of a number of branded risk exposures including, for example, reputational risk, credit risk, market risk, operational risk, strategic risk and/or legal risk. Therefore, analysts will need to investigate the cause of financial condition concerns to determine the extent of the group's exposure to branded risks in these areas.

PROCEDURE #10 assists analysts in evaluating the leverage of the group. There are generally two kinds of leverage: 1) operating leverage; and 2) financing leverage. Procedures related to operating leverage are generally very closely related to those regarding overall capital/equity adequacy/evaluation. This is because by definition, leverage is generally intended to be a relative measure of risk, and for insurers, operating leverage is created every time they generate an insurance policy. As alluded to within Procedure #4, insurance legal entity capital requirements already address such facts. Additionally, insurance legal entity capital requirements already address the other major causes of leverage created from operations, including asset leverage. Asset leverage is created when insurers generate risk within their invested asset portfolios. However, when considering the group's financial condition and leverage, analysts must consider the extent to which these same types of operating leverage are created by non-insurance affiliates within the group. Consistent with Procedure #8, leverage can be measured by reviewing the ORSA Summary Report. For those entities that do not prepare an ORSA, the regulator should use the information from the Form F, in connection with any additional consolidating information to determine if there is other operating leverage within the group. Financing leverage is more easily analyzed when its source is debt, which is generally very transparent and easily analyzed in terms of its impact or potential impact on a group's operations. Most public groups that own insurance operations have some level of debt, although most insurance groups do not carry the same level of debt as other financial institutions. This is important because debt by its very nature can generate a significant amount of strain on any entity. This strain can be captured with another simple ratio that should be considered for analysis on any group with debt, the interest coverage ratio (income/interest expense). Similar to the debt/equity ratio, this ratio should be looked at over a period of time (e.g., five years). The following presents different gauges for evaluating this ratio.

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Interest Coverage	Benchmarks
Extremely strong	10 to 1 and higher
Strong	5 to 1
Adequate	4 to 1
Marginal	3 to 1
Weak	2 to 1
Extremely weak	1 to 1

The interest coverage ratio can either be expressed as a percentage or as a factor over 1. The interest coverage ratio is a major driver of any corporate entity's credit rating, and in many cases, it can be as high as 10 to 1 or 1000%. A ratio this high demonstrates that the interest expense is only a small portion of the group's operations, or a very small strain on the operations. As this number decreases, it suggests that such debt is a strain. It also demonstrates the amount of funds that are not available for stockholder dividends. Therefore, it can also indicate a potential concern for investors, and as a result, the ability to raise additional capital, or at a minimum be subject to more pressure from shareholders. More pressure to generate higher profits often times forces a group to take higher risks, and thus creates more leverage.

Another measure of debt is the debt-to-equity ratio (debt/equity). There are different ways to measure this ratio, and usually short-term operating debt is excluded because the intent of the ratio is to demonstrate the overall capital position of the group. As the ratio increases, it creates a greater possibility that shareholders would be left with less value in a bankruptcy because stockholders' claims are subordinate to bondholders. Therefore, similar to other ratios, it is an indicator that it may be difficult for the group to obtain more capital because investors may not be attracted to such groups.

Asset leverage may be demonstrated through the group's use of derivatives or other complex invested assets. Analysts should work with the group to gain a full understanding of the group's purpose for using these instruments, as they may be subject to significant shifts that can impact the profitability, financial position and/or liquidity of the group. Derivatives may be held by the company to hedge against existing business risks or to generate income for the group. The purpose of the group's use of derivatives as well as their effectiveness over an extended period of time should be evaluated and considered. In addition, analysts should consider the impact that any collateral requirements associated with these instruments may have on the group's financial position and liquidity.

Concerns regarding the group's leverage position may indicate, or result from, any one of a number of branded risk exposures including, for example, market risk, credit risk, reserving risk, strategic risk, operational risk and reputational risk. Therefore, analysts will need to investigate the cause of leverage concerns to determine the extent of the group's exposure to branded risks in these areas.

PROCEDURE #11 assists analysts in evaluating the liquidity of the group. Liquidity is important for any type of organization, but can be more important for others, including certain insurers or types of insurers who may have products or other aspects of their business plan that make them susceptible to immediate withdrawals. Having said that, most insurers' cash flows are predictable, and it is an area that insurance regulation or business practices already address, including asset/liability matching required for life/annuity writers and the maintenance of very liquid assets. But this procedure requires an analysis that can generally only be conducted through understanding information developed by the group, which may be available through the risk-focused examination or otherwise requested by analysts. Updated information may be best obtained in the periodic meeting with the group as discussed within Section VI.F. Own Risk and Solvency Assessment (ORSA) Procedures, unless the group is more susceptible to immediate withdrawals, in which case analysts may want to

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obtain/discuss the issue with the group sooner. Generally, issues impacting liquidity that are identified through holding company analysis should be presented within the liquidity lisk classification of branded risk assessments.

PROCEDURE #12: The procedure instructs the analyst to review the results of the stress test scenarios included in the LST filing to supplement the assessment of the insurance group's overall liquidity. Because the LST is performed at a legal entity level and risks are aggregated for the group, assess if the results of the LST identifies material risks at the insurance legal entity that should be included in the analysis and/or communicated to the non-lead state domestic state insurance regulator.

The instructions for the LST filings are outlined in the *NAIC 2020 Liquidity Stress Test Framework* which is located on the Financial Stability (E) Task Force webpage of the NAIC's website at: *https://content.naic.org/cmte_e_financial_stability_tf.htm*.

PROCEDURE #13 assists analysts with identifying if there are any concerns regarding the insurance holding company system's independent public audit report and other related reports.

PROCEDURE #14 assists analysts in identifying any significant risks identified through a review of the IPS obtained for its domestic insurer(s) in the group. As the IPS presents the exposure of individual legal entities to the branded risk classifications, the lead state analyst may be able to identify exposures in the legal entity IPS to assist in conducting holding company analysis and preparing a GPS.

PROCEDURE #15 is intended for analysts to identify, evaluate and document during the holding company analysis any material concerns or issues that may have a material impact on the lead state's domestic insurer(s). This may include, but not limited to: affiliated risks, interdependence within the holding company entities and the insurer, reputational risk, and holding company debt service and other corporate initiatives that impact the lead state's domestic insurer(s). A summary of the evaluation of the impact of the holding company on the insurer(s) should be included in the appropriate section of the IPS of the insurer(s).

Additional Procedures on Key Risk Areas – Insurance Holding Company System

The following are available procedures that the lead state may consider performing in analyzing the financial condition of the holding company in part or in total to address current or prospective risks at the discretion of analysts, depending on the level of concern, the area in which the risk was identified, and the degree of interdependence within the holding company entities.

Analysts should use his or her judgment in determining if any of the following procedures should be applied to the group analysis, where the primary input for determining what is appropriate would depend on sophistication, complexity and overall financial position of the insurance holding company system. Documentation of the results of holding company analysis is in the GPS. After each additional procedure, examples of the branded risk classification(s) that may be associated with the procedure have been referenced in parentheses for use in mapping the procedures to branded risk classifications in the GPS.

1. Review the distribution of the insurance holding company's invested assets in order to assess the overall asset quality and note any shift in the mix. (CR, MK, LQ, ST)
2. Is the insurer(s) the only member(s) or the primary member(s) of the insurance holding company system that holds cash and invested assets? (CR, MK, LQ, ST)
3. If there are significant investments in non-investment grade bonds, unlisted stocks, mortgages, real estate or other invested assets, review the supporting schedules in greater detail to determine exposure to default, credit, and liquidity risk. (CR, MK, LQ, ST)
4. Review the distribution of the non-invested assets, and assess the overall collectability risk. (CR, LQ)
5. Review the level of goodwill and intangible assets. Determine the level of goodwill and intangible assets relative to the value of equity. (LQ, OP) If significant, summarize the following:
    a. Nature of intangible assets

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b. Change or trend in goodwill

c. Source of goodwill

d. Impairment of goodwill

6. Assess whether the insurance holding company system is reliant on the insurance operations for any of the following (LQ, ST):

a. Service debt

b. Provide financing

c. Provide revenue streams

d. Provide services and/or facilities/equipment

e. Provide guarantees for the benefits of its affiliates

f. Pledge assets for the benefit of its affiliates

g. Contingently liable on behalf of its affiliates

7. Has debt shown an increasing pattern? If “yes,” explain any unusual changes. (ST)

8. Determine the level of insurance holding company debt and its relative value-to-equity. (ST, LQ) If significant, summarize the following:

a. Type of debt

b. Terms of the debt covenants

c. Maturity schedules

d. Interest payment schedules

e. Ability to meet payments (e.g., principal and interest)

f. Business purpose

9. Review the insurance holding company system’s commitments and contingent liabilities.

a. Has the insurance holding company been subject to substantial complaints, class action lawsuits or other litigation or investigations? If "yes”, document the nature and outcome of those matters. (RP, LG)

b. Are any contingencies expected to have a material impact on the financial condition of the insurance holding company? If so, document whether the holding company estimated the potential costs and established a reserve liability. (RV, LG)

10. Gain an understanding of and document the use of collateral across the holding company system. (ST, LQ).

Financial Position

11. Review the insurance holding company’s statement of shareholders’ equity. (ST, OP)

a. Has equity decreased from the prior year or deteriorated over the past three years? If “yes,” describe the reason(s) for the decline.

b. Does the net worth of the insurer(s) represent the total net worth or the majority of the net worth of the insurance holding company system?

c. Is the net worth of the insurance holding company system less than the net worth of the insurer(s)?

12. If publicly traded, review the changes in the insurance holding company’s outstanding common stock. Document and understand the nature and business purpose of the following: new stock issuance; stock repurchase, stock split, short sales, or change in major exchange listings. (ST)

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13. Have any insurer(s) of the insurance holding company paid extraordinary dividends upstream? If "yes":
    a. Assess the nature of the dividends and the amount of dividends paid in relation to prior year surplus to determine the materiality of the insurance company dividends. (OP, ST)
    b. Compare current year extraordinary dividends to prior year dividends to identify any excessive trends in payments. (ST)
14. Review the revenue of the group.
    a. Identify each business segment as identified on the 10K, and review the net income from each. Discuss any notable changes in performance. Are there any business segments that are troubled or pose unusual risks to the insurance holding company system? (PR/UW, ST)
        i. Is the insurer(s) the only or primary revenue producer within the insurance holding company system?
        ii. If affiliates produce net income independently of the insurer(s), what percentage of total net income is produced independently of the insurer(s)?
    b. Has the insurance holding company entered into any new lines of business or types of non-insurance business or discontinued any business? (ST, OP)
    c. Has the volume of business increased or decreased significantly over the prior year? If "yes," explain the reason for the change. (ST, OP)
15. If the insurance holding company group places a significant amount of gross business with reinsurers, assess the following regarding reinsurance agreements:
    a. Risk transfer (CR)
    b. Collateralization to unauthorized reinsurance (CR)
    c. Recent reinsurance transactions (CR, ST)
    d. Credit quality of the reinsurer (CR)
    e. Collectability of recoverables (CR)
    f. Level of surplus aid (ST)
16. The annual group capital calculation (GCC) is a new analytical tool. To gain an understanding of the framework and results provided in the filing:
        a. Follow the five procedure steps as outlined in VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures to review and document the results of the GCC.
        b. Review the background information and context concerning the issues/considerations an analyst should consider when using the GCC for an insurance holding company group that completed the GCC where required as provided in VI.I. Group-Wide Supervision – Group Capital Calculation (Lead State) Analyst Reference Guide.

Profitability

17. Review investment income and realized capital gains and losses.
    a. Has net investment income increased or decreased significantly over the prior year? If "yes," explain the reason for the change. (ST, MK)
    b. Document the amount of investment income by sector that is attributed to dividends received from insurance subsidiaries. (ST)

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c. Document the annual investment yield. Has the yield decreased materially over the prior year? If "yes," explain the reason(s) for the change. (ST, CR, MK)

d. Review the components of investment income. Has investment income from any asset category changed significantly over the prior year? If "yes," explain the reason for the change. (ST, CR, MK)

e. Did the insurance holding company report material realized capital gains/losses? If "yes," identify the cause of the loss. (ST, CR, MK)

18. Review all other sources of revenue, and note any material changes or weaknesses. (PR/UW, ST)

19. Review expenses.

a. Have losses increased or decreased substantially over the prior year? If "yes," explain the reason for the change. (RV)

b. Have administrative and other expenses increased significantly over the prior year? If "yes," explain the reason for the change. (OP)

c. Summarize the loss and expense ratios by line of business for material insurance lines and review the trend. (OP, RV, PR/UW)

20. Has the insurance holding company reported any non-recurring revenues or expenses that materially inflate or reduce earnings? If "yes," describe the reason for the revenue or expense. (ST, OP)

21. Did the insurance holding company report income or losses from discontinued operations? If "yes," summarize the nature of those operations and evaluate the earnings from those operations. (ST, OP)

22. Examine cash flow and document if there has been a negative trend in operating, investing, or financing activities over the past year or the past three years. (LQ)

23. Evaluate any downstream payments and explain the reason(s) for the downstream contributions. (LQ)

PROCEDURES #1 - 3 assist analysts in reviewing the invested assets of the group, noting any significant increases or decreases from the prior reporting period. Identify the most significant concentration of assets, and review the quality distribution of the asset portfolio. Assess the group's asset risk including credit, default, sector, and/or concentration risk. Include a review of affiliated ownership and any upstream holdings.

PROCEDURES #4 - 5 assist analysts in reviewing the non-invested assets of the group, noting any significant increases or decreases from the prior reporting period. Assess the group's exposure to risk related to high recoverable and receivables and miscellaneous balances. Also, assess the risk related to any miscellaneous assets such as goodwill or other intangible assets.

PROCEDURES #6 - 10 assists analysts in reviewing the liabilities of the group, noting any significant increases or decreases from the prior reporting period. Determine if debt exists at the holding company level that may be material and could affect the insurance companies. Debt includes not only long-term debt financed through the issuance of bonds, but also includes other long-term debt granted by a financial institution, as well as short-term vehicles such as commercial paper, repurchase agreements or bank credit facilities. Consider all types of debt arrangements when determining the amount and timing of cash flow payments.

PROCEDURES #11 - 13 assist analysts in reviewing the holding company's overall financial position. Holding company equity is usually reported on a GAAP consolidated basis and represents the retained earnings of the holding company and its ownership share of the equity of its subsidiaries.

The initial focus of insurance holding company analysis centers on the current level of equity. The amount of equity is primary in evaluating the organization's capacity to write business and its ability to cover unanticipated loss payments and expenses, uncollectible premiums and receivables, and capital losses to invested assets. Analysts should take note of the trend over past reporting periods and the factors that have significantly influenced an increase or decline.

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PROCEDURES #14 - 15 assist analysts in reviewing the operations of the group. A required component of certain holding company filings, including SEC filings, is the reporting of premium or other non-insurance business segments. The segment disclosure is fairly broad, including information for each segment on net income, total revenue, and total assets. This information is helpful because it provides analysts with information that management considers in evaluating the results of the entire organization. Reporting segments may include:

- **Operational**—This segment reports the holding company results by categories such as property/casualty, life, bank, non-insurance, or financing and may describe the major operational divisions.
- **Special Sectors**—This segment may identify writing categories or specific lines of business in which an organization specializes. Examples include program business such as artisan contractors.
- **Geographic Concentrations**—Some organizations report their results according to the geographic areas in which the insurance coverage is written or the location of the controlling branch office. This is a fairly common type of reporting for international organizations.
- **Managing General Agents (MGA) and Third-Party Administrators (TPA)**—This segment identifies business produced by MGAs or TPAs. For additional information regarding MGAs and TPAs, refer to Part III. Analyst Reference Guide—Operational Risk.

Analysts should focus on the overall profitability of the segments as well as the stability of earnings over a period of time. To the extent that the segment has reported inconsistent earnings or has reported any losses, analysts may wish to obtain a greater understanding of the causes.

Review the insurer's overall plan of operations, including mission statement, business plan, financial projections, marketing strategies, investment policy and management's philosophy.

- **Mission Statement**—Overall focus and philosophy is clearly stated.
- **Business Plan/Financial Projections**—Determine whether the group has a current business plan that includes details on its primary lines of business and growth strategies, geographic focus, and a plan of operation that contains the group's annual financial and marketing goals. Determine that the group has projected future financial results that appear reasonable based on the variances between plan versus actual results.
- **Marketing Strategies**—Determine whether the group has in place a viable marketing plan that outlines the methods of marketing its products and services, (e.g., direct marketing, agent force, managing general agents, projected sales growth, geographic strategies, and the development and sales of new products).
- **Investment Policy**—Determine the methodology of investment practice, (e.g., investment pool, investment manager, and investment consultants). Ensure that the domestic insurer is in compliance with state investment laws. Evaluate management's philosophy on high-risk securities, affiliated investments (both insurance and non-insurance), and asset and liability matching.
- **Management's Philosophy**—Gain an understanding of the group's culture, management's expertise, and management's future vision of the group.

Determine whether the reinsurance programs in place support the overall risk profile of the group. Determine whether significant errors exist relating to the accounting for reinsurance. Review reinsurance recoverables for materiality and collectability. Identify whether reinsurance between affiliates within the group involve any unusual shifting of risk from one affiliate to another. Determine whether any of the companies within the group are using reinsurance for fronting purposes, and if so, whether any potential problems exist.

PROCEDURE #16 assist analysts in gaining insight into the background, context, and framework of the GCC analytical tool. The procedure primarily instructs the analyst to refer to the specific procedures provided in VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures in reviewing and documenting the results of the GCC. However, before proceeding with these steps, it is recommended the analyst follow the

background information outlined in VI.I. Group-Wide Supervision – Group Capital Calculation (Lead State) Analyst Reference Guide.

PROCEDURES #17 - 21 assist analysts in evaluating the profitability of a holding company, which is measured by its ability to generate earnings and reported on a consolidated basis as net earnings (loss). The earnings statement includes revenues and expenses and the contributing factors to net income. Attention should be focused on special reporting items such as earnings or expenses from discontinued operations. Losses from discontinued operations may represent a significant source of drain on the holding company's earnings. These operations should be investigated thoroughly to identify the types of operations involved, expected durations, and their impact on holding company earnings.

PROCEDURES #22 - 23 assist analysts in reviewing a group's cash flow. The three primary sections within a holding company cash flow statement include cash from operating, investing, and financing. These categories detail the cash inflows and the expenses associated with the activities of the holding company.

A positive cash flow from operations is essential to the continued financial stability of a holding company. A negative cash flow from operations or a negative cash flow trend could present a drain on assets.

Analysts should assess the level of liquid assets to current liabilities to determine the proper matching of assets to claims obligations. Analysts should also assess the material risk associated with low-quality assets and understated reserves.

ADDITIONAL PROCEDURES FOR U.S. BASED INTERNATIONALLY ACTIVE INSURANCE GROUPS (IAIGS)

The following general procedures are outlined for the group-wide supervisor of U.S.-based IAIGs to use in analyzing the financial condition of the IAIG. Analysts should use their judgment in determining how to apply the procedures to group analysis and document the results, but they should not duplicate efforts if these considerations are already addressed in other holding company analysis, corporate governance, or ORSA review procedures. However, as other jurisdictions expect the U.S. group-wide supervisor to address these elements on a regular basis, the analyst should consider the level of documentation to produce in this area. In addition, findings and relevant information from the completion of these procedures should be incorporated into the GPS and shared with other affected state insurance regulators, including supervisory college members, as deemed appropriate.

1. Consider and evaluate the complexity of the IAIG's group structure and the resulting risks to effective group-wide supervision.
    a. See also Procedure #1 of Appendix C in Section VI.F Group-Wide Supervision – Own Risk and Solvency Assessment (ORSA) Review Template.
2. Consider and evaluate the impact of the complexity of the IAIG's group structure on the effectiveness of its corporate governance framework.
    a. See also Procedures #6–8 in Section VI.D Group-Wide Supervision – Corporate Governance Disclosure Procedures.
3. Review the IAIG's capital adequacy and the availability of capital to meet group-wide capital expectations, considering the regulatory capital requirements for each insurance legal entity within the IAIG. Consider the information provided in the GCC in conducting this review, as well as information provided in Section 3 of the group's ORSA Summary Report (see related procedures in Section VI.F). When applicable and available, review group capital reporting, such as the Aggregation Method (AM) or the Reference Insurance Capital Standard (ICS) as reported to the International Association of Insurance Supervisors (IAIS), to prepare for discussions with international supervisors participating in a supervisory

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college. See also Section VI.J for guidance regarding discussions of group capital during IAIG supervisory college sessions.

a. Recognize and assess the effect of potential legal, regulatory, and operational impediments to the IAIG's ability to transfer capital and assets within the group, including on a cross-border basis.

4. If significant concerns are identified related to the IAIG's current or prospective solvency, whether due to legal entity or group-wide risks, determine whether additional supervisory measures, as outlined in Model #440, should be implemented to obtain the information necessary and appropriate to assess enterprise risk and compel the development and implementation of reasonable measures designed to ensure that the IAIG is able to timely recognize and mitigate enterprise risks to members of the IAIG that are engaged in the business of insurance.

   a. Coordinate with other involved supervisors, including the Crisis Management Group (CMG), if appropriate, before requiring a specific preventive or corrective measure if that measure will have a material effect on the supervision of the IAIG or an insurance legal entity within the IAIG, unless exceptional circumstances preclude such coordination.

   b. Coordinate with other involved supervisors, including the CMG, if appropriate, if the head of the IAIG or an insurance legal entity within the IAIG fails to take action to address the group-wide supervisor's or other involved supervisors' identified concerns.

      i. If an insurance legal entity within the IAIG fails to take preventive or corrective measures, as required by the involved supervisor, inform the head of the IAIG and coordinate with other involved supervisors and the head of the IAIG to address this.

The following procedures—#5 through #11—are outlined for the group-wide supervisor to utilize in assessing various elements of an IAIG's internal control framework, including specific functions, strategies, and policies. As many of these assessments and considerations are detailed in nature and may be more effectively assessed during group examination efforts at the IAIG, the analyst is generally encouraged to collaborate with and place reliance on the examination function in this area, where appropriate. In addition, the analyst should not duplicate efforts if these considerations are already addressed in other holding company analysis, corporate governance, or ORSA review procedures.

5. Review the results of the most recent group examination efforts at the IAIG to understand the internal control assessment performed and determine if any follow-up is necessary to address concerns or recommendations.

   a. Consider the extent to which the examination addressed controls and processes related to the outsourcing of critical functions, including:

      i. Policies and contractual requirements, due diligence prior to entering new outsourcing agreements, ongoing risk assessment and oversight of outsourced functions, and contingency plans for emergencies and service disruptions.

   b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam has the potential to affect the group's ability to address:

      i. Diversity and the geographical reach of activities, intra-group transactions, the interconnectedness of entities, and applicable laws and regulations of the jurisdictions in which the IAIG operates.

6. Review the results of the most recent group examination efforts at the IAIG to understand the compliance function assessment performed and determine if any follow-up is necessary to address concerns or recommendations.

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a. Consider the extent to which the examination addressed the compliance function's ability to ensure compliance with relevant legislation and supervisory requirements applicable at both the group and material legal entity levels.

b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam have the potential impact on the group's ability to maintain an effective compliance function.

7. Review the results of the most recent group examination efforts at the IAIG to understand the actuarial function assessment performed and determine if any follow-up is necessary to address concerns or recommendations.

   a. Consider the extent to which the examination addressed the actuarial function's ability to provide oversight of the group's actuarial activities, functions, and risks emanating from insurance legal entities within the IAIG, including:

      i. Policies and controls, actuarial concerns at the group or legal entity level, current and prospective solvency position, adequacy of reinsurance arrangements, actuarial-related risk modelling in ORSA and the use of internal models, coordination with legal entity actuarial functions, and providing independent advice and regular reporting to the IAIG Board or one of its committees.

   b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam have the potential impact on the group's ability to maintain an effective actuarial function.

8. Review the results of the most recent group examination efforts at the IAIG to understand the internal audit function assessment performed and determine if any follow-up is necessary to address concerns or recommendations.

   a. Consider the extent to which the examination addressed the internal audit function's ability to provide independent assessment and assurance regarding:

      i. Policies, processes, and controls; the preservation and protection of assets and the prevention of fraud; the reliability, integrity, and completeness of accounting, financial, management, information technology (IT), and risk reporting information; the capacity and adaptability of IT systems to provide accurate and timely information to the Board and senior management; and the design and operational effectiveness of risk management and internal controls systems.

   b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam has the potential to affect the group's ability to maintain an effective internal audit function.

9. Review the results of the most recent group examination efforts at the IAIG to understand the review performed of the investment policy, or similar policies and practices, and determine if any follow-up is necessary to address concerns or recommendations.

   a. Consider the extent to which the examination addressed whether the investment policies and practices incorporate the following criteria:

      i. Guidelines/limits for investment quality, guidelines/limits to ensure proper diversification and mitigation of asset concentration risk, a counterparty risk appetite statement to limit credit risk from a single counterparty, guidelines/limits for intra-group investments, tracking and monitoring of investments to ensure compliance with policies, and guidelines to avoid placing undue reliance on assessments by credit rating agencies for investment selection and risk management process.

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b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam has the potential to affect the group's ability to maintain effective investment policies and practices.

10. Review the results of the most recent group examination efforts at the IAIG to understand the review performed of the claims management policy, or similar policies and practices, and determine if any follow-up is necessary to address concerns or recommendations.

    a. Consider the extent to which the examination addressed whether the claims management policies and practices incorporate the following criteria:

        i. Guidelines for claims estimation and settlement, feedback into the group's underwriting policy and reinsurance strategy, and claims data reporting for group analysis.

    b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam has the potential to affect the group's ability to maintain effective claims management policies and practices.

11. Review the results of the most recent group examination efforts at the IAIG to understand the review performed on the strategy for reinsurance and other forms of risk transfer and determine if any follow-up is necessary to address concerns or recommendations.

    a. Consider the extent to which the examination addressed whether the following issues are appropriately addressed:

        i. Interaction with the group's risk and capital management strategies; achievement of underwriting risk appetite, both gross and net; appetite for and practices in place to address reinsurer credit risk; policies and practices around legal entity reinsurance arrangements and group aggregation; procedures for managing reinsurance recoverables; intra-group reinsurance strategy and practices; use of alternative risk transfer; and effectiveness of risk transfer in adverse circumstances.

    b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam has the potential to affect the group's ability to maintain effective strategies for reinsurance and other forms of risk transfer.

IAIG Procedures #1 and 2 assist the analyst in evaluating the impact of the group's complexity on the effectiveness of group supervision and the IAIG's governance processes. As many IAIGs have multiple levels of holding companies, various legal entities incorporated in various jurisdictions, and a significant number of shared services and interconnectedness, it is important for the analyst to consider the impact of this complexity on the group's risks and corporate governance activities.

***IAIG Procedure* #3** assists the analyst in assessing the group-wide capital position of the IAIG, as well as any potential issues related to capital fungibility. The focus of this review should be utilizing information provided in the GCC and ORSA Summary Report to assess the IAIG's capital position. For additional guidance on utilizing information provided in the ORSA Summary Report and GCC to assess group capital, see supporting guidance and review procedures at Sections VI.E, VI.F, and VI.H. Also, when applicable, this procedure assists the analyst in understanding the ICS if calculated and provided by the IAIG or other reporting, such as the AM, during the ICS Monitoring Period. Understanding the group capital information reported to the IAIS can assist the analyst in communicating with international supervisors and participating in discussions on the ICS at supervisory college sessions (see additional guidance in Section VI.J). The IAIS's ICS Monitoring Period runs from 2020 through the end of 2024, and it is intended to assess the effectiveness of the newly developed standard. The main objective of the Monitoring Period is to receive feedback from state insurance regulators on the Reference ICS and, if applicable, feedback on additional reporting. During the Monitoring Period, the ICS is not designed for the purpose of supervisory intervention based on capital adequacy. During the Monitoring Period, U.S. IAIGs may report an alternative GCC to the IAIS known as the AM, which is expected to be similar to the GCC. The AM will

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be subject to a Comparability Assessment, and by the end of 2024, it will be deemed to produce, or not produce, comparable outcomes to the ICS. The NAIC supports the development of the AM as an outcome-equivalent approach for the implementation of the ICS.

IAIG Procedure #4 assists the analyst in determining whether additional supervisory measures should be taken in response to risks or concerns identified during the holding company analysis for the IAIG. As the group-wide supervisor assumes responsibility for overseeing the overall solvency monitoring for the group, it is important that risks or issues requiring supervisory intervention are identified and addressed in a timely manner through coordination with other involved supervisors.

IAIG Procedure #5 assists the analyst in coordinating with the examination function to evaluate control processes and functions. As discussed in Procedures #1 and #2, the structure and complexity of an IAIG can lead to various challenges, including challenges in effectively organizing and coordinating control functions across holding companies, legal entities, and jurisdictions. However, as the evaluation of control processes is generally performed during on-site examination efforts, the analyst should review and follow up on relevant results of the most recent examination and consider whether any recent changes in group structure or strategy have affected control functions.

IAIG Procedure #6 assists the analyst in coordinating with the examination function to evaluate the compliance function and how it ensures compliance with regulatory requirements at both the group and legal entity levels.

IAIG Procedure #7 assists the analyst in coordinating with the examination function to evaluate the actuarial function and its role in providing oversight of the group-wide actuarial activities, functions, and risks emanating from insurance legal entities within the IAIG.

IAIG Procedure #8 assists the analyst in coordinating with the examination function to evaluate the internal audit function and its role in providing independent assessment and assurance regarding internal controls, systems, and risk management practices.

IAIG Procedure #9 assists the analyst in coordinating with the examination function to evaluate investment policies and practices, including whether they set criteria for investment quality and address the selection of, and exposure to, low-quality investments or investments whose security is difficult to assess.

IAIG Procedure #10 assists the analyst in coordinating with the examination function to evaluate claims management policies and practices, including whether they include procedures for claims estimation and settlement, feedback into the group's underwriting policy and reinsurance strategy, and claims data reporting for group analysis.

IAIG Procedure #11 assists the analyst in coordinating with the examination function to evaluate the strategy for reinsurance and other forms of risk transfer, including whether the strategy is consistent with risk and capital management strategies, in line with underwriting risk appetites and addresses credit risk with reinsurance counterparties.

CONTENTS OF THE GROUP PROFILE SUMMARY (GPS)

The following analysis work should be documented in the GPS:

- **Holding Company System Summary** – Include an understanding the holding company system by discussing the structure and business operations, including any significant recent events, changes in structure, key business segments, international activity, rating organization changes/actions and key entities/persons within the insurance holding company system. Include discussion of new and material affiliated transactions/relationships, management and third-party agreements and non-insurance agreements as well as the impact of these agreements to the group/insurers.

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- **Corporate Governance Summary** – Present a summary of the group's overall corporate governance structure, including a review of the Corporate Governance Annual Disclosure – CGAD (if filed on a group basis) and an overall assessment for the holding company system.
- **Enterprise Risk Management Summary** – Present a summary and assessment of the enterprise risk management function in place at the holding company system, as well as a discussion of ORSA Summary Report filing/review status (if applicable).
- **Branded Risk Assessments** – Include a summary assessment of the group's exposure to branded risk classifications, including prospective risks, the financial strength of the insurance holding company system, including finanical position, liquidity, leverage, and profitability. Such documentation should include summarizing key risks noted within the IPSs from respective domestic regulators within the group.
- **Overall Conclusion** – Present an overall conclusion as to the group's financial condition, including key strengths and weaknesses or material concerns that regulators may have with the group's operations going forward.
- **Supervisory Plan** – Present any specifically identified items that require further action and/or monitoring by analysts or specific testing by the examiner.
- **Other Functional Financial Regulators/Supervisors** – Where appropriate, it may be necessary to document an understanding of other functional financial regulators/supervisors involved with legal entities within the insurance holding company system, including international regulators/supervisors and U.S. federal banking regulators.

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XX DEPARTMENT OF INSURANCE

GROUP PROFILE SUMMARY

GROUP NAME

As of 12/31/20XX

Updated as of XX/XX/20XX

Group Number
List here

Lead State
List here

Group-wide Supervisor
List here

Group Credit Rating
List here

Publicly Traded
List ticker and exchange

International Jurisdictions
Country/Capital Regime (Solvency II, Swiss Solvency Test, etc.)

Contact at Group
List name, phone and email

CPA Firm
List here

Analyst
List here

Last Coordinated Exam

Holding Company System Summary

Identify the ultimate controlling person (UCP), and provide a summary of the structure and business operations of the holding company system, including any significant recent events or changes in structure.

EXAMPLE:

Ultimate Controlling Person*: COMPANY 1 is a mutual holding company that acts as the ultimate controlling person for the group.*

Organizational Structure*: The group is structured as a mutual holding company. The majority of the entities within the group are 100% owned by COMPANY 1. The group provides a wide range of financial products to its customers, but operates under a fairly direct and simple organizational structure.*

Business Segments*: The GROUP is divided into three business segments: insurance, banking and financial services/planning. All of the business segments are designed for and marketed to TARGET MARKET. The insurance segment makes up approximately 70% of the group's total revenue, which includes both property & casualty (55% of total revenue) and life insurance (15% of total revenue). Banking services make up approximately 15% of total revenue, with the remaining 15% attributed to financial services/planning and other minor segments.*

Insurance policies are sold through the internet, mail, and telephone on a direct basis, primarily from its LOCATION office. There are 13 financial centers in cities with TARGET MARKET LOCATION to assist members with insurance, banking and investments. The company is exposed to some level of risk concentration due to its concentration in the TARGET MARKET, which exposes it to certain geographic concentrations.

Sample text:

The [name of parent] has [issued or modified] a parental guarantee agreement [or capital support agreement] under which the Parent will be responsible for ensuring that the insurance Companies [LIST APPLICALBE PARTIES TO THE AGREEMENT] have sufficient capital and liquid assets to pay claims. The Parent will also maintain capital at a level that ensures a minimum RBC level of ##.#% ACL.

Insurance Entities and Jurisdictions: *The group has seven different insurance legal entities domiciled across three different states in the U.S. In addition, COMPANY 9 is an alien insurer domiciled in FOREIGN LOCATION. The Company is authorized to provide insurance in the other countries in that region and is subject to insurance*

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supervision by the FOREIGN SUPERVISOR. COMPANY 9 reported $547 million in retained profit in 20xx, so its operations are not overly significant to the Group.

Captives: *The group has established COMPANY 14 as a captive life insurer, to assume XXX and AXXX reserve liabilities from COMPANY 6. COMPANY 14 is domiciled in CAPTIVE STATE X and is subject to coordinated supervision. The initial transaction to transfer reserve liabilities was subject to review and approval by the CEDING STATE and the CAPTIVE DOMICILE and is subject to ongoing review and oversight. During a Dec. 31, 20XX, coordinated examination, it was determined that the group continues to operate in accordance with the approved transaction restrictions and maintains sufficient reserves, collateral and surplus to support the captive reinsurance structure.*

Non-Insurance Entities: *The group offers many banking and financial products including credits cards, consumer loans, home equity loans, mortgages, auto loans, checking and savings accounts through COMPANY10 and COMPANY 11. The Office of the Comptroller of the Currency (OCC) and the Federal Deposit Insurance Corporation (FDIC) regulate the banks and the LEAD STATE communicates with those supervisors on a regular basis regarding group issues.*

In 20XX, the Group was examined by the Federal Reserve Bank (FRB). No significant findings were noted during the exam. In 20XX, the Group issued $800 million in additional bank debt through Company 1. However, this additional debt does not appear to significantly increase the group's current leverage position, which is conservative in comparison to most competitors and does not represent a significant concern at this time.

In 20XX, the Federal Reserve conducted stress testing on the bank in COMPANY10. The bank passed the latest stress tests, demonstrating that they have sufficient capital to withstand adverse scenarios.

Other Information: *A recent press release announced the group's intentions to partner with UNAFFILIATED COMPANY A to offer additional financial services products to its existing customers. The partnership is not expected to have a significant financial impact in the near term.*

Financial Snapshot (Selected Summary Data)

Provide financial data as well as any notes and explanations of the data to outline the group's financial position, segment performance and other key information that is customized and relevant for an understanding of the specific group. Financial information provided in the GPS may be more detailed as compared to the insurer profile summary of a legal entity insurer since the availability of group data differs significantly from one group to the next and fewer tools are available at the group level. However, the information presented may vary depending upon the availability of consolidated financial data from one group to the next.

EXAMPLE:

Consolidated Balance Sheet (U.S. GAAP)

Years Ended December 31 (Dollars in millions)	*20XX*	*20XY*
Insurance Assets	*$*	*$*
Non-Insurance Assets	*$*	*$*
[Add detail based on group specifics]	*$*	*$*
TOTAL ASSETS	*$*	*$*
Holding Company Debt	*$*	*$*
[Add detail based on group specifics]	*$*	*$*
TOTAL LIABILITIES	*$*	*$*
EQUITY	*$*	*$*

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TOTAL LIABILITIES AND EQUITY	*$*	*$*
[Add detail based on group specifics]	*$*	*$*
Total revenues	*$*	*$*
Total losses, benefits and expenses	*$*	*$*
NET INCOME	*$*	*$*
CASH FLOW	*$*	*$*

NET INCOME BY SEGMENT	*20XX*	*20XY*
Property & Casualty Insurance	*$*	*$*
Life Insurance	*$*	*$*
Banking & Finance	*$*	*$*
Non-Financial	*$*	*$*
Corporate	*$*	*$*

INSURANCE OPERATIONS BY JURISDICTION	*20XX*	*20XY*
[Add international detail based on group, e.g., premium, revenue, or assets under management]	*$*	*$*

EXAMPLE:

Significant Financial Performance Notes:

- *The Group continues to experience positive financial results including steady revenue growth, increasing capital/surplus levels, positive net income and positive cash flow from operations.*

Corporate Governance Summary

Provide a summary of the corporate governance structure and an overall assessment for the holding company.

EXAMPLE:

The Group is governed by a board of directors at the mutual holding company level and separate boards are in place for each insurance and banking entity, but they are led by company employees and have limited responsibilities. Strategic direction is set by the COMPANY 1 board and the audit committee for COMPANY 1 has assumed responsibility for the financial reporting and internal controls of all insurance entities. The board is made up of 10 members, 8 of which are independent from management. The Board and its committees are governed by formal written charters and the board meets a minimum of 4 times a year to fulfill its responsibilities. Based on the results of the most recent financial exam, board members of Company 1 were deemed suitable for their positions with a wide-range of experience and expertise demonstrated including financial and actuarial knowledge. A review of insurance board meeting materials and minutes indicated that the board is actively engaged in reviewing reported financial results of the organization and taking action to address strategy when necessary.

Senior management is led by a CEO that has been in place since 20XX and has a background in insurance company leadership going back more than 25 years. Based on the most recent discussions with management at the department and through discussions at the last supervisory college, the CEO appears to be well informed in regards to all significant operations of the group. All of the other members of senior management appear to have appropriate knowledge, background and experience to fulfill their responsibilities and appear to be actively engaged in the group's strategic initiatives. The assignment of authority and responsibility across the group appears to be clear and effective and the management team has demonstrated its competence through numerous interviews and meetings with the department. Overall, the Group's corporate governance is assessed as strong.

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Enterprise Risk Management Summary

Provide a summary of the enterprise risk management function and an overall assessment for the holding company, as well as a discussion of the ORSA Summary Report filing status.

EXAMPLE:

The Enterprise Risk Management function is organized at the COMPANY 1 level, although an ERM function is also organized for the banking subsidiaries. Both are overseen by a Risk Management Committee of the board. The Risk Management Committee is governed by a charter that makes it responsible for developing, communicating and implementing a risk appetite statement and supporting risk limits/tolerances across the organization. The Chief Risk Officer oversees the Enterprise Risk Management function for COMPANY 1 and reports to the Risk Management Committee at least quarterly, providing updates on the organization's compliance with risk limits/tolerances, describing new and emerging risks the organization is facing, and seeking input on changes to risk limits/tolerances and remediation efforts to address breaches. Individual risks are assigned to risk owners for development of mitigation strategies, monitoring and day-to-day management. The results of the organization's ERM efforts are documented in an ORSA Summary Report and similar information is reviewed and approved by the Risk Management Committee and the Board of Directors on an annual basis.

The Group's assessment of its key risks through its ERM framework generally align with the department's understanding of the Group and its exposures, with the exception of geopolitical risk (see other branded risk) that is of concern to the department but not directly addressed by the Group as a key risk. A recommendation has been made for the Group to incorporate additional geopolitical risk considerations into its ERM framework going forward.

Amongst a wide range of other risk exposures, the Group also reviews liquidity (see liquidity branded risk) and discusses contingency funding to mitigate potential liquidity stresses due to catastrophic events or severe market fluctuations.

Group Capital Calculation Summary

Provide a summary of an assessment of the GCC both quantitatively and qualitatively, including any such items as may not be applicable to a branded risk category. The GCC summary is intended to be high-level. Therefore, other more detailed observations from reviewing the GCC should generally not be documented into the GPS unless they are specifically insightful, add to a high-level understanding of the Group's financial condition, or are specific to a branded risk category as stated.

It may be appropriate to indicate whether the review of the Group's GCC indicated the scope of the application is consistent with the lead state's determination and summarize the general scope of the GCC. For example, "*the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries"*.

It may also be appropriate to identify key drivers of risks for the Group within the GCC as those risks supplement existing risk assessments derived from holding company analysis or are new risks that warrant further review.

EXAMPLE:

"*The Group's GCC of 201% in the current year was impacted by a decline in total available capital of $X which is related to the Group's non-insurance operations in Bermuda and as well as the negative impact of market risks in the U.S. insurance legal entity ratio components, which based on further analysis has resulted from the recent financial market volatility*".

Branded Risk Assessments

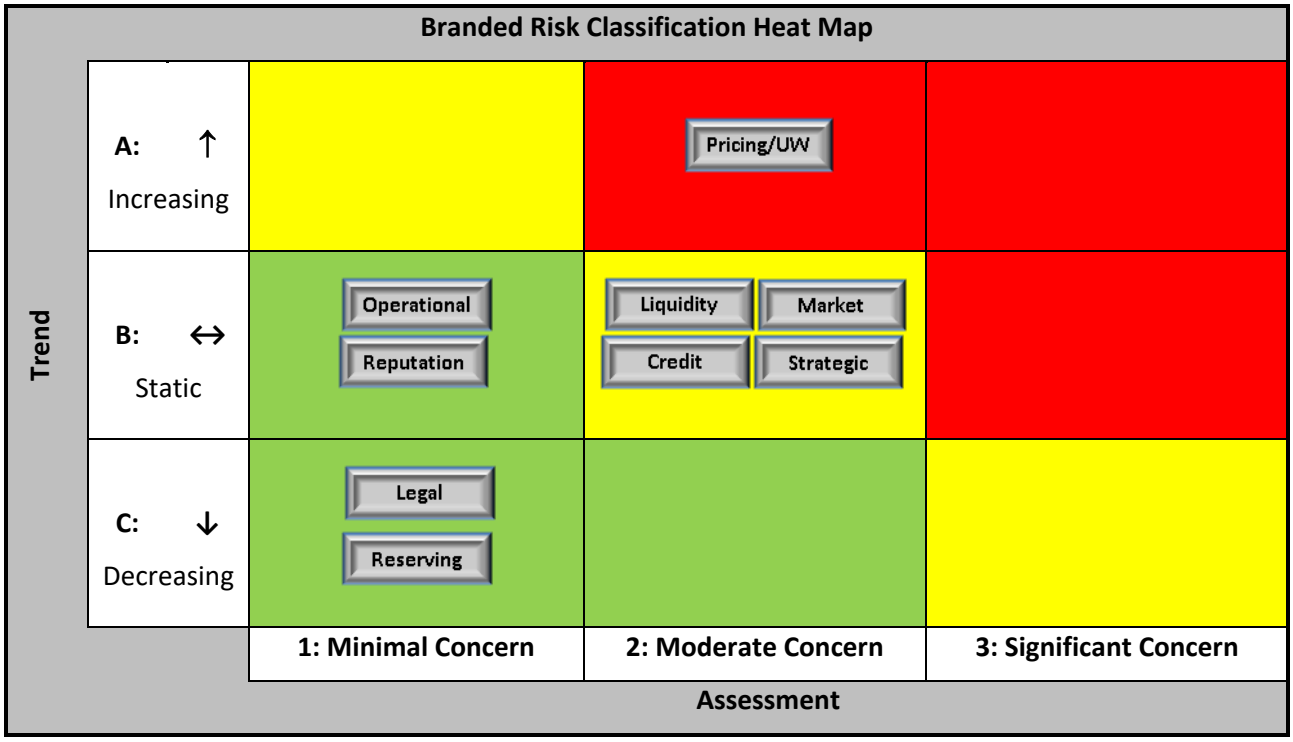
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Summarize your assessment of the branded risk classifications for the Group based upon both quantitative (e.g., 5-year trending of key ratios) and qualitative information. An assessment of each significant individual risk component (including prospective risks) relevant to the classification should be provided by indicating either "minimal concern," "moderate concern," or "significant concern" as well as the direction in which the risk is trending. If no material individual risk components are identified for a branded risk classification, documentation should be provided to support this conclusion. Consider the materiality and/or significance of each individual risk component in aggregating the overall assessment and overall trend, including positive considerations and mitigating factors, for each branded risk classification. Update the Branded Risk Classification Heat Map to illustrate your conclusions.

The following is an interactive map. Click and drag the risk classification to the appropriate section of the risk classification heat map after assessing the trend in each individual category.



EXAMPLE:



Credit:

- ***Loan Portfolio*** *- The primary credit risk for the Group appears to be in the banking segment. The banks have a significant amount invested in mortgages and automobile loans. Through discussions with the group wide supervisor, the Federal Reserve Bank, and a review of documentation they provided, it appears that the loans carry a moderate risk of default. However, current loans past due are less than 1% of loans receivable, indicating that the Group appears to manage its loan portfolio well.*
- ***Insurer Investments*** *– Other investments are heavily concentrated in investment grade bonds associated with the insurance operations, which represent a minimal concern. We requested the Group provide us with summary investment information for the Group, which indicated that there were no*

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material concentrations in non-investment grade bonds, equities, private securities or other types of invested assets. In addition, the Group assesses credit within its economic capital model. Because most of these assets are within the individual insurers, we also reviewed the legal entity insurer profile summaries and noted no significant concerns with either investments or reinsurance.

Overall: *Credit risk is assessed as moderate and static driven by its loan portfolio from banking operations, as other insurance segment risks are minimal or immaterial to the overall Group.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Loan Portfolio		↔
Insurer investments			↔
Overall Credit Assessment: Moderate Concern		**Overall Trend: ↔**	

Legal: *No specific concerns identified through either review of the legal entity insurer profile summaries, results of recent coordinated exam, the ORSA Summary Report, other holding company filings, discussions with the Federal Reserve, communication with the FOREIGN SUPERVISOR of COMPANY 9, or any other sources.*

- ***Claim Lawsuits*** *– The Group is periodically involved in individual claim lawsuits, but frequency has trended downward and results are not historically significant.*
- ***Regulatory Risk*** *– As a Group with US insurance, banking and financial services operations and international operations, regulatory risk associated with prospective regulatory changes and compliance costs are identified as a risk to the Group, but considered minimal at this time.*

Overall: *Due to the company's strong management of existing exposures to legal issues, the legal risk is assessed as minimal and declining.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Claim lawsuits			↓
Regulatory Risk (incl. Federal and International)			↔
Overall Legal Assessment: Minimal Concern		**Overall Trend: ↓**	

Liquidity: *As previously discussed, although the insurance assets are fairly conservative, and despite identifying no specific liquidity concerns in the insurance segment, this may be an area requiring greater focus at the Group level moving forward.*

- ***Liquidity of Banking Operations –*** *The Federal Reserve indicated that the banking operations were subject to liquidity strain under certain conditions. The banking operations passed the latest stress tests and demonstration solvency in all but the extreme scenario, however the specific conditions of the scenario testing were not provided for the lead state's review.*
- ***Liquidity Stresses –*** *The Group has a liquidity risk appetite statement and liquidity risk limits and determines if the current liquidity position is within the risk appetite and limit. Given in part the Group's exposure to certain types of catastrophic risks as well as certain risks with its banking operations, the Group has in place a strategy to liquidate assets and access sources of contingency funding in times of stress.*

The analyst suggests as an area of focus during the next coordinated on-site examination, this contingency funding, specifically the $XXM Federal Home Loan Bank (FHLB) letter of credit; as well as reviewing the current liquidity position compared to the risk limits; and reviewing the banking stress test scenario to better understand the entire Group's liquidity management.

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Overall: *Liquidity risk is assessed as moderate and static due to liquidity strain at the non-insurance operations and contingency funding in place to address stress scenarios. Both will be considered for further assessment during a future examination.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Liquidity of Banking operations		↔
	Liquidity Stresses (CAT scenario or market fluctuations)		↔
Overall Liquidity Assessment: Moderate Concern		**Overall Trend: ↔**	

Market: *The Group is exposed to market risk with:*

- ***Loan Portfolio*** *– Similar to credit risk, through discussions with the Federal Reserve, market risks related to the loan portfolio were identified, as these loans can be subject to market swings during certain economic conditions. Although general concerns were communicated in this area, specific concerns related to the company's stress test results for various scenarios were not communicated.*
- ***Insurance Portfolio*** *– Despite the relatively conservative investment portfolio, the Company identified through stress tests specifically reviewing the capital effects for interest rate changes/levels on the insurer's portfolio that market risk was an area where a moderate risk, or at least a moderate amount of capital, may be needed to absorb certain specific economic conditions. However, based on discussions with management, despite the use of various types of derivatives to reduce such risks, the company indicates that its cost-benefit analysis suggests that further hedging is not used to manage this extreme tail risk that has a somewhat low probability. Further review of such need not be performed until the next five-year examination.*
- ***Geopolitical Risk*** *- The Group is exposed to geopolitical risk and uncertainty related to its investment in COMPANY 9, which is an alien reinsurer operating in Country XX. As the stability of Country XX's government has been weakened due to recent protests related to government corruption, the Group's investment in COMPANY 9 is of some concern. However, as the Group's total investment in COMPANY 9 ($547 million at Dec. 31, 20XX) represents less than 3% of overall capital and surplus, the situation warrants only a moderate concern at this time.*

Overall*: Based on the above, market risk is assessed as moderate and static attributed to both the insurance and non-insurance segments as the economic market remains volatile.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Loan Portfolio		↔
	Insurance Portfolio		↔
	Geopolitical risk (COMPANY 9)		↔
Overall Market Assessment: Moderate Concern		**Overall Trend: ↔**	

Operational:

- ***Earnings*** *– Consolidated GROUP reported net income of $2,128 million in the current year compared to $2,637 million in the prior year. In the current year, GROUP P/C companies experienced significant catastrophe events, which included tornadoes, floods, hail, wildfires, earthquakes and hurricanes. However, even with the heightened number of catastrophes faced by the Group, the overall financial results were favorable and Group capital, according to the Group, appears to be well above target even*

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under adverse conditions. The Group is not structured like most companies and its overall approach is geared towards its policyholders.

- ***Internal Control Documentation*** *– Although the last examination revealed that governance risk was low, certain internal control processes were not clearly documented. The Group indicated that it was in the process of working with its internal audit department to enhance its documentation. Through discussions with the Federal Reserve, it appears that the Group has recently developed additional documentation around internal controls. These activities will be verified during the next onsite examination.*
- ***Cybersecurity*** *– The Group identified cyberattack as a key risk with moderate concern due to the number of entities, IT platforms, lines of business, and counties that the insurer operates within. Therefore, the company has purchased a cyber policy for $5 million. The analyst will recommend the exam team confirm and review the provisions of the policy. Additionally, the Group's stress testing shows that the insurer's capital could absorb a moderate cyber event with reinsurance and controls that are in place. However, stress testing also shows that a combination event with both a cyber attack and an underwriting (CAT) event would require the insurer to obtain additional capital to absorb.*

Overall: *Operational risk is assessed as minimal and static at this time due to strong profitability, slightly offset by potential risks noted within documentation of internal controls and cybersecurity.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Earnings			↔
	Internal control documentation		↓
	Cybersecurity		↓
Overall Operational Assessment: Minimal Concern		**Overall Trend: ↔**	

Pricing/Underwriting: *Our review of pricing/underwriting risk focused on the insurers within the organization, as similar risks in the banking segment were evaluated as an element of credit risk.*

- ***Auto/Home Underwriting & Pricing*** *– Underwriting performance within the auto and homeowner's lines of business remain within expectations for premium revenue growth and earnings groupwide. However, expansion and the shift to more property lines (Auto and Homeowners), may result in higher pricing risks going forward.*
- ***CAT Risk*** *– Company 6 has a concentration of catastrophe risk in one state, which was identified as a significant concern by State Y. However, after further review, and detailed discussions with management, we determined that CAT risk for the entire Group as a whole was moderate. The Company has taken steps in the current year to minimize this risk further by creating a separate legal structure to reduce this risk through the issuance of insurance linked securities. Although this is a risk mitigator, a target exam is recommended to review the details of the structure and we will continue to monitor this activity closely as it could represent a significant concern if not structured effectively.*
- ***WC Underwriting & Pricing*** *– The Group's workers' compensation (WC) line of business appears to contain some risk for the Group, where despite relatively strong historical performance, we're noticing an industry trend of decreasing prices. As this line of business represents more than 25% of the Group's total gross written premiums, we believe a detailed review of national underwriting procedures and current pricing on workers' compensation may be appropriate during the next onsite exam (scheduled for two years from now).*

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***Overall**: Pricing/underwriting risk is assessed as moderate and increasing due to uncertainties in the changing product focus and expansion, as well as potential for pricing trends to impact the WC line of business, which is material to the Group.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Auto/home underwriting & pricing			↔
	CAT risk		↔
	WC underwriting and pricing		↑
Overall Pricing/Underwriting Assessment: Moderate Concern		**Overall Trend: ↑**	

Reputation: *No material risks were identified. The Group appears to monitor its reputation and strong financial strength and credit ratings on a regular basis.*

***Overall:** Reputation risk is assessed as minimal and static due to the Group's historically strong reputation, ratings, and demonstration of strong corporate governance in managing its reputational risk, despite the challenging insurance markets.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Overall Reputation Assessment: Minimal Concern		**Overall Trend: ↔**	

***Reserving:** Our review of reserving risk focuses on the insurance segment of the Group, as the risk associated with bank lending activities are addressed in Credit.*

- ***Adequacy of Reserves and Leverage –** The Group sets P&C reserves at a level slightly above the actuary's central estimate and maintains a conservative ratio of reserves to equity of 80% although this ratio has been trending slightly negative.*
- ***Loss Development –** Although the group sets P&C reserves slightly above the actuary's central estimate, it reported unfavorable prior year reserve development, following three consecutive years of favorable development (see graphic below). This unfavorable development stemmed from reserve strengthening in the auto liability line, driven by industry-wide trends of increased claims severity attributed to social inflation. The Group maintains internal actuarial expertise but has limited experience in some of the new markets they are operating in.*

	CY	***PY***	***PY1***	***PY2***	***PY3***
Two Year Develop	*12.0%*	*-10.0%*	*-10.4%*	*-5.6%*	*1.1%*
Loss & LAE/C&S	*79.8%*	*76.8%*	*75.2%*	*73.7%*	*71.9%*

- ***Life Insurance Reserve Adequacy of Ceded Business -** The Company cedes a material portion of life insurance to its affiliated captive insurer. As noted above, during the Dec. 31, 20XX, coordinated examination, it was determined that the group maintains sufficient reserves, collateral and surplus to support the captive reinsurance structure. Per the domiciliary state IPS, the 20XX Actuarial Opinion and RAAIS has been reviewed and no concerns were identified since the last exam.*

***Overall**: The Group continues to maintain a conservative reserve leverage position and has a history of favorable development, although expansion into new property markets may become a challenge. At this point, reserving risk is assessed as minimal and increasing overall.*

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Minimal Concern	Moderate Concern	Significant Concern	Trend
Adequacy of Reserves and Leverage			↔
Loss development			↔
Life Insurance Reserve Adequacy of Ceded Business			↔
Overall Reserving Assessment: Minimal Concern		**Overall Trend: ↔**	

Strategic: *The primary risks for the Group are divided into insurance and banking segments.*

- ***Competition (Insurance)*** *– The Group has proven risk mitigation strategies in the insurance companies and has managed those risks well. However, the Group is facing new competition in a number of its primary insurance markets as competitors seek to duplicate the Group's strong financial performance. While the Group appears to be aware of the increased competition and responding to the emerging threats in this area, these threats bear monitoring as a moderate concern.*
- ***Group Capital and Capital Modeling*** *– COMPANY 1 uses an internally developed economic capital model to determine the required capital to absorb unexpected losses in the 12 months arising from the following key risks: insurance, market, catastrophe and credit. Additionally, strategic risk and operational risk are quantified outside the economic capital model. The aggregate required capital is then compared to the available capital to determine the solvency position of the company. The required capital and available capital are projected and stressed over the next three years to assess the ability of the company to remain solvent over the duration of the business plan. The projections and stress tests demonstrate the ability of the company to remain solvent under all but very extreme scenarios. The Group's GCC is assessed as low-risk and stable and is a positive consideration in the overall assessment of strategic risk. The GCC has generally been reasonable and consistent over the past five years as illustrated in the following table. Additionally, refer to the GCC summary for further details.*

	CY	***PY***	***PY1***	***PY2***	***PY3***
GCC Ratio	*201%*	*207%*	*163%*	*202%*	*197%*

- ***Liquidity Strategy –*** *One area of risk that has not been easy to assess at the Group level is its liquidity planning and strategy (see LQ Risk for more information). Additional discussions on this topic are recommended during the next meeting with management.*
- ***Holding Company Debt*** *– While the Group's holding company has issued debt to fund operations, the Group's interest coverage ratio (provided below) shows that the Group is not overly reliant on cash flow from the insurance entities to cover the holding company debt.*

	CY	***PY***	***PY1***	***PY2***	***PY3***
Interest Coverage	*4.5X*	*4.4X*	*4.4X*	*2.2X*	*5.2X*

Overall*: Strategic risk is assessed as moderate and static driven primarily to the competitive nature of the Group's lines of business, but offset by a strong capital position.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Competition		↑
Group Capital and Capital Modeling			↔

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	Liquidity strategy		↔
Holding Company Debt			↔
Overall Strategic Assessment: Moderate Concern		**Overall Trend: ↔**	

Overall Conclusion

This section should include the analyst's overall conclusion as to the Group's financial condition, discuss key strengths that potentially mitigate the risks assessed above, and highlight any key weaknesses or material concerns the analyst may have with the Group's operations going forward. Include a discussion on the interconnections within the holding company Group that have a significant impact on the insurance segment. Include any material actions that have been taken by the lead state or other jurisdictions (e.g., significant holding company transactions, prior or planned meetings with management, referrals to/from other divisions, and communications with other regulatory jurisdictions, etc.).

EXAMPLE:

Based on the branded risk assessments provided above as well as the company's financial results reported in recent periods, the Group appears to be financially stable with no major sources of potential contagion risk to the insurance entities identified. However, some of the key weaknesses and material concerns facing the Group include increased competition, geopolitical risk to operations in Country XX, overall liquidity planning and the Group's pricing/underwriting of workers' compensation business. These concerns are somewhat offset by company strengths including a conservative investment portfolio, strong reputation and history of strong financial performance. While the Group has issued new holding company debt, the risk of dependence upon cash flows from the subsidiaries, including the insurance operations, to make payments is minimal at this time.

The department meets annually with Group leadership with the next meeting scheduled for the first quarter of 20XX to discuss annual results. During the meeting, the department plans to ask about the impact of increased competition on the Group as well as liquidity planning.

The company has in place a capital support agreement with each of the U.S. insurance entities in which it will be responsible for ensuring that each of the insurance entities has sufficient capital and liquid assets to pay claims. The Company will also maintain capital at a level that ensures a minimum U.S. RBC level of ##.#% ACL for both life and property operations.

Supervisory Plan

List any specifically identified items that require further action and/or monitoring by the analyst or specific testing by the examiner. In addition, indicate if the Group is or should be subject to any enhanced monitoring, such as monthly reporting, meetings with the department, a targeted examination, or a more frequent exam cycle. Note if any regulatory actions have recently been taken.

EXAMPLE:

Analysis Follow Up

- *Discuss the Group's strategy to address increased competition in several of its primary markets as part of the next annual meeting [scheduled for DATE], supervisory college [scheduled for DATE] and/or holding company analysis.*
- *Monitor the situation in Country XX to consider its impact on the Group's investment in COMPANY 9.*
- *Discuss any significant negative developments with the Group's executives.*

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- *Discuss liquidity planning and strategy during the next scheduled meeting with management (see also exam considerations).*

Examination Follow-Up

Interim Target Examination

- *Perform a targeted examination on the Group's newly developed insurance linked securities in order to understand all aspects of the program including its interaction with other forms of projection, limits, the monitoring used by the company, etc.*

Next Coordinated Examination

- *The next coordinated examination is scheduled for the period ending Dec. 31, 20xx. The following are recommended areas of focus*
- *National underwriting procedures and current pricing on workers' compensation during the next coordinated examination.*
- *Entire Group's (including banking) liquidity management program.*
    - *Specifically review the liquidity risk appetite statement and liquidity risk limits to determine if the current liquidity position is within the risk appetite and review documentation of the insurer's control of monitoring limits.*
    - *Verify the existence of the FHLB letter of credit for contingency funding since it is the primary source of additional funding during a stress event. R*
    - *Review the banking stress testing scenarios to determine the impact of the scenarios to liquidity.*
- *Review of the economic capital model including the CAT model component that calculates the risk exposures by peril.*
    - *Assess if the insurer approves the appropriateness of the model(s) framework and ensures that all key risks are assessed either in the model or under a separate assessment.*
- *Reinsurance given the Group indicates it is the primary control of the Group's catastrophic risk.*
    - *Review the reinsurance program as outlined in the reinsurance interrogatory tower consider how aggregated/modeled loss exposures are utilized by the company to reach reinsurance decisions in the context of overall reinsurance strategy.*
    - *Review the probable maximum loss (PML) for catastrophe perils and compare them to the catastrophic reinsurance structure that has been selected*.

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VI.C.2. Group-Wide Supervision – Non-Insurance Company Grid Template

Non-Insurance Company Grid

NAIC #	FEIN	Name of Securities Exchange if Publicly Traded (U.S. or International)	Name of Parent, Subsidiaries or Affiliates	Domicile	Primary Regulator and Contact	Primary Regulator Email	Description & Purpose of Entity	Business Segment	Inter-Company Guarantee (Yes/No)	Revenue	Net Income	A.M. Best Rating	Moody's Rating	S & P Rating	Prospective Risks

Special Note: The following procedures do not supersede state regulation but are merely additional guidance an analyst may consider useful.

The *Corporate Governance Annual Disclosure Model Act (#305)* and *Corporate Governance Annual Disclosure Model Regulation (#306)* provide a summary of an insurer or insurance group's corporate governance structure, policies and practices to permit the Commissioner to gain and maintain an understanding of the insurer's corporate governance framework.

States should also consider completion of applicable guidance and procedures within the Operational and Strategic risk categories of this Handbook based upon the level of concern an analyst may have with management performance and the driving forces behind operations.

INTRODUCTION

Models #305 and #306 require an insurer, or an insurance group, to file a summary of an insurer or insurance group's corporate governance structure, policies and practices with the commissioner by June 1 of each calendar year. Model #305 allows the information to be at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. Because most corporate governance is driven at a controlling or intermediate holding company level, this guidance is contained within this section dealing with group supervision. As such, reviewing the corporate governance disclosure of a group is a responsibility of the lead state. In addition to the role of the lead state, other analysts from participating states may also review corporate governance since it is common for most groups to have some level of governance at the individual legal entity level.

Non-Lead State Reliance on the Lead State Analysis of Corporate Governance Annual Disclosure:

Model #305 requires the filing to be made with the lead state; however, non-lead domestic states may request the CGAD filing from the insurer. Because the filing may be made on a group basis or legal entity basis, it may contain group information that applies to all insurers within the group, or it may contain information applicable to a specific legal entity.

Similar to other solvency regulation models, Model #305 contemplates both off-site and on-site examination of the CGAD information, therefore, it may be necessary or acceptable for the lead state to share its work papers with another state during an exam, related to such filing, provided such information is shared in accordance with the confidentiality provisions of Model #305.

The lead state should take primary responsibility for reviewing the CGAD filing, if it is filed on a group basis, and should incorporate any takeaways or concerns into the Group Profile Summary (GPS). Takeaways should be incorporated into the corporate governance summary in the GPS and/or the discussion of various branded risks, as deemed appropriate. There is no requirement or expectation for the analyst to create a separate CGAD checklist or create additional review documentation for sharing with another state or for internal documentation purposes.

If the CGAD highlights any issues that are only relevant to a particular insurance entity in the group, the lead state should notify the domestic state of this issue and share the relevant information from the CGAD with that state in a timely manner.

Internationally Active Insurance Group (IAIG) Considerations:

While the considerations outlined in this chapter are generally applicable to all insurers/insurance groups, depending on the level at which the CGAD filing is made, there are some additional corporate governance

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assessment considerations applicable to U.S.-based internationally active insurance groups (IAIGs) on an annual basis that are incorporated into this section. It is the responsibility of the group-wide supervisor to ensure that the group meets minimum governance expectations at both the legal entity, for its domestic insurers, and head of the IAIG level. As such, the group-wide supervisor should request and review additional information from the head of the IAIG, as necessary, to complete this assessment, which may include requesting information similar to what is provided in a CGAD and/or additional information (e.g., biographical affidavits, conflict of interest statements) at the head of the IAIG level. In addition, the analyst should utilize other filings and resources already available to the department, including holding company filings—i.e., Form B, Form F—Own Risk and Solvency Assessment (ORSA), and any other relevant information (e.g., U.S. Securities and Exchange Commission [SEC] Proxy Statements, voluntary disclosures) to complete this assessment.

PROCEDURES #1 - 2 provides a guide to assist analysts in reviewing the Corporate Governance disclosure for completeness and help guide analysts through each of the major items of information required by Model #306. As noted above, concerns should be documented in the GPS, as there is no requirement or expectation for the analyst to create a separate CGAD checklist or create additional review documentation.

PROCEDURES #3 - 5 provides a guide to assist analysts in summarizing any concerns relative to the insurer or insurance group's corporate governance and its impact.

PROCEDURES #6 - 8 assist analysts in assessing the corporate governance practices of IAIGs on an annual basis.

COMPLIANCE WITH CORPORATE GOVERNANCE DISCLOSURE REQUIREMENTS

The following procedures are intended to guide the analyst through a review of the CGAD. These procedures do not represent a documentation requirement.

1. Does the disclosure provide information regarding the following areas as required by Model #306?
    a. The insurer's or insurance group's corporate governance framework and structure including consideration of the following.
        i. The Board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and
        ii. The duties of the Board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of Chief Executive Officer (CEO) and Chair of the Board within the organization.
    b. The policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:
        i. How the qualifications, expertise and experience of each Board member meet the needs of the insurer or insurance group.
        ii. How an appropriate amount of independence is maintained on the Board and its significant committees.
        iii. The number of meetings held by the Board and its significant committees over the past year as well as information on director attendance.

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iv. How the insurer or insurance group identifies, nominates and elects members to the Board and its committees. The discussion should include, for example:

1. Whether a nomination committee is in place to identify and select individuals for consideration.
2. Whether term limits are placed on directors.
3. How the election and re-election processes function.
4. Whether a Board diversity policy is in place and if so, how it functions.

v. The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).

c. The policies and practices for directing senior management, including a description of the following factors:

i. Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

1. Identification of the specific positions for which suitability standards have been developed and a description of the standards employed.
2. Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

ii. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

1. Compliance with laws, rules, and regulations.
2. Proactive reporting of any illegal or unethical behavior. [1]

iii. The insurer's or insurance group's processes for performance evaluation, compensation, and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Commissioner to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk-taking. Elements to be discussed may include, for example:

1. The Board's role in overseeing management compensation programs and practices.
2. The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid.
3. How compensation programs are related to both company and individual performance over time.
4. Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels.
5. Any "clawback" provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted.

[1] See additional discussions of conflicts of interest, which could be covered in this section of the CGAD under Assessment of U.S.-Based Internationally Active Insurance Group Corporate Governance below.

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6. Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk- management objectives are met by incentivizing its employees.

iv. The insurer's or insurance group's plans for CEO and senior management succession.

d. The insurer or insurance group shall describe the processes by which the Board, its committees and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

i. How oversight and management responsibilities are delegated between the Board, its committees and senior management;

ii. How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks;

iii. How reporting responsibilities are organized for each critical risk area. The description should allow the commissioner to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the Board. This description may include, for example, the following critical risk areas of the insurer:

1. Risk management processes (an ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to the *Risk Management and Own Risk and Solvency Assessment Model Act (Model #505)*);

2. Actuarial function

3. Investment decision-making processes

4. Reinsurance decision-making processes

5. Business strategy/finance decision-making processes

6. Compliance function

7. Financial reporting/internal auditing

8. Market conduct decision-making processes

2. If the insurer or insurance group has not disclosed specific information listed in Procedure 1 above, was other information included that adequately describes why such information was not included?

Assessment of Corporate Governance Disclosure

3. Is the analyst aware of any significant and material corporate governance information not reported in the disclosure? If "yes," refer to the Management Considerations section of IV.A. Financial Analysis and Reporting Considerations for additional guidance.

4. Do any of the concerns pose an immediate risk to the insurer's or insurance group's operations, policyholder surplus or capital position?

Assessment of U.S.-Based Internationally Active Insurance Group—Corporate Governance

5. Based on the analyst's review of the CGAD and any additional information received (e.g., biographical affidavits, conflict of interest statements), document any material concerns related to the individual and collective suitability of Board members, senior management and key persons in control functions at the IAIG.

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a. In reviewing the information received and assessing suitability, consider whether the IAIG Board has the necessary information and processes in place to understand the group-wide corporate governance framework and structure; activities of the legal entities and associated risks; supervisory regimes applicable to the IAIG; issues that arise from cross-border business and international transactions; and the risk management, compliance, audit, actuarial, and related areas of the group.

b. In reviewing the information received, consider whether the group-wide corporate governance framework includes policies and processes to identify and avoid, or manage, conflicts of interest that may adversely affect the IAIG as a whole or any of its legal entities.

6. Based on the analyst's review of the CGAD and any additional information received, document any material concerns related to the appropriateness of the corporate governance framework, given the structure, business, and risks of the IAIG, including the risks of its legal entities; and the reporting lines in place between the material legal entities and the head of the IAIG.

   a. Consider what role or influence the head of the IAIG plays in setting corporate governance expectations at the legal entity level, including establishing the "tone at the top."

7. Based on the analyst's review of the CGAD and any additional information received, document any material concerns related to whether the IAIG's group-wide governance structure promotes effective oversight of the group-wide operations independent of day-to-day management.

For the U.S. lead state:

- ❑ Analysts should update the Group Profile Summary and Supervisory Plan with any material information.
- ❑ Analysts should notify the domestic state of any issues that are only relevant to a particular insurance entity in the group and share the relevant information from the CGAD with that state in a timely manner.
- ❑ Analysts should communicate to the examiner-in-charge (EIC) any prospective risks identified in the review of the corporate governance annual disclosure that affects the domestic insurer. In addition, analysts should share information or open items related to group-wide corporate governance assessments with the EIC to facilitate the effective review and follow-up of the analysis during on-site exam activities.

Recommendations for further action, if any, based on the overall conclusion above:

For the U.S. lead state that is also the group-wide supervisor:

- ❑ Contact the holding company seeking explanations or additional information
- ❑ Meet with the holding company management
- ❑ Suggest that assessment or follow-up procedures be completed during the next examination
- ❑ Pursue, as appropriate, within an international supervisory college
- ❑ Other (explain)

<u>For the U.S. lead state that is not the group-wide supervisor:</u>

- ❑ Contact the group-wide supervisor, seeking explanations or additional information
- ❑ Pursue, if applicable and as appropriate, within an international supervisory college
- ❑ Other (explain)

<u>For a non-lead state:</u>

- ❑ Contact the lead state, seeking explanations or additional information if questions exist about information noted in the GPS
- ❑ Pursue, if applicable and as appropriate, within an international supervisory college (if applicable)

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INTRODUCTION

The process for assessing enterprise risk management (ERM) within the group will vary depending upon its structure and scale. Approximately 90 percent of the U.S. premium is subject to reporting an annual Own Risk Solvency Assessment (ORSA) Summary Report. However, all insurers are subject to an assessment of risk management during the risk-focused analysis and examination, and this review is a responsibility of the lead state. In addition, all groups are required to submit the Form F - Enterprise Risk Report under the requirements of the NAIC *Insurance Holding Company System Regulatory* Act (#440) unless they have been granted an exemption by the state. In addition, both the ORSA Summary Report and the Form F are subject to the supervisory review process, which contemplates both off-site and on-site examination of such information proportionate to the nature, scale and complexity of the insurer/group's risks. Those procedures are discussed in the following two sections. In addition, any risks identified throughout the entire supervisory review process are subject to further review by the lead state in either the periodic meeting with the insurer/group and/or any targeted examination work. When reviewing the ORSA and Form F, the lead state analyst should consider consistency between the documents, as well as information provided in the Corporate Governance Annual Disclosure (CGAD).

ORSA SUMMARY REPORT

The NAIC *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) requires insurers above a specified premium threshold, and subject to further discretion, to submit a confidential annual ORSA Summary Report. Model #505 gives the individual insurer and the insurance group discretion as to whether the report is submitted by each individual insurer within the group or by the insurance group as a whole. Regardless of whether the ORSA is filed on an individual or group basis, any noninsurance operations that present material and relevant risks to the insurer should be included in the scope of the ORSA Summary Report. (See the NAIC *Own Risk Solvency Assessment Guidance Manual* (ORSA Guidance Manual) for further discussion).

- **Lead State:** In the case where the insurance group chooses to submit one ORSA Summary Report for the group, it must be reviewed by the lead state. The lead state is to perform a detailed and thorough review of the information and initiate any communications about the ORSA with the group. The suggestions below set forth some possible considerations for such a review. At the completion of this review, the lead state should prepare a thorough summary of its review, which would include an initial assessment of each of the three sections. The lead state should also consider and include key information to share with other domestic states that are expected to place significant reliance on the lead state's review. The lead state should share the analysis of ORSA with other states that have domestic insurers in the group. The group ORSA review and sharing with other domestic states should occur within 120 days of receipt of the ORSA filing.
- **Non-Lead State:** Non-lead states are not expected to perform an in-depth review of the ORSA, but instead rely on the review completed by the lead state. The non-lead states' review of the lead state's ORSA review should be performed only for the purpose of having a general understanding of the work performed by the lead state, and to understand the risks identified and monitored at the group-level so the non-lead state may better monitor and communicate to the lead state when its legal entity could affect the group. Any concerns or questions related to information in the ORSA or group risks should be directed to the lead state.
- **Single Insurer ORSA:** In the case where there is only one insurer within the insurance group, or the group decides to submit separate ORSA Summary Reports for each legal entity, the domestic state is to perform a detailed and thorough review of the information, which would include an initial assessment of each of the three sections and initiate any communications about the ORSA directly with the legal entity. Such a review should also be shared with the lead state (if applicable) so it can develop an understanding of the risks within the entire insurance group. Single insurer ORSA reviews should be completed within 180 days of receipt of the ORSA filing.

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Throughout a significant portion of the remainder of this document, the term "insurer" is used to refer to both a single insurer for those situations where the report is prepared by the legal entity, as well as to refer to an insurance group. However, in some cases, the term group is used to reinforce the importance of the group-wide view. Similarly, throughout the remainder of this document, the term "lead state" is used before the term "analyst" with the understanding that in most situations, the ORSA Summary Report will be prepared on a group basis and therefore reviewed by the lead state.

Background Information

To understand the appropriate steps for reviewing the ORSA Summary Report, regulators must first understand the purpose of the ORSA. As noted in the ORSA Guidance Manual, the ORSA has two primary goals:

1. To foster an effective level of ERM at all insurers, through which each insurer identifies, assesses, monitors, prioritizes and reports on its material and relevant risks identified by the insurer, using techniques that are appropriate to the nature, scale and complexity of the insurer's risks, in a manner that is adequate to support risk and capital decisions.
2. To provide a group-level perspective on risk and capital, as a supplement to the existing legal entity view.

In addition, separately, the ORSA Guidance Manual discusses the regulator obtaining a high-level understanding of the insurer's ORSA and discusses how the ORSA Summary Report may assist the commissioner in determining the scope, depth and minimum timing of risk-focused analysis and examination procedures.

There is no expectation with respect to specific information or specific action that the lead state regulator is to take as a result of reviewing the ORSA Summary Report. Rather, each situation is expected to result in a unique ongoing dialogue between the insurer and the lead state regulator focused on the key risks of the group. For this reason, as well as others, the lead state analyst may want to consider additional support in the form of a broader review team as necessary in reviewing the ORSA Summary Report, subject to the confidentiality requirements outlined in statute. In reviewing the final ORSA filing prior to the next scheduled financial examination, the analyst should consider inviting the lead state examiner to participate on the review team. Regardless of which individuals are involved on a review team, the 120-day or 180-day timeliness standards are applicable to the review. Additionally, the lead state analyst and examiner may want to include the review team in ongoing dialogues with the insurer since the same team will be part of the ongoing monitoring of the insurer and an ORSA Summary Report is expected to be at the center of the regulatory processes.

These determinations can be documented as part of each insurer's ongoing supervisory plan. However, the ORSA Guidance Manual also states that each insurer's ORSA will be unique, reflecting the insurer's business model, strategic planning and overall approach to ERM. As regulators review ORSA Summary Reports, they should understand that the level of sophistication for each group's ERM program will vary depending upon size, scope and nature of business operations. Understandably, less complex insurers may not require intricate processes to possess a sound ERM program. Therefore, regulators should use caution before using the results of an ORSA review to modify ongoing supervisory plans, as a variety of practices may be appropriate depending upon the nature, scale and complexity of each insurer.

General Summary of Guidance for Each Section

The guidance that follows is designed to assist the lead state analyst in the review of the ORSA and to allow for effective communication of analysis results with the non-lead states. It is worth noting that this guidance is expected to evolve over the years, with the first couple of years focused on developing a general understanding of ORSA and ERM. It should be noted that each of the sections can be informative to the other sections. As an example, Section II affords an insurer the opportunity to demonstrate the robustness of its process through its assessment of risk exposure. In some cases, it's possible the lead state analyst may conclude the insurer did not summarize and include information about its framework and risk management tools in Section I in a way that

allowed the lead state analyst to conclude its effectiveness, but in practice by review of Section II, such a conclusion was able to be reached. Likewise, the lead state analyst may assess Section II as effective but may be unable to see through Section III how the totality of the insurer's system is effective because of a lack of demonstrated rigor documented in Section III. Therefore, the assessment of each section requires the lead state analyst to consider other aspects of the ORSA Summary Report. This is particularly true of Section I, because as discussed in the following paragraphs, the other two sections have very distinct objectives, whereas the assessment of Section I is broader.

Background information procedures are provided to assist the regulator in gaining an overall understanding of the ORSA Summary Report and assessing compliance with ORSA Guidance Manual reporting requirements (i.e., attestation, and entities in scope).

Section I procedures are focused on assessing the insurer's overall risk management framework. The procedures are presented as considerations to be taken into account when reviewing and assessing an insurer's implementation of each of the risk management principles highlighted in the NAIC's ORSA Guidance Manual. In assessing implementation, regulators should consider whether the design of ERM/ORSA practices appropriately reflects the nature, scale and complexity of the insurer.

Section II takes a much different approach. It provides guidance to allow the lead state analyst to better understand the range of practices they may see in ORSA Summary Reports. However, such practices are not intended to be requirements, as that would eliminate the "Own" aspect of the ORSA and defeat its purpose. As such, analysts should not expect or require insurers to organize or present their risks in a particular manner (i.e., by branded risk classification). Rather, the guidance can be used in a way to allow the lead state analyst to better understand the information in this section. Section II guidance has been developed around reviewing key risks assessed by the insurer, evaluating information provided on the assessment and mitigation of those risks and classifying them within the nine branded risk classifications outlined in the Handbook, which are used as a common language in the risk-focused surveillance process for ongoing tracking and communication. As such, the analyst should attempt to classify each key risk assessed by the insurer into a branded risk classification(s) for incorporation into general analysis documentation Insurer Profile Summary (IPS) or Group Profile (GPS) as appropriate. The branded risk classifications are intentionally broad in order to allow almost any risk of an insurer to be tracked within one or more categories, but the analyst may also use an "Other" classification as necessary to track exposures.

Section III is also unique in that it provides a specific means for assisting the lead state analyst in evaluating the insurer's determinations of the reasonableness of its group capital and its prospective solvency position on an ongoing basis. Section III of the ORSA Summary Report is intended to be more informative regarding capital than other traditional methods of capital assessment since it sets forth the amount of capital the group determines is reasonable to sustain its current business model rather than setting a minimum floor to meet regulatory or rating agency capital requirements.

Background Information

The ORSA Guidance Manual encourages discussion and disclosure of key pieces of information to assist regulators in reviewing and understanding the ORSA Summary Report. As such, the following considerations are provided to assist the regulator in reviewing and assessing the information provided in these areas.

- **Attestation** – The report includes an attestation signed by the chief risk officer (CRO) (or other executive responsible for ERM oversight) indicating that the information presented is accurate and consistent with ERM reporting shared with the board of directors (or committee thereof).
- **Entities in Scope** – The scope of the report is clearly explained and identifies all insurers covered. The scope of a group report also indicates whether material non-insurance operations have been covered. The lead state analyst could utilize Schedule Y, the Lead State report and other related tools/filings to review which entities are accounted for in the filing.
- **Accounting Basis** – The report clearly indicates the accounting basis used to present financial information

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in the report, as well as the primary valuation date(s).

- **Key Business Goals** – The report provides an overview of the insurer's/group's key business goals in order to demonstrate alignment with the relevant and material risks presented within the report.
- **Changes From Prior Filing(s)** – The report clearly discusses significant changes from the prior year filing(s) to highlight areas of focus in the current year review including significant changes to the ERM framework, risks assessed, stress scenarios, overall capital position, modeling assumptions, etc.

Review of Section I - Description of the Insurer's Risk Management Framework

The ORSA Guidance Manual requires the insurer to discuss the key principles below in Section I of the ORSA Summary Report. For purposes of evaluating the ORSA Summary Report, and moreover, the lead state analyst's responsibility to assess the insurer's risk management framework, the lead state analyst should review the ORSA Summary Report to ascertain if the framework meets the principles. Additional guidance is included to provide further information on what may be contemplated in assessing such principles.

Key Principles:

A. Risk Culture and Governance

B. Risk Identification and Prioritization

C. Risk Appetite, Tolerances and Limits

D. Risk Management and Controls

E. Risk Reporting and Communication

Documentation for Section I

When reviewing the ORSA Summary Report, the lead state analyst should consider the extent to which the above principles are present within the insurer. In reviewing these principles, examples of various considerations are provided for each principle in the following sections. The intent in providing these considerations is to assist the lead state analyst in assessing the risk management framework. However, these considerations only highlight certain elements associated with the key principles and practices of individual insurers that may vary significantly. The lead state analyst should document a summary of the review of Section I by outlining key information and developing an assessment of each of the five principles set forth in the ORSA Guidance Manual using the template located in the next section of this Handbook.

A. Risk Culture and Governance

It is important to note some insurers view risk culture and governance as the cornerstone to managing risk. The ORSA Guidance Manual defines this item to include a structure that clearly defines and articulates roles, responsibilities, and accountabilities, as well as a risk culture that supports accountability in risk-based decision making. Therefore, the objective is to have a structure in place within the insurer that manages reasonably foreseeable and relevant material risk in a way that is continuously improved. Key considerations in reviewing and assessing risk culture and governance might include, but are not limited to:

- **Roles and Responsibilities** - Roles and responsibilities of key stakeholders in risk and capital management are clearly defined and documented in writing, including members of the board (or committee thereof), officers and senior executives, risk owners, etc.
- **Board or Committee Involvement** – The board of directors or appropriate committee thereof demonstrates active involvement in the oversight of ERM activities through receiving regular updates from management on ERM monitoring, reporting and recommendations.
- **Strategic Decisions** – Directors, officers and other members of senior management utilize information generated through ERM processes in making strategic decisions.
- **Staff Availability and Education** – The insurer maintains suitable staffing (e.g., sufficient number, educational background, and experience) to support its ERM framework and deliver on its risk strategy. Staff is kept current in its risk education in accordance with changes to the risk profile of the insurer.
- **Leadership** – The chief risk officer (CRO), or equivalent position, possesses an appropriate level of knowledge and experience related to ERM and receives an appropriate level of authority to effectively

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fulfill responsibilities. This includes clear and direct communication channels between the CRO and the BOD or appropriate committee thereof.

- **Compensation** – The insurer demonstrates that incentives, compensation and performance management criteria have been appropriately aligned with ERM processes and do not encourage excessive risk taking given the capital position of the insurer.
- **Integration** – The insurer integrates and coordinates ERM processes across functional areas of the insurer including human resources, information technology, internal audit, compliance, business units, etc.
- **Assessment** – The insurer's ERM framework is subject to regular review and assessment, with updates made to the framework as deemed necessary.

B. Risk Identification and Prioritization

The ORSA Guidance Manual defines this as key to the insurer. Responsibility for this activity should be clear, and the risk management function is responsible for ensuring the processes are appropriate and functioning properly. Therefore, an approach for risk identification and prioritization may be to have a process in place that identifies risk and prioritizes such risks in a way that potential reasonably foreseeable and relevant material risks are addressed in the framework. Key considerations in reviewing and assessing risk identification and prioritization might include, but are not limited to:

- **Resources** – The insurer utilizes appropriate resources and tools (e.g., questionnaires, external risk listings, brainstorming meetings, conference calls with regulators, etc.) to assist in the risk identification process that are appropriate for its nature, size and structure.
- **Stakeholder Involvement** – All key stakeholders (i.e., directors, officers, senior management, business unit leaders, risk owners, etc.) are involved in risk identification and prioritization at an appropriate level.
- **Prioritization Factors** – Appropriate factors and considerations are utilized to assess and prioritize risks (e.g., likelihood of occurrence, magnitude of impact, controllability, speed of onset, etc.).
- **Process Output** – Risk registers, key risk listings and risk ratings are maintained, reviewed and updated on a regular basis.
- **Emerging Risks** – The insurer has developed and maintained a formalized process for the identification and tracking of emerging risks.

C. Risk Appetite, Tolerances and Limits

The ORSA Guidance Manual states that a formal risk appetite statement, and associated risk tolerances and limits are foundational elements of a risk management framework for an insurer. While risk appetites, tolerances and limits can be defined and used in different ways across different insurers, this guidance is provided to assist the regulator in understanding and evaluating the insurer's practices in this area.

Risk appetite can be defined as the amount of specific and aggregate risk that an insurer chooses to take during a defined time period in pursuit of its business objectives. Articulation of the risk appetite statement ensures alignment of the risk strategy with the business strategy set by senior management and reviewed and evaluated by the board. Not included in the ORSA Guidance Manual, but widely considered, is that risk appetite statements should be easy to communicate, be understood, and be closely tied to the insurer's strategy.

After the overall risk appetite for the insurer is determined, the underlying risk tolerances and limits can be selected and applied to business units and specific key risks identified by the insurer. "Risk tolerance" can be defined as the aggregate risk-taking capacity of an insurer. "Risk limits" can be defined as thresholds used to monitor the actual exposure of a specific risk or activity unit of the insurer to ensure that the level of actual risk remains within the risk tolerance. The insurer may apply appropriate quantitative limits and qualitative statements to help establish boundaries and expectations for risks that are hard to measure. These boundaries may be expressed in terms of earnings, capital, or other metrics (growth, volatility, etc.). The risk tolerances/limits provide direction outlining the insurer's tolerance for taking on certain risks, which may be established and communicated in the form of the maximum amount of such risk the entity is willing to take. However, in many cases these will be coupled with more specific and detailed limits or guidelines the insurer uses.

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Due to the varying level of detail and specificity that different insurers incorporate into their risk appetites, tolerances and limits, lead state regulators should consider these elements collectively to reach an overall assessment in this area and should seek to understand the insurer's approach through follow-up discussions and dialogue. Key considerations in reviewing and assessing risk appetites, tolerances and limits might include, but are not limited to:

- **Risk Appetite Statement** – The insurer has developed an overall risk appetite statement consistent with its business plans and operations that is updated on a regular basis and subject to appropriate governance oversight.
- **Risk Tolerances/Limits** – Tolerances and limits are developed for key risks in accordance with the overall risk appetite statement.
- **Risk Owners** – Key risks are assigned to risk owners with responsibility for risk tolerances and limits, including actions to address any breaches.

D. Risk Management and Controls

The ORSA Guidance Manual stresses managing risk as an ongoing ERM activity, operating at many levels within the insurer. This principle is discussed within the governance section above from the standpoint that a key aspect of managing and controlling the reasonably foreseeable and relevant material risks of the insurer is the risk governance process put in place. For many companies, the day-to-day governance starts with the relevant business units. Those units put mechanisms in place to identify, quantify and monitor risks, which are reported up to the next level based upon the risk reporting triggers and risk limits put in place. In addition, controls are also put in place on the backend, by either the ERM function or the internal audit team, which are designed to ensure compliance and a continual enhancement approach. Therefore, one approach may be to put controls in place to ensure the insurer is abiding by its limits. Key considerations in reviewing and assessing risk management and controls might include, but not limited to:

- **Lines of Accountability** – Multiple lines of accountability (i.e., business unit or risk owners, ERM function, internal audit) are put in place to ensure that control processes are effectively implemented and maintained.
- **Control Processes** – Specific control activities and processes are put in place to manage, mitigate and monitor all key risks.
- **Implementation of Tolerances/Limits** – Risk tolerances and limits are translated into operational guidance and policies around key risks through all levels of the insurer.
- **Indicators/Metrics** – Key risk indicators or performance metrics are put in place to monitor exposures, provide early warnings and measure adherence to risk tolerances/limits.

E. Risk Reporting and Communication

The ORSA Guidance Manual indicates risk reporting and communication provides key constituents with transparency into the risk-management processes as well as facilitates active, informal decisions on risk-taking and management. Transparency is generally available because of reporting that can be made available to management, the board, or compliance departments, as appropriate. However, the most important is how the reports are being utilized to identify and manage reasonably foreseeable and relevant material risks at either the group, business unit or other level within the insurer where decisions are made. Therefore, one approach may be to have reporting in place that allows decisions to be made throughout the insurer by appropriately authorized people, with ultimate ownership by senior management or the board. Key considerations in reviewing and assessing risk reporting and communication might include, but not limited to:

- **Training** – The importance of ERM processes and changes to the risk strategy are clearly communicated to all impacted areas and business units through ongoing training.
- **Key Risk Indicator Reporting** – Summary reports on risk exposures (i.e., key risk indicators) and compliance with tolerances/limits are maintained and updated on a regular basis.

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- **Oversight** – Summary reports are reviewed and discussed on a regular basis by the appropriate members of management, and when appropriate, directors.
- **Breach Management** – Breaches of limits and dashboard warning indicators are addressed in a timely manner through required action by management and, when appropriate, directors.
- **Feedback** – A feedback loop is embedded into ERM processes to ensure that results of monitoring and review discussions on key risks by senior management and the board are incorporated by business unit leaders and risk owners into ongoing risk-taking activities and risk management processes.

Overall Section 1 Assessment

After summarizing the information reviewed for each of the key principles individually, the lead state analyst should provide an overall assessment of the insurer's ERM framework, including any concerns or areas requiring follow-up investigation or communication. In preparing the assessment, the lead state analyst should understand that ORSA summary reports may not always align with each of these specific principles. Therefore, the lead state analyst must use judgment and critical thinking in accumulating information to support their evaluation of each of these principles. The overall evaluation should focus on critical concerns associated with any of the individual principles and should also address any other ERM framework concerns that may not be captured within these principles.

The lead state analyst should also be aware that the lead state examiner is tasked with supplementing the lead state analyst's assessment with additional onsite verification and testing. The lead state analyst should direct the lead state examiner to those areas where such additional verification and testing is appropriate and could not be performed by the lead state analyst. Where available from prior full scope or targeted examinations, information from the lead state examiner should be used as a starting point for the lead state analyst to update. Consequently, on an ongoing basis, the lead state analyst's update may focus on changes to ERM processes and the ORSA Summary Report since the prior exam in directing targeted onsite verification and testing.

The lead state analyst, after completing a summary of Section I, should consider if the overall assessment, or any specific conclusions, should be used to update either the ERM section of the GPS (if the ORSA Summary Report is prepared on a group basis) or information in the IPS (if the ORSA Summary Report is prepared on a legal entity basis). In addition, key information from the review should be incorporated into or referenced in the Risk Assessment Worksheet (RAW) during the next full analysis (quarterly or annual) of the insurer where relevant.

Review of Section II - Insurer's Assessment of Risk Exposure

Section II of the ORSA Summary Report is required to provide a high-level summary of the quantitative and/or qualitative assessments of risk exposure in both normal and stressed environments. The ORSA Guidance Manual provides examples of reasonably foreseeable and relevant material risk categories (e.g., credit, market, liquidity, underwriting, and operational risks). In reviewing the information provided in this section of the ORSA, lead state analysts may need to pay particular attention to risks and exposures that may be emerging or significantly increasing over time. To assist in identifying and understanding the changes in risk exposures, the lead state analyst may consider comparing the insurer's risk exposures and/or results of stress scenarios to those provided in prior years.

Section II provides risk information on the entire insurance group, which may be grouped in categories similar to the NAIC's nine branded risk classifications. However, this is not to suggest the lead state analyst or lead state examiner should expect the insurer to address each of the nine branded risk classifications. In fact, in most cases, they will not align, but it is not uncommon to see some similarities for credit, market, liquidity, underwriting and operational risks. A fair number of insurer risks may not be easily quantified or are grouped differently than these nine classifications. Therefore, it is possible the insurer does not view them as significant or relevant. The important point is not the format, but for the lead state analyst or lead state examiner to understand how the insurer categorizes its own risks and contemplate whether there may be material gaps in identified risks or categories of risks.

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Documentation for Section II

Prepare a summary and assessment of Section II by identifying and outlining key information associated with the significant reasonably foreseeable and material relevant (key) risks of the insurer per the ORSA Summary Report. Following the documentation on each key risk per the report, the lead state analysts should include an analysis of such risk. In developing such analysis, the lead state analyst is encouraged to use judgment and critical thinking in evaluating if the risks and quantification of such risks under normal and stressed conditions are reasonable and generally consistent with expectations. The lead state analyst should be aware that the lead state examiner is tasked to update the assessment by supplementing the lead state analyst's assessment with additional on-site verification and testing. The lead state analyst should direct the lead state examiner to those areas where such additional verification and testing is appropriate and could not be performed by the lead state analyst. Suggested information to be documented on each key risk, including supporting considerations, is outlined below:

- **Risk Title and Description** – Provide the title for each key risk as identified/labeled by the insurer as well as a basic description.
- **Branded Risk** – Provide information on the primary branded risk classification(s) that apply to the key risk and briefly discuss how they apply/relate.
- **Controls/Mitigation** – Summarize information known about the controls and mitigation strategies put in place by the insurer to address the key risk.
- **Risk Limits** – Provide information on any specific risk tolerances or limits associated with the key risk and how they are monitored and enforced.
- **Assessment** – Discuss how the key risk is assessed by the insurer, including whether the assessment is performed on a quantitative or qualitative basis. Describe the methodology used, the key underlying assumptions and the process utilized to set these assumptions.
- **Normal Exposure** – Summarize the insurer's normal exposure to this key risk based on budget information or historical experience.
- **Stress Scenario(s)** – Discuss the stress scenario(s) identified and applied to the key risk and how they were determined and validated by the insurer.
- **Stressed Exposure** – Provide information on the impact of the stress scenario(s) on the key risk and potential impact on the insurer's surplus position and business strategy/operations.
- **Inclusion on IPS/GPS** – Discuss whether the key risk will be recognized on the IPS/GPS of the insurer, including the risk component it will be incorporated into.
- **Regulator Review and Assessment** – Assess the adequacy of the risk assessment performed by the insurer on each key risk (including the appropriateness of controls/limits and reasonableness of methodology, assumptions and stress scenarios used) and whether any specific issues or concerns are identified that would require further investigation or follow-up communication.

After completing a summary and assessment for each key risk addressed in Section II, the lead state analyst should use the information to update the risk assessment in either the GPS (if the ORSA is prepared on a group basis) or the IPS (if the ORSA is prepared on a legal entity basis) and supporting documentation if deemed necessary. In addition, key information from the review should be incorporated into or referenced in the RAW during the next full analysis (quarterly or annual) of the insurer where relevant.

Overall Section II Assessment

The lead state analyst should complete an overall assessment of the information provided in Section II, including an evaluation of the insurer's risk assessment processes and whether all material and relevant risks were assessed and presented at an appropriate level of detail. This should include consideration of whether there is consistency between the insurer's risk identification and prioritization process discussed in Section I and risks that are assessed and reported on in Section II (i.e., have all key risks been addressed). In addition, this should focus on critical concerns associated with the assessment of individual key risks as well as whether the insurer's overall assessment

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process (i.e., methodology, assumptions and stress scenarios) is adequate and well-supported.

Review of Section III - Group Assessment of Risk Capital

In reviewing Section III of the ORSA Summary Report, the lead state analyst should recognize this section is generally presented in a summarized form. Although this section requires disclosure of aggregate available capital compared against the enterprise's risk capital (i.e., the amount deemed necessary to withstand unexpected losses arising from key risks), the report may not provide sufficient detail to fully evaluate the group capital position. As such, the lead state analyst may need to request the assistance of staff actuaries when available in evaluating the reasonableness and adequacy of the stress tests selected, request additional detail from the insurer in order to understand and evaluate the group capital position and/or refer additional investigation to the financial examination function.

The ORSA Guidance Manual requires the insurer to estimate its prospective solvency under stressed conditions by identifying stress scenarios that would give rise to significant losses that have not been accounted for in reserves. Furthermore, the Manual requires the insurer to estimate its prospective solvency in Section III by projecting the aggregate capital available and comparing it against the enterprise's risk capital. Insurers may include information in the ORSA Summary Report developed as part of their strategic planning and may include pro forma financial information that displays anticipated changes to key risks as well as projected capital adequacy in those future periods based on the insurer's defined capital adequacy standard. In reviewing information on prospective solvency, the lead state analyst should carefully consider projected changes to the group capital position as well as significant shifts in the amount of capital allocated to different risks, which could signal changes in business strategy and risk exposures.

In addition to evaluating the adequacy of capital, the insurer should also discuss the effect of liquidity risk on its overall solvency, including calls on the insurer's cash position due to microeconomic factors—i.e., internal operational—and/or macro-economic factors; i.e., economic shifts. The insurer should assess its resilience against severe but plausible liquidity stresses and whether the current liquidity position is within any liquidity risk appetite and/or limits. The insurer should describe in the ORSA the policies and processes in place to manage liquidity risk, as well as contingency funding or other plans to mitigate potential liquidity stresses.

Documentation for Section III

Insurance groups will use different means to manage capital and they will use different accounting and valuation frameworks. For example, they may determine the amount of capital they need to fulfil regulatory and rating agencies' requirements, but also determine the amount of capital (risk capital) they need to absorb unexpected losses that are not accounted for in the reserves. The lead state analyst may need to request management to discuss their overall approach to capital management and the reasons and details for each approach so that they can be considered in the evaluation of estimated risk capital.

Many insurers use internally developed capital models to quantify the risk capital. In these cases, the ORSA Summary Report should summarize the insurer's process for model validation to support the quantification methodology and assumptions chosen to determine risk capital. The lead state analyst should use the model validation information to assess the reasonableness of the quantification methodology and assumptions used. If the ORSA Summary Report does not provide a summary of the model validation process, the lead state analyst should request copy of the validation report prepared by the insurer. With regard to the determination of the risk capital under stressed conditions, because the risk profile of each insurer is unique, there is no standard set of stress conditions that each insurer should run. However, the lead state regulator should be prepared to dialogue with management about the selected stress scenarios if there is concern with the rigor of the scenario. In discussions with management, the lead state analyst should gain an understanding of the modeling methods used to project available and risk capital over the duration of the insurer's business plan as well as the potential changes to the risk profile of the insurer over this time horizon (i.e., changes to the list of key risks) based on the business plan. The aforementioned dialogue may occur during either the financial analysis process and/or the financial examination process.

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The lead state analyst, after completing a summary of Section III, should assess the overall reasonableness of the capital position compared to the group's estimated risk capital. Additionally, the lead state analyst should also consider if any of the information, or any specific conclusions, should be used to update either the GPS or IPS.

An assessment of the reasonableness of group risk capital and the process to measure it should be provided by developing a narrative that provides the following for each individual element of the insurer's assessment of risk capital:

- **Discussion of Capital Metric(s) Used** – Discuss the method(s) used by the group in assessing group risk capital and their basis for such a decision. Identify the capital metric(s) used to estimate group risk capital, as well as the level of calibration selected. Consider whether the capital metric(s) utilized to assess the group's overall capital target are clearly presented and described. Metrics may consist of internally developed economic capital models (deterministic or stochastic) and/or externally developed models, such as regulatory capital requirements for risk-based capital (RBC) or A.M. Best's Capital Adequacy Ratio (BCAR). In discussing calibration, consider both the method used (e.g., Value at Risk, Tail Value at Risk) and its level to evaluate whether the results are calibrated to an appropriate confidence level. Discuss whether the capital metric(s) selected address all key risks of the group. Of particular importance is considering whether the metric used fits the approach used to determine the group's risk appetite. Document the extent to which the lead state analyst believes the approach used by the insurer is reasonable for the nature, scale and complexity of the group and if this has any impact on the lead state analyst's assessment of the insurer's overall risk management.
- **Group Risk Capital - By Risk and in Aggregate** – Provide information on the amount of risk capital determined for each individual key risk and in aggregate. In reviewing the results for each individual risk, evaluate whether all key risks are adequately accounted for in the metric by assessing the amount of capital allocated to each risk. Consider significant changes in group risk capital from the prior filing, the drivers of such change, and any decisions made as a result of such movement.
- **Impact of Diversification Benefit** – Discuss the impact of any diversification benefit calculated by the group in aggregating its group risk capital. Diversification benefit is typically calculated by aggregating individually modeled risk capital and then accounting for potential dependencies among those risks to allow for an offset or reduction in the total amount of required capital (group risk capital). In evaluating the group's diversification benefit, consider whether the benefit is calculated based on dependencies/correlations in key risk components that are reasonable/appropriate.
- **Available Capital** – Provide information on and discuss the amount of capital available to absorb losses across the group, recognizing that there may be fungibility issues relating to capital trapped within various legal entities and jurisdictions for which regulatory restrictions and supervisory oversight constrain the extent and timing of capital movement across the group. Describe management's strategy to obtain/deploy additional capital across the group should the need arise. Determine if there is any double counting of capital through the stacking of legal entities.
- **Excess Capital** – Discuss the extent to which the group available capital amount exceeds the group risk capital amount per the ORSA Summary Report. In evaluating the overall adequacy of excess capital, consider any concerns outlined above relating to the capital metric(s), group risk capital, impact of diversification and available capital. If the level of excess capital or its availability/liquidity is of concern, evaluate the group's ability to remediate capital deficiencies by obtaining additional capital or reducing risk where required. If further concerns exist, contact the group to discuss and communicate with department senior management to determine whether additional investigation or regulatory action is necessary.
- **Impact of Stresses on Group Risk Capital** – Discuss whether additional stress scenarios have been applied to the model results to demonstrate the group's resiliency to absorb extreme unexpected losses, including severe by plausible liquidity stresses. This step is particularly important when reviewing the use of external capital models that may not be tailored to address the enterprise's specific exposures. Evaluate the range and adequacy of any stress scenarios applied and the resulting impact on the group's ability to accomplish its business strategy, provide sufficient liquidity and meet the capital expectations of rating agencies and regulators.

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- **Governance and Validation** – Discuss and evaluate the group's model governance process and the means by which changes to models are overseen and approved. Consider whether members of senior management are adequately involved. Discuss the extent to which the group uses model validation (including validation of data inputs) and independent review to provide additional controls over the estimation of group capital.
- **Prospective Solvency Assessment** – Discuss the information provided by the group on its prospective solvency position, including any capital projections and liquidity considerations. Consider whether the business goals of the insurer and its strategic direction are adequately discussed and incorporated into the prospective solvency assessment. For example, are expected changes in risk profile presented and discussed? Also consider whether prospective solvency is projected across the duration of the current business plan. To the extent the prospective assessment suggests that the group capital or liquidity position will weaken, or recent trends may result in certain internal limits being breached, the lead state analyst should understand and discuss what actions the insurer expects to take as a result of such an assessment (e.g., reduce certain risk exposure, raise additional capital, implement contingency funding plans, etc.).

Overall Section III Assessment

In addition, after summarizing the assessment of each individual element above, the lead state analyst should provide an overall assessment of the insurer's risk capital assessment process, including any concerns or areas requiring follow-up investigation or communication. The overall evaluation should focus on critical concerns associated with any of the individual elements noted above and should also address any other risk capital assessment concerns that may not be captured within these principles.

The lead state analyst, after completing a summary of Section 3, should consider if the overall assessment, or any specific conclusions, should be used to update either the ERM section of the GPS (if the ORSA Summary Report is prepared on a group basis) or information in the IPS (if the ORSA Summary Report is prepared on a legal entity basis). In addition, key information from the review should be incorporated into or referenced in the RAW during the next full analysis (quarterly or annual) of the insurer if relevant.

Feedback to the Insurer

After completing a review of the ORSA Summary Report, the lead state should provide practical and constructive feedback to the insurer related to the review. Feedback plays a critical role in ensuring the compliance and effectiveness of future filings. Feedback also provides a means for asking follow-up questions or requesting additional information to facilitate the review and incorporation of ORSA information into ongoing solvency monitoring processes.

During the review, topics for feedback communication to the insurer can be accumulated on **Appendix A** of the template. The appendix encourages the lead state to accumulate positive attributes to reinforce the effectiveness of certain practices and information in the summary report. In addition, the appendix encourages the lead state to identify areas for constructive feedback to encourage the insurer to provide additional information or clarify the presentation of certain items in future filings. Finally, the appendix encourages the lead state to list requests for additional information that may be necessary to complete a review and evaluation of the insurer's ORSA/ERM processes.

Suggested Follow-up by the Examination Team

After completing a review of the ORSA Summary Report, the lead state analyst should direct the lead state examiner to those areas that could benefit from focused inquiries and interviews during an on-site risk-focused examination. In some instances, the analyst may want the examiner to determine, through limited testing, if the data provided and processes described in the ORSA Summary Report are consistent with the insurer's ERM/ORSA operations. These items can be accumulated on **Appendix B** of the template for follow-up and communication. If there are specific reports, information and/or control processes addressed in the ORSA Summary Report that the

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lead state analyst feels should be subject to additional review and verification by the examination team, the lead state analyst is expected to provide direction as to its findings of specific items and/or recommended testing and such amounts should be listed in the template by the lead state analyst. During planning for a financial examination, the lead state examiner and lead state analyst should work together to develop a plan for additional testing and follow-up where necessary. The plan should consider that the lead state examiner may need to expand work to address areas of inquiry that may not be identifiable by the lead state analyst.

In addition to this specific expectation, during each coordinated financial condition examination, the exam team as directed by the lead state examiner and with input from the lead state analyst will be expected to review and assess the insurer's risk management function through utilization of the most current ORSA Summary Report received from the insurer. Also, the lead state analyst will ask the examination team to address the unresolved questions and concerns arising from the analyst's review of the ORSA documented in the template (see Appendix B), through focused inquiries and interviews and testing during an on-site risk-focused examination. Information included in the report and the operating effectiveness of various risk management processes can be supported/tested on a sample basis (e.g., reviewing certain supporting documentation from Section I; assessing the reasonableness of certain inputs into stress testing from Section II; and reviewing certain inputs, assumptions and outputs from internal capital models).

U.S.-BASED INTERNATIONALLY ACTIVE INSURANCE GROUP RISK MANAGEMENT ASSESSMENT CONSIDERATIONS

While the considerations covered in this chapter are generally applicable to all insurers/insurance groups filing an ORSA Summary Report, there are additional risk management assessment considerations for the supervision of internationally active insurance groups (IAIGs) that are outlined in the ORSA Guidance Manual. As such, U.S. lead states functioning as group-wide supervisors should document their assessment of the specific IAIG risk management practices, as highlighted in **Appendix C** of the template. If such practices are already assessed and documented in the general review template, the documentation provided in this appendix can state and cross-reference to where those practices are covered.

To complete the IAIG assessment, the group-wide supervisor may need to request and review additional information from the head of the IAIG, which could include an ORSA Summary Report, CGAD, and/or additional information on risk management practices at the head of the IAIG level. The group-wide supervisor should utilize other filings and resources already available to the department, including holding company filings—i.e., Form B, Form F—and public information sources, before requesting additional information to complete the assessment.

In completing the assessment, the group-wide supervisor should consider whether certain elements are more appropriately assessed and addressed, as necessary, during an on-site examination and coordinate with the examination function. In addition, the analysis function should follow up on findings from the previous examination, as well as identify and assess significant changes in operations and risk management functions at the head of the IAIG since the last examination, as appropriate.

FORM F - ENTERPRISE RISK REPORT

The 2010 revisions to Model #440 and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) introduced a new filing requirement for a Form F. The Form F requires the ultimate controlling person to identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The Form F may be completed using information contained in the financial statement, annual report, proxy statement, statement filed with a governmental authority, or other documents

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if such information meets the disclosure requirements. Form F is focused on disclosing the enterprise risk associated with the entire insurance holding company system including non-regulated entities. The Form F is filed with the lead state commissioner of the insurance holding company system for every insurer subject to registration under Model #440. Adoption of the applicable Form F and related confidentiality provisions outlined in the 2010 revisions to Model #440 is required for a state to be designated the lead state for Form F filings. Lead states and other domestic states receiving and sharing the Form F must have in place confidentiality agreements as prescribed in Model #440.

Lead State Responsibility for Analysis of Form F

The Lead State should take primary responsibility for reviewing the Form F filing and should incorporate any takeaways, risks or concerns into the GPS. Takeaways, risks and concerns should be incorporated into the ERM summary in the GPS and/or the discussion of various branded risks, as deemed appropriate. There is no requirement or expectation to create a separate Form F checklist or create additional review documentation for sharing with another state or for internal documentation purposes.

If the Form F highlights any issues or risks that are only relevant to a particular insurance entity in the group, the Lead State should notify the domestic state of the issue and share the relevant information from the Form F with that state in a timely manner.

Non-Lead State Reliance on the Lead State Analysis of Form F

The Form F must be reviewed by the lead state and significant findings incorporated into the GPS. The non-lead state is encouraged to review the ERM summary and other information provided by the lead state in the GPS to access relevant information shared through Form F. There is no expectation of additional information shared by the lead state in this area, unless Form F highlights issues or risks that are only relevant to a particular insurance entity in the group. In that case, the non-lead state(s) should rely on the Lead State to proactively provide this information in a timely manner.

If there are material concerns noted in the GPS and additional information is needed, the non-lead state should request additional information from the lead state or company, if available. Such information could include additional information from the Form F filing, if relevant.

Upon the receipt of any additional information, the non-lead state should document any material concerns regarding enterprise risk that could impact the financial condition of the domestic insurer and conclude whether any of the risks identified pose an immediate material risk to the insurer's policyholder surplus or risk- based capital position, insurance operations (e.g., changes in writings, licensure, and organizational structure), balance sheet, leverage, or liquidity.

NAIC Enterprise Risk Report (Form F) Implementation Guide

In March 2018, the Group Solvency Issues (E) Working Group adopted *the NAIC Enterprise Risk Report (Form F) Implementation Guide,* which is located at:

https://content.naic.org/sites/default/files/inline-files/committees_e_isftf_group_solvency_related_form_f_guide.pdf

As outlined in the Guide, it is intended to assist insurers and regulators in maximizing the usefulness of the Form F by proposing best practices for consideration in preparing and reviewing filings. Therefore, while the Guide does not constitute authoritative guidance for information to be included in a Form F filing, filers are requested to consider the best practices outlined within the Guide when preparing their Form F filing. By adhering to the best practices outlined within the Guide, registrants will be able to reduce the extent of regulator follow-up and correspondence necessary to utilize the information provided, which should lead to a more effective and efficient process. The regulators' goal in developing this document was to provide some consistency and uniformity across states in reviewing and utilizing information obtained through the Form F. Therefore, it is recommended that states utilize the best practices outlined in the Guide to support their review and feedback process.

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Insurance holding company systems are expected to provide a Form F filing to the appropriate regulator on an annual basis, unless they have been granted an individual exemption from the reporting provisions. Situations where it might be appropriate to consider granting an exemption could include the following:

- An ORSA Summary Report has been filed with the commissioner at the ultimate controlling person (UCP) level and addresses all enterprise risk exposures that would be disclosed in a Form F filing.
- Based on the very limited size, structure and nature of an insurance holding company system, the Form F filing would not provide additional valuable information to the commissioner.

PROCEDURES #1 - 2 provides a guide to assist analysts in reviewing the Form F filing for completeness and help guide analysts through each of the major items of information required by Form F. Analysts should review Form F in conjunction with a review of Form B and should document any nondisclosure of information. As noted above, concerns should be documented in the GPS, as there is no requirement or expectation for the analyst to create a separate Form F checklist or create additional review documentation.

PROCEDURES #3 - 7 provides a guide to assist analysts in evaluating the risks described within Form F. Analysts should consider whether any enterprise risks not reported in Form F exist, and for all risks identified both within Form F and by analysts, analysts should review information available and document any concerns. Analysts should also evaluate whether the risks identified result in an impact to the insurer's financial condition (e.g., surplus, RBC, insurance operations, balance sheet, leverage, and liquidity. Risks and concerns should be documented in the GPS.

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ORSA Review Template

Group/Insurer: _____
Group Code/CoCode: _____
State _____
Valuation Date: _____
Submission Date: _____

General Instructions:

This template is intended to be used to document a review and assessment of the ORSA Summary Report by the lead/domestic state. Regulators should document the results of their annual review of the ORSA and utilize the appendixes to track and communicate feedback to the insurer and procedures for regulatory follow-up. See VI.E. Group-Wide Supervision – Enterprise Risk Management Process Risks Guidance for additional guidance in completing this template.

Prepared/Reviewed By:	Date:

Date of Last Exam:	
Date of Next Exam:	

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Background Information

Summarize and assess background information provided in the report, where available. Key documentation elements are presented below.

1. **Attestation**:

2. **Entities in Scope:**

3. **Accounting Basis:**

4. **Key Business Goals:**

5. **Changes from Prior Filing(s):**

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Section I – Description of the Insurer's Enterprise Risk Management (ERM) Framework

Summarize and assess key information from Section I of the ORSA Summary Report for each of the five principles of a risk management framework.

1. **Risk Culture and Governance:**

2. **Risk Identification and Prioritization:**

3. **Risk Appetite, Tolerances and Limits:**

4. **Risk Management and Controls:**

5. **Risk Reporting and Communication:**

Overall Section 1 Assessment—After reviewing and considering each principle individually, develop an overall assessment of the group's/insurer's risk management framework including any concerns or areas requiring follow-up investigation or communication:

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Section II – Insurer Assessment of Risk Exposures

Prepare documentation summarizing a review and assessment of information provided on the reasonably foreseeable future and relevant material risks of the insurer/group.

THE FOLLOWING TABLE SHOULD BE COMPLETED FOR EACH KEY RISK

Risk Title/Description	
Branded Risk(s)	
Controls/Mitigation	
Risk Limits	
Assessment (QT/QL)	
Normal Exposure	
Stress Scenario(s)	
Stressed Exposure	
Inclusion on GPS/IPS	
Regulator Review & Assessment:	

Overall Section 2 Assessment—After reviewing and considering each key risk individually, develop an overall conclusion regarding the group's/insurer's process to assess key risk exposures including any concerns or areas requiring follow-up investigation or communication:

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Section III – Assessment of Risk Capital and Prospective Solvency

Prepare documentation summarizing a review and assessment of key elements of the risk capital and prospective solvency process as follows.

1. **Discussion of Capital Metric(s) Used:**

2. **Group Risk Capital (GRC) – By Risk and In Aggregate:**

3. **Impact of Diversification Benefit:**

4. **Available Capital:**

5. **Excess Capital:**

6. **Impact of Stresses on GRC:**

7. **Governance and Validation:**

8. **Prospective Solvency Assessment:**

Overall Section III Assessment—After reviewing and considering each of the key elements individually, develop an overall assessment of the risk capital and prospective solvency of the insurer/group including any concerns or areas requiring follow-up investigation or communication:

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Appendix A – Feedback to Insurer

Feedback to the insurer on the ORSA Summary Report is critical for the compliance and effectiveness of future filings. The purpose of this form is to help the lead/domestic state gather and provide constructive and practical feedback to the insurer.

Positive Attributes:
1.
2.
3.

Constructive Feedback:
1.
2.
3.

Requests for Additional Information:
1.
2.
3.

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Appendix B – Recommended Exam Procedures/Areas for Follow-Up Investigation

In completing a review of the ORSA Summary Report, the lead state/domestic regulator should consider whether certain elements could benefit from focused inquiries and review during an on-site risk-focused examination. In some instances, the analyst may want the examiner to determine through limited testing, if the data provided and processes described in the ORSA Summary Report are consistent with the insurer's actual ERM/ORSA operations. Such procedures and issues can be accumulated here for communication and tracking.

Background Information

1.
2.
3.

Section I - ERM Framework

1.
2.
3.

Section II - Risk Assessment

1.
2.
3.

Section III - Risk Capital and Prospective Solvency

1.
2.

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Appendix C – U.S. Based IAIG Risk Management Assessment Considerations

While the considerations provided in this template are generally applicable to all insurers/insurance groups filing an ORSA Summary Report, there are additional risk management assessment considerations for the supervision of Internationally Active Insurance Groups (IAIGs) that have been incorporated into this template. As such, U.S. lead states functioning as group-wide supervisors should document their assessment of specific IAIG risk management practices here, if not already addressed above.

1. Based on the analyst's review of the ORSA Summary Report and any additional information received, assess whether the head of the IAIG ensures that the risk management strategy and framework (whether located at the Head of the IAIG or within another legal entity of the IAIG) encompasses the levels of the head of the IAIG and legal entities within the IAIG, promotes a sound risk culture, and covers:
    - diversity and geographical reach of activities;
    - nature and degree of risks in entities/business lines;
    - aggregation of risks across entities within the IAIG;
    - interconnectedness of entities within the IAIG; level of sophistication and functionality of IT/reporting systems at the group level; and
    - applicable laws and regulations.

2. Assess whether the risk management strategy is approved by the IAIG Board and implemented at the group level; with regular risk management reporting provided to the IAIG Board or one of its committees.

3. Assess whether the risk management function, the actuarial function and the internal audit function are involved in the risk management of the IAIG and which activities they perform.

4. Assess whether the risk management function coordinates and promotes consistent implementation, with any material differences in practices across the group being clearly documented and explained.

5. Assess whether the risk management function is adequately independent from risk taking activities.

6. Assess whether the head of the IAIG reviews, at least annually, the risk management framework to ensure that existing and emerging risks as well as changes in structure and business strategy are taken into account.
    - Assess whether the group-wide risk assessment framework, or components thereof, is independently reviewed[1] at least once every three years, in order to ascertain that it remains fit for the risk profile, structure and business strategy of the IAIG.
    - Assess whether necessary modifications and improvements are made to risk management framework in a timely manner.

[1] Independent review could be performed by internal audit function, if deemed independent from risk management functions of the group

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7. Assess whether the following key elements are appropriately incorporated and addressed within the IAIG's ORSA framework:
    - The ORSA should describe how risks are managed in a cross-border context across the IAIG. These risks should include at least: insurance risk, market risk, credit risk, liquidity risk, concentration risk, operational risk, group risk and strategic risk. The ORSA should also explain how assets are properly diversified and asset concentration risk is mitigated across the IAIG.
    - Mechanisms to keep track of intra-group transactions that have a significant impact on the IAIG, the risks arising from these transactions and the qualitative and quantitative restrictions on these risks.
    - The ORSA framework measures risks using an economic capital model that takes into account the risks faced in different sectors, jurisdictions and economic environments
    - The ORSA shows both the economic and the regulatory capital at the Head of the IAIG level and it includes a discussion of the fungibility of capital and the transferability of asset within the group
    - Risk measurement includes stress testing, including reverse stress testing and scenario analysis, as appropriate for its risk profile
    - Risk measurement demonstrates resilience of the total balance sheet against plausible macroeconomic stresses
    - Risk measurement also includes an assessment of aggregate investment counterparty exposures and analyzes the effect of stress events on those exposures through scenario analysis or stress testing
    - The ORSA reports on the IAIG's management of liquidity risks and assesses its resilience against severe but plausible liquidity stresses to determine whether current exposures are within the liquidity risk appetite and limits
        - The ORSA demonstrates that the IAIG maintains an adequate level of unencumbered highly liquid assets in appropriate locations, as well as a contingency funding plan to mitigate potential stresses
    - The ORSA discusses at a high-level the severe stresses that could trigger a recovery plan and should summarize the recovery options available. The ORSA should also discuss how the management information systems are able to produce information relevant to the recovery plan on a timely basis.

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Special Note: The following procedures do not supersede state regulation but are merely additional guidance an analyst may consider useful.

COMPLIANCE WITH REPORTING REQUIREMENTS

The following procedures are intended to guide the analyst through a review of the Form F. These procedures do not represent a documentation requirement.

1. Does Form F provide information regarding the following areas that could pose enterprise risk [provided such information is not disclosed in Form B – Insurance Holding Company System Annual Registration Statement]?
    a. Material developments regarding strategy, compliance or risk management affecting the insurance holding company system, or internal audit findings.
    b. Acquisition/disposition of insurance entities and/or reallocation of existing financial or insurance entities within the insurance holding company system.
    c. A change in shareholders of the insurance holding company system that exceed (10% or more of voting securities.
    d. Development in investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system.
    e. A business plan of the insurance holding company system and summarized strategies for the next 12 months.
    f. Identify material concerns of the insurance holding company system raised by the supervisory college.
    g. Identify capital resources and material distribution patterns of the insurance holding company system.
    h. Identify any negative movement, or discussions with rating agencies that may have caused, or may cause, potential negative movement in credit ratings and insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook).
    i. Corporate or parental guarantees throughout the insurance holding company system and the expected source of liquidity should such guarantees be called upon.
    j. Identify any material activity or development that, in the opinion of senior management, could adversely affect the insurance holding company system.

2. If the registrant/applicant has not disclosed information listed in procedure 1 above, did the registrant/applicant include a statement that, to the best of his or her knowledge and belief, he or she has not identified enterprise risk subject to disclosure?

ASSESSMENT OF FORM F – ENTERPRISE RISK REPORT

3. Is the analyst aware of any enterprise risk to the insurer not reported in Form F?
4. Based on the analyst's review of Form F and any additional information related to enterprise risk available (e.g., Form B, other filings), document any material concerns regarding enterprise risk to the group.
5. Do any of the risks identified pose an immediate risk to policyholder surplus or risk-based capital position of insurers in the group?
6. Do any of the risks identified result in material impact to the insurance operations of the group? (e.g., changes in writings, licensure, and organizational structure)?

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7. Do any of the risks identified result in material impact to the group's balance sheet, leverage or liquidity?

For the U.S. Lead State:

- ❑ Analysts should update the Group Profile Summary and the Supervisory Plan with the risks identified and results from the Form F review.
- ❑ Analysts should notify the domestic state of any issues that are only relevant to a particular insurance entity in the group and share the relevant information from the Form F with that state in a timely manner.
- ❑ Analysts should communicate to the examiner-in-charge (EIC) any prospective risks identified in the review of Form F that affects the domestic insurer.

RECOMMENDATIONS FOR FURTHER ACTION, IF ANY, BASED ON THE OVERALL CONCLUSION ABOVE

For the U.S. lead state that is also the group-wide supervisor

- ❑ Contact the holding company seeking explanations or additional information
- ❑ Meet with the holding company management
- ❑ Pursue, as appropriate, within an international supervisory college
- ❑ Other (explain)

For the U.S. lead state that is not the group-wide supervisor

- ❑ Contact the group-wide supervisor, seeking explanations or additional information
- ❑ Contact the holding company directly if deemed appropriate by the group-wide supervisor given the Form F is a U.S. only filing
- ❑ Pursue, if applicable and as appropriate, within an international supervisory college
- ❑ Other (explain)

For a non-lead state

- ❑ Contact the lead state, seeking explanations or additional information
- ❑ Pursue, if applicable and as appropriate, within an international supervisory college (if applicable)

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REVIEW OF THE GROUP CAPITAL CALCULATION

Consideration of the Insurance Holding Company System Structure

As the lead state begins to review the annual Group Capital Calculation (GCC) filing for a particular group, it is important for the lead state to do so with consideration of the existing knowledge of both the organizational structure of the group, including changes in the structure from year to year, but more importantly the overall activities of each of the entities in the group which otherwise have the potential to transmit material risk to the insurers within the group. While the GCC will provide additional quantitative information on the entities in the group, the actual activities of the entities are also important in determining the scope of application of the GCC. The lead state is responsible for determining if any of the entities in the holding company structure should be excluded from the calculation, resulting in a smaller "scope of application" for the entities included in the GCC ratio. The filing includes a column for the group to propose what should be excluded as well as an additional column for the final determination made by the lead state. In general, the determination of scope of the application is suggested by the group but made in consultation and agreement with the lead state. This exercise should be undertaken in a manner that yields a clearly documented rationale for excluding entities or subgroups of the larger group. The *Group Capital Calculation Instructions* describes the basis for making this determination and the calculation itself is structured to facilitate this determination, with the inclusion in Schedule 1 of financial data for all entities within the holding company. Related to exclusion from the calculation itself is review of data for cases in which subgroups are completely excluded from the larger group, particularly with regard to Schedule 1; the rationale for the exclusion(s) should be provided in the Group Profile Summary (GPS). The concept is that this Schedule 1 data should be utilized by the lead state in conjunction with its existing knowledge of the group and its activities (obtained from the Schedule Y, ORSA, Forms B/C, Form F, the non-insurance grid, etc.), and therefore likely material risks, to make this determination. To the extent the entities included in Schedule 1 differ from the analyst's knowledge of the group, further discussion and follow-up should be held with the group.

In the initial year(s) of a GCC filing, to help the analyst get comfortable with the Inventory and Schedule 1 process, consider the following:

- Gather appropriate background information for your group(s) (e.g., GPS, ORSA, RBC Reports, Schedule Y).
- Determine that all Schedule Y entities are listed in schedule 1 or in the Schedule BA list in the other information tab or that an entity's omission is understood / explained.
- Evaluate requests for exclusion of non-insurance/non- financial entities without material risk to determine if you agree with exclusion.
- Confirm that all insurers and financial entities are de-stacked in the inventory tab.
- Determine if grouping has been properly applied.
- Evaluate the level of risk assigned by the filer to financial entities without regulatory capital requirements.
- On a sample basis, check that the numbers reported in Schedule 1 and Inventory Tab look reasonable, especially for the insurers. A sample check should be sufficient.

The holding company structure and activities should also be utilized by the lead state in determining how to understand the GCC ratio. More specifically, information on structure can help in understanding the flow of capital used by the group among entities within the holding company structure. Also, understanding the following can assist in evaluating the flow of capital resources:

- Domestic insurance operations.
- International insurance operations.
- Banking or other financial services operations subject to regulatory capital requirements.

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- Financial and non-financial operations not subject to regulatory capital requirements. *

  *The GCC instructions provide examples of financial versus non-financial entities in this category. All financial entities should be included in the scope of application of the GCC. However, there can be a broad array of entities that could be considered financial. The lead state should document the rationale for cases in which it concludes that an entity that may be financial in nature can nonetheless be classified in the group's GCC filing as "non-financial" and thus excluded from the scope of the group for the GCC.

GCC as Input into Group Profile Summary

The GCC is intended to be used as an input into the GPS. The expectation is that the GCC summary section will help to document a high-level summary of the analyst's take away of the GCC, as well as the Strategic branded risk. The manner in which the analyst determines what else should be documented beyond the GCC Summary and the Strategic branded risk should be based upon the following steps, since these steps contemplate the previously mentioned concept that the existing evaluation of the financial condition should be used in evaluating the depth of review of the GCC.

The GCC is a new analytical tool for use by regulators, and it will take a number of years before there is both: 1) sufficient data for any given group to provide the trend identification ultimately anticipated for the GCC; and 2) experience by regulators with its use. Analysts should be mindful that any stated threshold in the following procedures is for analysis purposes only and DOES NOT constitute a trigger for regulatory action. Rather, the stated threshold should be used as an opportunity for an analyst to understand issues and concerns that may be emerging and address them with the group, if needed. Nonetheless, the following procedure steps provide analysts with a framework to consider the GCC results in conjunction with other data and tools at their disposal, and to begin to gain and benefit from experience in utilizing the GCC as a new analytical tool.

- Procedure Step 1 suggests that a review of the components of the GCC is appropriate when the GCC ratio is trending downward.
- When Procedure Step 1 identifies the need to look further, Procedure Step 2 suggests determining, at a high level, the drivers of any decreases in the total available capital pursuant to the GCC. While there are numerous benefits of the GCC over consolidated approaches, the ability to drill down on the drivers is one of the more significant benefits and is consistent with the states' approach to not just looking at capital, but to the drivers of capital issues.
- When Procedure Step 1 identifies the need to look further, Procedure Step 3 suggests determining, at a high level, the driver of any increases in operating leverage, which is typically what drives insurance capital requirements up, be it asset risk/leverage or writings leverage. Similar to drivers of capital decreases, the GCC has detailed information on financial figures and ratios that can be used to isolate the issues.
- When either Procedure Step 2 or Step 3 identify the need to understand the situation better, Procedure Step 4 is similar in that it utilizes detailed information on capital allocation patterns used by the group over time that are necessary for the analyst to understand if there are any future negative trends in the GCC.
- When Procedure Step 2, Step 3 and Step 4 together identify the need to understand the situation better, Procedure Steps 5, helps understand the steps the group/company is already taking or plans to take in order to address the issues they feel are appropriate, if any, considering existing capitalization levels may drive the group's evaluation and therefore when steps may not be necessary.
- The guidance in these procedures is not intended to be exhaustive, but rather should give the analyst a starting point in better understanding the various issues.
- If the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document their understanding of the material risks of the group observable from the GCC (as well as the required information to be included in all GPS from the GCC), the rational for this determination should be documented by the analyst in any workpapers deemed appropriate by the state In

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making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgement based upon and existing understanding of the group and existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that decision.

Procedure Step 1 – Understand the Adequacy of Group Capital

1. Determine if the group capital position presents a risk its insurance subsidiaries based upon its recent trends and/or current measures in the GCC ratio.

	Branded Risk	*Benchmark*
a. Has there been a decrease in the GCC ratio over last two or more years? If "yes", determine the cause(s) of the decline.	ST	a. <-10% (this is not a point change)
b. Has there been a decrease in the GCC total available capital from prior year? If "yes", determine the cause(s) of the decline.	ST	<-10%
c. Has there been a negative trend in the GCC ratio over the past five years suggesting an overall pattern of declining capital?	ST	N/A

If the answer to any of the above questions is "yes", but it is obvious that the negative trend is caused by something such as a restriction on the allowable debt, or a change in a corporate tax rate, or some other factor external to the group's operations, note as such but do not proceed to Procedure Step 2. In addition, if it is obvious that the negative trend is clearly driven from one entity in the group, understand the cause and document as such but do not proceed to Procedure Step 2. However, in all other cases if the answer to any of the above questions is "yes", then the analyst should proceed with Procedure Step 2, understand decreases in total GCC available capital and/or procedure step 3, understand increases in operating leverage to determine the cause(s) of the negative trends.

Procedures Step 2 – Understand Decreases in Total Available Capital

2. Determine the source(s) of decreases in the GCC ratio or the GCC total available capital.

Recognizing that not all declines in capital ratios are necessarily "negative", i.e., they may be the result of sound capital management and Enterprise Risk Management (ERM) to more efficiently utilize capital, approved changes in the scope of application, or changes in underlying authority requirements, the intent of Procedure Step 2 (and Step 3) is to determine the actual source of the negative issues. In most cases, this equates to pinpointing the legal entity(ies) driving any negative trends. The analyst should proceed to Procedure Steps 4 and 5, to understand more fully the actions the group, or the legal entity(ies) driving the negative trends, are already taking or plan to take to address the issues identified in Procedure Step 2 that the group believes is needed. However, the analyst may already have a deep understanding of any such plans, and as a result, in some cases, it is possible that no further follow-up with the group will be necessary and that the lead state should simply update the GPS to be certain the main understanding of the issues is known to all regulators utilizing the GPS.

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	Branded Risk	*Benchmark*
a. Review the ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends.		<-10%
b. If the change in the GCC is not driven from a legal entity, and instead the change in allowable debt, note as such.	ST	N/A
c. Review the levels of profitability for each of the reported entities in the GCC in the current and prior years (as reported in the GCC) to determine if there are particular entities showing losses or signs of material decreasing profitability, which may eventually lead to future decreases in the GCC ratio or total available capital.	OP, PR/UW	<-10%
d. For each of the reported entities showing either 1) a meaningful decrease in the GCC due to a decrease in the total available capital, or 2) material negative profitability trends, request information that identifies the issues by inquiring of the legal entity regulator first or the group itself (e.g., non-insurance company), if applicable.	OP, PR/UW, ST	N/A
e. If due to pricing or underwriting issues, understand if the issues are the result of known pricing policies that are currently being modified or if the business is in runoff, whether new product lines have been developed, geographic or other concentrations, volume/growth business strain, or other issues. When considering pricing that is being modified, include those products for which the price is adjusted through crediting rates.	PR/UW	N/A
f. If due to reserve issues, understand the reserve development trends, whether reserve and pricing adjustments have been made and changes in business strategy apart from those products.	RV, ST	N/A
g. If due to market risk issues—i.e., capital losses—understand not only why the losses occurred, but also the likely near-term impact given current and likely prospective economic conditions. Market issues include not only changes in equity prices, but also impact/exposure to interest rates and other rates such as foreign currency exchange rates or rates on various hedging products used by the group.	MK, CR	N/A
h. If due to strategic issues such as planned growth, planned decline in writings or changes in the investment strategy, utilize the business plan from the Form F to better understand the anticipated changes and how the actual changes compare. Understanding the variance from the business plan is important in assessing the ongoing risk either in projected future profitability or in some cases the investments.	ST, PR/UW, OP	N/A

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i. If due to negative reputational issues, for example, that have adversely affected new business or retention of existing business, understand the issues more closely, whether potential ongoing changes in stock prices or financial strength ratings that may further affect market perception, or what the group is doing to address the potential future impact be it sales projections or access to the capital markets.	RP	N/A
j. If due to credit losses, understand the current and future concentration in credit risks, be it investments, reinsurance, or other source of credit losses.	CR, MK	N/A
k. If due to operational issues, such as extremely large catastrophe events, information technology (IT) or cybersecurity events or relationships, understand the current and prospective impact.	OP, ST	N/A
l. If due to legal losses, understand the underlying issues and degree of potential future legal losses.	LG	N/A
m. If due to non-insurance reported entities in the group, understand the relationship of the non-insurance operations to the insurance entities and the potential impact to the insurance operations (i.e., intercompany agreements, services, capital needs, etc.).	ST, OP	N/A

Procedure Step 3 – Understand Increases in Operating Leverage

3. Determine the source(s) of any decreases in the GCC ratio due to increases in leverage.

Like Procedure Step 2, the intent of Procedure Step 3 is to determine the actual source of the negative issues. The difference between step 3 and step 2 is simply the types of issues. Procedure Step 2 is focused on issues that have resulted in negative capital trends. Step 3; however, is focused on the issues that affect the risk being considered in the GCC. In most cases that risk is either from the asset side or from the liability side where in both cases there has been an increase in such risk that has not been offset by a corresponding or equal increase in capital. In general, this is referred to as operating leverage, where this risk can manifest itself either through increased insurance writings (e.g., the ratio of premiums to capital or liabilities to capital), or through increased assets that also carry risk. The expectation is that other regulated entities also have capital requirements that increase as these different types of risks increase, similar to how the NAIC RBC considers different types of products and assets that carry more risk. It is also possible to have increased leverage outside of the insurance companies and other regulated entities. However, similar to other items noted in this document, such increases do not necessary represent negative trends; the analyst should further understand the drivers of such. In most cases, this equates to pinpointing the legal entity(ies) driving any negative trends. Similar to Procedure Step 2, using an understanding of items in Procedure Step 4, to understand more fully the actions the group, or the legal entity(ies) driving the negative trends already being taken or planned to be taken by the group to address the issues identified in Procedure Step 2 that the group believes is needed.

	Branded Risk	*Benchmark*
a. Review the ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to	MK, CR, RV, ST, OP, RP	<-10%

the negative trends based upon corresponding increases in leverage (e.g., writings/capital ratios or liability to capital ratios).		
b. Review the levels of operating leverage for each of the reported entities in the GCC as well as the same for the prior years as reported in the GCC to determine if there are particular entities showing signs of increasing operating leverage which may lead to future decreases in the GCC ratio or total available capital.	MK, CR, RV, ST, OP, RP	<-10%
c. For each of the reported entities contributing to a meaningful decrease in the GCC due to an increase in operating leverage, request information that identifies the issues by inquiring first from the legal entity regulator or the group itself (e.g., non-insurance company), if applicable.	MK, CR, RV, ST, OP, RP	N/A
d. If operating leverage has increased, consider if growth may have resulted from underpriced products or a change in underwriting. Specifically inquire to determine if pricing was reduced to increase sales, or whether the growth is in new product lines or new geographic focus where the group may not have expertise. When considering pricing being modified, include those products that the price is adjusted through crediting rates.	PR/UW, OP, ST	N/A
e. If operating leverage has increased, consider if reserving risk has also increased, through potential underpricing that ultimately manifests itself into reserve adjustments. To do so, obtain current profitability information on the products leading to the increased leverage.	RV	N/A
f. If operating leverage has increased, obtain current information on the asset mix to be certain that there is a corresponding decrease in riskier assets to mitigate the otherwise likely increase in market and credit risk.	CR, MK	N/A

The analyst should proceed to Procedure Step 4 and Procedure Step 5 to understand more fully the actions the group, or the legal entity(ies) driving the negative trend, is already taking or plan to take to address the issues identified in Procedure Step 3, if that is not already clear from the information obtained in Procedure Step 3. However, in some cases, it is possible that no further follow up with the group will be necessary, and that the lead state should simply update the GPS.

Procedure Step 4 – Understand the Capital Allocation Patterns

4. Determine the capital allocation patterns to determine if some entities may put pressure on other legal entities.

Procedure Step 2 and Procedure Step 3 are critical in understanding the issues faced by the group and in identifying the source of negative trends. While additional follow up with the group is expected, before proceeding to Procedure Step 5, the lead state should understand the historical capital allocation patterns within the group and the future capital allocation actions that may be needed by the group if negative trends continue. The GCC includes data on historical capital allocation patterns (e.g., contributed capital

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received/paid or dividends received/paid), which help to illustrate which entities have historically needed more capital and which entities have capital that they have provided other entities in the group. While these patterns do not necessarily repeat themselves from one period to the next, there is often consistency in terms of entities that need capital or have excess capital, which may or may not be driven by losses, or by a change in strategy (e.g., increased writings at one company over another) by the group. These trends can also assist in discussions with the group about where capital may come from as a result of a future unexpected material event. Where similar information is also disclosed in Form F, the detail in the GCC may confirm what is already known by the analyst in this area and in some cases may provide greater detail.

	Branded Risk	*Benchmark*
a. Review the underlying data from the GCC Analytics tab to determine the historical capital allocation patterns within the group and summarize the result of this analysis.	ST	N/A
b. Using this data, as well as any recent information on net losses, or likely expected funding, determine if there may be an impact on the capital available to the insurance entities (either through the likelihood of higher dividends or through less capital being available for infusions).	OP, ST	N/A

Procedure Step 5 – Consider the Need for Company Discussions for Reductions in Risk

5. Determine the group's plans for addressing source(s) of any meaningful decreases in the GCC ratio or total GCC available capital. Please note, that in some cases, the plan may be as simple as actions designed by the group to reverse a single negative trend.

Procedure Step 5 is designed to assist in understanding the group's plans for addressing any meaningful decreases in the GCC ratio or total available capital that were not intended by the group (i.e., that are not the results of capital management so as to efficiently utilize capital while still maintaining sufficient levels for ERM needs). The specific plans of the group may or may not fully address all the issues but to the extent the group believes they have addressed what is needed, ultimately what is most important is that such information and the regulators plan for evaluating and monitoring the situation are known to the other regulators. There is a multitude of possibilities, and this guidance is not intended to address all of those. This includes the possible actions by the group and its legal entities. This also includes the possible actions to be taken by the regulators of the individual legal entities, which may include regulators choosing to put their legal entity into supervision, conservation, or some other form of receivership (which, by necessity and intent, would presumably be done based upon existing legal entity authority since there is no authority provided under the GCC). Similar to other areas, where similar information is also disclosed in Form F, further information may already be known in this area.

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	Branded Risk	*Benchmark*
a. Obtain a copy of the group's most recent business plan and compare it to the prior year plan for variances. (See Additional Procedures below for additional follow-up analysis).	ST	N/A
b. Request information from the group on how it intends to address the issues or negative trends (those that are not planned or due to approved changes to the GCC scope of application or the result of changes in underlying legal entity capital requirements) identified in Procedure Steps 1-3. More specifically, determine how the group intends to decrease risk, and by what means.	ST	N/A
c. Based on information received in Procedure Step 5.b., determine the group's capacity to reduce risks or raise additional capital.	ST	N/A
d. Where the remaining capital is adequate, document the findings in the GPS (or another document) and make available to the supervisory college and or domestic states with the presumption no further action is deemed necessary.	ST	N/A
e. Consider whether the collective information suggests that any of the U.S. legal entity regulators should deem the legal entity to be in a "Hazardous Financial Condition" and take appropriate action to address based upon the facts and circumstances and the provisions of the state's law (similar to the *Model* Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition #385).	N/A	N/A
f. Where appropriate, consider holding a meeting of the supervisory college or of all the domestic states to fully understand the group's plans. Where appropriate, require the group to present its plans to the supervisory college or all the domestic states.	N/A	N/A
g. Where appropriate, determine if the plans proposed by the group are considered inadequate by any of the legal entity regulators, and more specifically if any are considering taking action over their applicable legal entity. If this is the case, hold a meeting of the supervisory college or of all the domestic states to provide this information.	N/A	N/A
h. Where appropriate, consider holding a broader meeting of all impacted jurisdictions in which the group is selling insurance. Where appropriate, require the group to present its plans to all such regulators and for the regulators to announce their plans.	N/A	N/A

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Analyst:	Date:
Supervisor Review:	Date:
Supervisor Comments:	

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PURPOSE OF THE GROUP CAPITAL CALCULATION (GCC) IN HOLDING COMPANY ANALYSIS

The following information is intended to provide background and context concerning the issues/considerations for analysts when utilizing the NAIC group capital calculation (GCC) for an insurance holding company group (hereafter referred to as "group") completing the GCC where required. The GCC is a tool to quantitatively understand the group's capital and the mathematically calculated risks within the group. The GCC framework is built on the risk-based capital (RBC) model. However, while RBC, as a capital requirement, has triggers in states' laws to take formal actions, the GCC is not designed for that purpose and is instead designed as an analytical tool.

Background Information

In 2008, the NAIC Solvency Modernization Initiative (SMI) began to consider whether there were any lessons learned from the financial crisis that would cause the solvency framework to be modified. The NAIC determined that changes should be made in the area of group supervision, starting with the new annual requirement for the lead state of each group operating in the U.S. to complete a written holding company analysis. Since that time, other changes to state laws have been made to further enhance group supervision (e.g., Form F, Own Risk and Solvency Assessment (ORSA), and Corporate Governance reporting). All of these new tools are inputs into the previously mentioned holding company analysis, which is now summarized into a consistent tool used by all states that is known as the Group Profile Summary (GPS).

Benefits of the GCC and Methods to Achieve Them

The GCC instructions describe the background, intent, and calculation for the GCC in detail. As stated in the GGCC instructions, the GCC and related reporting provides more transparency about a group's structure and related risks to insurance regulators and makes those risks more identifiable and more easily quantified. In this regard, this tool is intended to assist regulators in better understanding the risks that the non-insurance entities may pose to the group and ultimately regulated insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies' capital may be put at risk from the operations of non-insurance entities, potentially undermining the insurance company's financial condition. An analyst is not expected to understand non-insurance industries represented within the group but is expected to understand through this calculation if a non-regulated entity could place pressure on or provide relief to a regulated entity.

The manner in which the GCC achieves some of these intentions varies. For example, with regard to understanding how capital is distributed across an entire group, this can be seen in two ways. One is by viewing the tab titled Input 4-Analytics for the display of the "Ratio of Actual to Required Capital". The other is by viewing the same tab for the display of "Required Capital" in a separate column. The degree of capital movement can also be seen in the Input 4-Analytics tab, with the display of the columns as follows: 1) Capital Contributions Received/(Paid); and 2) Net Income. While one year of information can provide insights, a better understanding will be obtainable after further years of the GCC are reported within the template. Once five years of data are displayed in this Input 4-Analytics tab, it will allow the analyst to better understand the financial condition of the group as a whole as well as the risks posed by non-insurance entities in the group. Of course, such conclusions can only be made once the analyst sees the data and understands from the group what is occurring that is leading to such figures.

Recognizing that legal entity supervision and related tools (e.g., RBC) are the primary means to address inadequate capital, the GCC may provide an additional early warning signal to regulators regarding risks or activities of non-insurers within the group that may pose material risk to the insurance operations. This early warning signal can be seen with the trending of the financial information in the Input 4-Analytics tab, as well as through the application of sensitivity analysis in the Input 5 tab and inclusion of other relevant information in the Input 6 tab. However, the analyst should also understand that other qualitative tools, such as the Form F, are capable of also

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providing early warning signals if properly reported by the group. In addition, since most holding company systems may have a larger percentage of their operations in the insurance businesses, the insurance trends for the U.S. insurers in the group should already be known and made available to the lead state by the legal entity regulator(s) of the insurer(s). However, in the context of added policyholder protection, this may largely come into play with respect to the added quantitative data about non-insurers.

The GCC is an additional reporting requirement with important confidentiality protections built into the legal authority to require such reporting. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide regulators with further insights to allow them to make informed decisions on both the need for action and the type of action to take as to the regulated entity, or additional requests for information from other entities. That said, the GCC and its related provisions in the Insurance Holding Company System Regulatory System Regulatory Act (#440) and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group's GCC. Regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

While the new information from the GCC may offer new insights, it is equally important to understand that it will be up to the analyst to work with the insurance group to actually understand what is leading to the figures reported in the GCC, and from that perspective, especially in the early years of the GCC, it will require learning by both the analyst and the group to really be able to utilize the GCC in a manner as suggested in these introductory paragraphs.

Other Considerations When Considering Such Benefits

Unforeseen events and economic conditions (e.g., pandemic, recession, etc.) may also create stresses on a group, reinforcing the value of the quantitative data included in the GCC. Some stresses are similar to those experienced during the financial crisis, and others are more unique. However, because the GCC is based upon a methodology that gets its inputs from individual legal entities, the capital calculated for each legal entity certainly can only capture the allowed capital resources of the legal entities in the group. While such an aggregation-based methodology is an appropriate group-level capital measure, until experience is gained with the GCC, it is not known how the GCC will behave in response to business cycles and various risk events, in part because it only recognizes limited diversification benefits among entities in the group except for the diversification embedded in existing entity specific regulatory capital requirements. And while the GCC is not meant to be used in a way that compares groups to each other, it is also true that it is unknown how it will behave across groups, peers, and even sectors. This is true because of its limited diversification benefit, the differences between group types (mutual vs. stock holding company), grouping of entities, and scope of entities included in the calculation. It is also true because application of jurisdictional accounting principles and use of scalars could have an impact on this as well via the foreign insurer profile of the group. The quantitative data collected in the GCC will evolve as state insurance regulators and groups increase their understanding of the impact on available capital and calculated capital.

The following guidance on the GCC is intended to be utilized in a manner that allows the GCC to enhance group-wide financial analysis and to be used as an additional input into the GPS. The GCC provides the quantification of risk within the group and when combined with the information from the ORSA on the amount of capital needed to run the company's current business model and related risk appetite, it puts the regulator in a much better position to understand the available capital and calculated capital within a group, as well as the financial condition of the group. Both are complementary tools to each other. The ORSA provides management's internal approach to capital management and an understanding of the economics of the group. The GCC provides a standard model that can better enable the analyst to understand where the entire group stands with respect to existing legal entity requirements, as well as broad measures of risk for non-insurers. Analysts should be mindful of the differences between the ORSA and the GCC. For example, in the case of a group with predominantly U.S.

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operations, the GCC will largely be based on the standard model/RBC of the U.S. subsidiaries. However, the ORSA is not constrained by a standard model and will reflect management's internal approach to capital management and may utilize or benefit from an economic capital model, other internal models, stress testing and other means. As a result, while the GCC is an additional input into the GPS, it may provide data and signals that do not align with the risk measures within the ORSA.

Overall Theme of Remaining Guidance

The previous information describes the purpose for considering the GCC within the context of the state's holding company analysis and corresponding GPS. In general, the remainder of this guidance provides more depth to the specific information to be included in the GPS, and it provides the analyst with a basic understanding of the GCC, including why the entities included within the GCC may be a subset of those entities that are within the holding company structure; whether the trends within the GCC suggests questions should be raised with the group's management; whether the underlying data suggests trends exist that should likewise be raised with the group or with the respective legal entity's supervisor; whether the information in the GCC filing is generally aligned with other information available to the analyst, and if not, why not; and whether that evidences other questions or concerns that should be addressed, or how they may already have been resolved. Notably, the purpose of the GCC is NOT to trigger regulatory action. Thus, even though the GCC is intended as a group-wide measure and provides insights as to capital adequacy and risks across the group, any regulatory action would have to result from other information made available to the regulator and based on legislative authority.

UTILIZATION OF THE GROUP CAPITAL CALCULATION IN THE LEAD STATE'S RESPONSIBILITIES

The lead state is responsible for completing the holding company analysis and documenting a summary of that analysis in the GPS. The depth and frequency of the holding company analysis will depend on the characteristics (i.e., sophistication, complexity, financial strength) of the insurance holding company (group) system (or parts thereof), and the existing or potential issues and problems found during review of the insurance holding company filings.

Similarly, in the analysis of the GCC, the depth of the review in the "five-step process" and specific inquiries will vary based on each group's unique situation. For example, in some groups, little if any work (inquiries of the group) will be done after the first step due to generally positive trends of the ratio over time. In other groups, the analyst may need to proceed through each of the five steps. Exactly how the analyst proceeds through the guidance will be dictated by a multitude of factors and requires judgement. As a result, the steps and sub-procedures should not be used as checklist, but rather as a guide in how to utilize the GCC to increase the analyst's understanding of the group.

GCC Construction That Also Affect its Utilization and Review

Some decision points may be addressed prior to the submission of a GCC template. These include: the scope of application (e.g., whether segments of the holding company system (group) should be excluded for financial conglomerates); whether a limited filing will be allowed (as permitted in Model #440 and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions [#450]); and whether subgroup reporting (as defined in the GCC instructions) of a foreign insurance group will be required. In general, the analytics provided by the GCC will be similar for all entities included in the template. See the primer on the GCC Formula) at the end of this section to better understand these points.

These factors are also a consideration in determining the depth of the analysis of the GCC and subsequent correspondence with the group. Refer to chapter VI.B. – Roles and Responsibilities of Group-wide Supervisor/Lead State for details on responsibilities for completing the GPS.

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The utilization of the GCC can be summarized as an additional input into the GPS. More specifically, once the analyst completes their review of the GCC and trend of the ratio, a summary should be incorporated into the GPS to help support the assessment of strategic risk.

Documentation of Review of the GCC in the Group Profile Summary

The purpose of these procedures is to explain how to document the GCC into the GPS. The following provides an example of a GCC summary that represents the minimum expected input of the GCC into the GPS, with new information reported within the strategic branded risk classification. The other purpose of this section is to determine if more follow-up with the group should be performed and, if so, to assess the information obtained from that additional review. The following is intended to assist in documenting the analyst's understanding of the group's GCC in the GPS.

Group Capital Calculation Summary

Summarize your assessment of the GCC both quantitatively and qualitatively, including any such items as may not be applicable to a branded risk category. For example, it may be appropriate to indicate "*The review of the group's GCC indicated the scope of the application is consistent with the lead state's determination*" and if possible, to summarize succinctly, the general scope of the GCC. For example, "*the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries"*. It may also be appropriate to identify key drivers of risks for the group within the GCC that are discussed later in the branded risk categories, as those risks supplement existing risk assessments derived from holding company analysis or are new risks that warrant further review. "*The group's GCC of 201% in the current year was impacted by a decline in total available capital of $X which is related to group's non-insurance operations in Bermuda and as well as the negative impact of market risks in the U.S. insurance legal entity ratio components, which based on further analysis has resulted from the recent financial market volatility*".

Branded Risk Assessment

Strategic: *The group's GCC is assessed as low-risk and stable and is a positive consideration in the overall assessment of strategic risk. The GCC has generally been reasonable and consistent over the past five years as illustrated in the following table. Additionally, refer to the GCC summary for further details.*

	CY	***PY***	***PY1***	***PY2***	***PY3***
GCC Ratio	*201%*	*207%*	*163%*	*202%*	*197%*

GCC Summary and Strategic Branded Risk Documentation

The above information documented in a summary section of the GPS and into the strategic branded risk classification is expected to be the primary type of information that is always documented into the GPS. The GCC provides a capital measurement of the group and, consistent with the branded risk categories, should be reported in the strategic risk section. Similar to how RBC for an individual insurance entity is helpful in allowing the analyst to better understand other potential issues, given capital represents a relative measure of cushion for adverse risks, the GCC (and its inclusion in the GPS) helps regulators to understand the same, relative to a group. While the GCC is not a capital requirement, with specified ladders of intervention, each of the insurance legal entity figures are relative to individual company requirements. Therefore, the GCC can provide a relative measure of risks in terms of the minimum capital levels of the insurers.

Other Branded Risk Documentation

To the extent the GCC ratio is trending negatively, or GCC available capital is decreasing, the analyst may choose to include more information in the strategic branded risk section of the GPS that summarizes any key drivers of

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such findings if they did not fall into one of the branded risk categories. Those drivers of the change might be documented in other specific branded risk categories – for example pricing/underwriting if driven by group-wide weak insurance underwriting, or reserving if the group-wide drivers were reserve deficiencies, etc. References to other branded risk categories may also be appropriate. However, this may not always occur or be possible for the analyst to pinpoint given the multitude of risks within any insurer's regulatory capital requirement formulas. This guidance is simply meant to suggest that if the GCC does in fact appear to show particular trends that are noteworthy on specific risks, further documentation into that (applicable) branded risk may be appropriate.

A determination for when documentation of risks from the GCC into other branded risk categories may be appropriate is driven by whether any of the thresholds in Procedures 1 were met, and by the rest of the GCC information as described in Procedures 2 - 4. The GCC summary is intended to be high-level. Therefore, other more detailed observations from reviewing the GCC should generally not be documented into the GPS unless they are specifically insightful, add to a high-level understanding of the group's financial condition, or are specific to a branded risk category as stated.

Other Considerations

In addition to the broad guidance provided herein on the documentation of the GCC in the GPS, the analyst should also understand the following more general points that could affect the GCC result for a particular group. Judgement is required when considering these points:

- Asset-liability accounting or economic mismatches may lead to volatility within components of the GCC ratio, and potentially in the GCC ratio as a whole. For instance, if an entity is in a market-based regime, and if economic risks are unhedged, the entity's solvency ratio may fluctuate with economic conditions. As another example, if an insurance entity's liabilities are subject to U.S. RBC and statutory valuations, and if associated hedging is subject to a market-based valuation, volatility may result due to accounting mismatches. The factors that create volatility will be significantly influenced by the accounting standards used in each applicable regime.
- Regime changes may lead to noticeable changes in the GCC ratio that are not necessarily reflective of changes in the entity's underlying business. Regime changes can include changes in valuation, RBC, available capital, tax rates, or the use/discontinuation of permitted or prescribed practices. In some jurisdictions a regime change could involve the use/discontinuation of an "internal model" or "partial internal model," which is a tailored set of risk charges and/or risk correlations and is intended to align insurer and regulatory perspectives of risk and capital.
- The GCC provides a means for analysts to identify non-insurance operations outside of the insurance group and to determine the extent of risk they may pose to the insures within the group. However, in doing so, analysts should understand that findings from review of Form B, Form D and Form F might be equally valuable in these situations.
- When understanding capital requirements for non-insurer financial entities that are not subject to regulatory capital requirements, consideration should be given to the appropriateness of the GCC's capital charge for a specific entity's financial operations (e.g., an entity conducting a large volume or large dollar of complex transactions but with little net revenue or equity).
- When understanding capital requirements for non-insurer/non-financial entities, consideration should be given to the appropriateness of the level of risk assigned to specific entities.

Detailed Observation Documentation

More detailed observations shall be documented separately from the GPS and in a form not dictated by this handbook. As in all holding company analysis, the level of documentation is determined by the lead state insurance department and is dependent on the characteristics and complexity of the group and its risks. These

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detailed observations generally need to only note the drivers of trends and/or actions being taken by the group to mitigate risks. In some cases, these points can be easily summarized into the GPS. In other cases, they are too detailed and should be documented instead within a separate document not dictated in form by this handbook. The analyst should not spend time documenting either subtle changes within the GCC or individual company movements that do not create a trend at the group level or identify a growing weakness in the group. However, judgment is required to make this determination. For example, a 10% (not point change) decrease in an RBC ratio of one of the smaller insurers within the group generally would not be documented. By contrast, a 10% decrease (not point change) in an RBC ratio in one of the larger insurers in the group that causes, either alone or jointly with other insurers, a 10% decrease in the GCC should be noted. However, it should be understood also that this 10% threshold is not intended to be a used as a "bright-line." In fact, it is possible the 10% is not necessarily indicative of any negative trends at all. This could be the case when for example there was a change in the regulatory capital requirement. Therefore, again, judgement is required in making these determinations and this, as well as other thresholds used in this guidance, are not meant to be bright lines. As the GCC is used more, both by the individual analyst and by the various states, using judgement around these thresholds is expected to become easier as the judgement is informed by experience.

SPECIFIC PROCEDURES FOR COMPLETING REVIEW AND UNDERSTANDING OF THE GCC

The following procedures should be used by the analyst in their review and documentation of results of the GCC. However, if the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in the GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state along with the general reasons supporting that conclusion. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner, and judgement based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that decision.

Procedures Step 1

The purpose of Procedures Step 1 is to assess the GCC level, and to identify the drivers of any changes in the GCC, in order to summarize and to document that overall assessment in the GPS and its strategic risk category, which is the minimum expected input of the GCC into the GPS. However, the analyst should understand that in the early years of the GCC, a limited amount of prior year(s) comparative data will be available, therefore requiring more judgement in determining if or where further analysis is warranted. Such judgement may need to be based upon various factors, including but not limited to, other known information regarding the applicable group obtained from other sources (ORSA, Form F, Form B, etc.).

Procedure 1 is also intended to help the analyst determine if more follow-up review work should be performed. However, if the answer to any of the questions in Step 1 is "yes", the analyst should proceed with Step 2, Understand Decreases in Total Available Capital and/or Step 3, Understand Increases in Operating Leverage to determine the cause(s) of the negative trends. In the example provided above, the trends are positive with no decreases in the base ratio except in PY1; presumably, the analyst may have performed some level of inquiry to the holding company to understand the driver of the drop.

Procedures Step 2a - 2m

Unlike Step 1, the intent of Step 2 (and Step 3) is to determine the actual source of the negative issues and where they should be documented in the GPS. Procedure Step 2a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at the ratio

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of actual-to-required capital for the legal entity insurers over the available years reported. The following sample of a table from the GCC calculation completed by the group from the data in Schedule 1 can be helpful in determining the source of the issues.

Insurance Capital Table Template Groupings		Ratio of Actual to Required Capital				
		2025	2025	2023	2022	2021
		[1]	[2]	[3]	[4]	[5]
RBC Filing U.S. Insurer (P/C)	[1]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Life)	[2]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Health)	[3]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Captive)	[4]	XXXX	XXXX	XXXX		
Non-RBC Filing US. Insurer	[5]	XXXX	XXXX	XXXX		
Canada - Life	[6]	XXXX	XXXX	XXXX		
Canadian – P/C	[7]	XXXX	XXXX	XXXX		
Bermuda - Other	[8]	XXXX	XXXX	XXXX		
Bermuda - Commercial Insurers	[9]	XXXX	XXXX	XXXX		
Japan - Life	[10]	XXXX	XXXX	XXXX		
Japan - Non-Life	[11]	XXXX	XXXX	XXXX		
Solvency II - Life	[12]	XXXX	XXXX	XXXX		
Solvency II -- Composite	[13]	XXXX	XXXX	XXXX		
Solvency II - Non-Life	[14]	XXXX	XXXX	XXXX		
Australia - All	[15]	XXXX	XXXX	XXXX		
Switzerland - Life	[16]	XXXX	XXXX	XXXX		
Switzerland - Non-Life	[17]	XXXX	XXXX	XXXX		

Procedure Step 2b recognizes that the GCC does allow some debt to be included in capital up to a predetermined limit and can drive the overall GCC ratio. The following sample table taken from the GCC calculation using the data in Schedule 1 can be helpful in making this determination. Cases where debt is issued to address risk-driven reductions in the GCC ratio may not offset those reductions. This data metric may not be available in the case of a "limited filing".

Debt/Equity Table Template Groupings		Debt/Equity ($)				
		2025	2024	2023	2022	2021
		[1]	[2]	[3]	[4]	[5]
Total	[8]	XXXX	XXXX	XXXX	0	0

Procedure Step 2c recognizes that profitability (e.g., net income/net loss) is generally one of the biggest drivers of changes in capital, and utilizing the following table from the GCC can assist in identifying if there are entities reporting net losses that may be driving the decreases in capital. The following table taken from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues.

Income & Leverage Table Template Groupings		Net Income ($)					Return on Capital				
		2025	2024	2023	2022	2021	2025	2024	2023	2022	2021
		[1]	[2]	[3]	[4]	[5]	[1]	[2]	[3]	[4]	[5]
US Ins	[1]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Non-US Ins	[2]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		

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Non-Financial Entities	[3]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Bank	[4]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Asset Manager	[5]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Other Financial with Capital Requirement	[6]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Financial Entities without Capital Requirements	[7]										
Total	[8]	XXXX	XXXX	XXXX	0	0	XXXX	XXXX	XXXX		

If the source of the issues is the insurers, the following sample from a table from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues among the insurers.

Core Insurance Table 1		**Net Income ($)**					**Return on Capital**				
Template Groupings		**2025**	**2024**	**2023**	**2022**	**2021**	**2025**	**2024**	**2023**	**2022**	**2021**
		[1]	[2]	[3]	[4]	[5]	[1]	[2]	[3]	[4]	[5]
RBC Filing U.S. Insurer (P/C)	[1]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Life)	[2]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Health)	[3]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Captive)	[4]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Non-RBC filing US. Insurer	[5]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Canada - Life	[6]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Canadian – P/C	[7]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Bermuda - Other	[8]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Bermuda - Commercial Insurers	[9]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Japan - Life	[10]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Japan - Non-Life	[11]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II - Life	[12]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II -- Composite	[13]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II - Non-Life	[14]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Australia - All	[15]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Switzerland - Life	[16]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Switzerland - Non-Life	[17]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		

Procedure 2d is focused on requesting more specific information from the legal entity regulator or the group to better identify the source of the issue(s). Procedures 2e - 2l simply contemplates that if the source of the issues can be identified into one of the branded risk categories, it should be documented in the detailed workpapers and into the appropriate branded risk category of the GPS. However, it is recognized that the source of issues may be in multiple branded risk categories, in which case documentation of each of the sources into the detailed workpapers is still appropriate. However, documentation into one of the single branded risk categories of the GPS is only appropriate if that risk category is a material driver of the negative trends. Procedure 2m is intended to

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identify if the source of the issues is related to non-insurance operations. The GCC is intended to provide for more consistent analysis of risks to an insurer that may originate from non-insurance entities within the holding company system.

Procedures Step 3a - 3f

Procedure 3a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at indicators of leverage, e.g., leverage ratios, where this risk may manifest itself either though increased writings or exposure, or through increased balances relative to capital and surplus. The following sample of a table from the GCC calculation using the data in Schedule 1 can be helpful in determining the source of the issues.

Insurance Leverage Table		Net Premium Written ($)					Liabilities ($)/Capital & Surplus				
Template Groupings		2025	2024	2023	2022	2021	2025	2024	2023	2022	2021
		[1]	[2]	[3]	[4]	[5]	[1]	[2]	[3]	[4]	[5]
RBC Filing U.S. Insurer (P&C)	[1]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Life)	[2]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Health)	[3]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Captive)	[4]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Non-RBC filing US. Insurer	[5]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Canada - Life	[6]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Canadian - P&C	[7]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Bermuda - Other	[8]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Bermuda - Commercial Insurers	[9]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Japan - Life	[10]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Japan - Non-Life	[11]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II - Life	[12]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II -- Composite	[13]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II - Non-Life	[14]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Australia - All	[15]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Switzerland - Life	[16]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Switzerland - Non-Life	[17]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Hong Kong - Life	[18]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Hong Kong - Non-Life	[19]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Singapore - All	[20]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Chinese Taipei - All	[21]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
South Africa - Life	[22]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
South Africa - Composite	[23]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
South Africa - Non-Life	[24]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Mexico	[25]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		

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China	[26]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
South Korea	[27]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Malaysia	[28]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Chile	[29]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Brazil	[30]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
India	[31]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Other Regime	[32]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
TOTAL	[33]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		

Procedure 3b is more forward-looking by suggesting the analyst look at the same leverage ratios used in Procedure 3a to determine if the trends might continue and lead to further decreases in the GCC ratio. Procedure 3c simply requests the analyst use the leverage information to target questions to the group to better identify the drivers. Procedure Steps 3d - 3f are all questions designed to help the analyst consider whether the changes in leverage will lead to greater underwriting risk, reserving risk, or market and credit risk. Procedures 3d - 3f provide general inquiries for additional information for the analyst. However, these inquiries may also appropriately provide a basis for the analyst to hold conversations with the group on the same topics to understand how the group views these topics and how the group is managing and monitoring these risks. For groups filing an ORSA, see also documentation within the ORSA report for additional information on the identified risks and the group's monitoring of risks, as well as consistency of the discussion with management and management's observations in the ORSA Summary report.

Procedures Step 4a - 4b

Procedure Step 4a is intended to help the lead state understand the historical capital allocation patterns or the likely future needed capital allocation patterns by simply documenting those in the detail analysis workpapers. This includes, for example, noting that there is consistency in the entities generating net income and distributing it further through the group, in some cases, this may require distribution through other insurers, which in the U.S. often requires approval if considered extraordinary. Procedure 4a is intended to utilize that knowledge, along with other planned actions of the group, to understand whether problems with repaying debt or other obligations in the group could occur. The intent is to be in a better position for discussions with the group on where the group may expect capital to come from to support future expected activity or future unexpected material events. The following sample of tables from the GCC calculation using data in Schedule 1 can be helpful in determining the source of the issues.

Insurance Capital Table		**Capital Contributions $ Received/(Paid)**				
Template Groupings		**20254**	**2024**	**2023**	**2022**	**2021**
		[1]	[2]	[3]	[4]	[5]
RBC Filing U.S. Insurer (P/C)	[1]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Life)	[2]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Health)	[3]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Captive)	[4]	XXXX	XXXX	XXXX		
Non-RBC filing US. Insurer	[5]	XXXX	XXXX	XXXX		
Canada - Life	[6]	XXXX	XXXX	XXXX		
Canadian – P/C	[7]	XXXX	XXXX	XXXX		
Bermuda - Other	[8]	XXXX	XXXX	XXXX		
Bermuda - Commercial Insurers	[9]	XXXX	XXXX	XXXX		
Japan - Life	[10]	XXXX	XXXX	XXXX		
Japan - Non-Life	[11]	XXXX	XXXX	XXXX		
Solvency II - Life	[12]	XXXX	XXXX	XXXX		
Solvency II -- Composite	[13]	XXXX	XXXX	XXXX		
Solvency II - Non-Life	[14]	XXXX	XXXX	XXXX		
Australia - All	[15]	XXXX	XXXX	XXXX		

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Switzerland - Life	[16]	XXXX	XXXX	XXXX		
Switzerland - Non-Life	[17]	XXXX	XXXX	XXXX		

Insurance Capital Table		**Intragroup Dividends $ Received/(Paid)**				
Template Groupings		**2025**	**2024**	**2023**	**2022**	**2021**
		[1]	[2]	[3]	[4]	[5]
RBC Filing U.S. Insurer (P/C)	[1]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Life)	[2]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Health)	[3]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Captive)	[4]	XXXX	XXXX	XXXX		
Non-RBC filing US. Insurer	[5]	XXXX	XXXX	XXXX		
Canada - Life	[6]	XXXX	XXXX	XXXX		
Canadian – P/C	[7]	XXXX	XXXX	XXXX		
Bermuda - Other	[8]	XXXX	XXXX	XXXX		
Bermuda - Commercial Insurers	[9]	XXXX	XXXX	XXXX		
Japan - Life	[10]	XXXX	XXXX	XXXX		
Japan - Non-Life	[11]	XXXX	XXXX	XXXX		
Solvency II - Life	[12]	XXXX	XXXX	XXXX		
Solvency II -- Composite	[13]	XXXX	XXXX	XXXX		
Solvency II - Non-Life	[14]	XXXX	XXXX	XXXX		
Australia - All	[15]	XXXX	XXXX	XXXX		
Switzerland - Life	[16]	XXXX	XXXX	XXXX		
Switzerland - Non-Life	[17]	XXXX	XXXX	XXXX		

Procedures Step 5a - 5h

Procedures 5a-5h are designed for those uncommon situations where the group believes they need to reduce risk because raising capital may be unlikely (see the appendix for further discussion on that topic). Before performing this procedure, Procedure Step 2 (Evaluating Decreases in Total Capital) and Procedure Step 3 (Evaluating Increases in Operating Leverage) will have already been performed to determine whether capital is decreasing, or operating leverage is increasing. As such, after considering information that may already be available to the regulator on the business plan, Procedure 5b is largely focused on better understanding directly from the group the group's reaction to the apparent negative trends. The analyst should understand that some of these trends may have already been known, through, for example, the ORSA review and discussions of the ORSA by the lead state. In fact, the key takeaways may already be documented in the GPS and, therefore, the remaining procedures in this section may be irrelevant and could be skipped if recently considered and understood. In addition, such trends from Procedure Step 2 and Procedure Step 3 may suggest no additional information is necessary. It is for this reason that the first procedure is focused on the group's existing business plan as it is possible these trends may have been expected. Further, Procedure Step 5a is based on the belief that reducing risk by the group may have been previously incorporated into the group's latest business plan, which may have been obtained from the Annual Form F Filing.

Procedure Step 5b, on the other hand, contemplates that the manner to address any unexpected negative trends may not have been incorporated into the latest business plan and thus further contemplates that the analyst speaks with the group or identified insurer causing the negative trend to understand how the issue is to be addressed. However, it should be recognized that some trends that may appear to be "negative", e.g., a decline in the reported GCC, may be due to the result of a conscious decision by the group to more efficiently deploying capital while remaining at sufficient levels from an enterprise risk management (ERM) perspective. This procedure is not meant to suggest action **must** be taken by a regulator, but only to help the analyst understand whether a

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trend is in fact "negative" or not, and if so, what the group has already decided or plans on doing to address the issue, if anything, and appropriately document. Some of what the group is currently doing may already be known by the lead state, either through the ORSA, the Form F, or a periodic meeting with the group that some states conduct annually. However, the procedure provides an opportunity for the analyst to ensure they understand the drivers and what, if anything, the group is already doing to address the underlying issues as the group thinks is appropriate. To be clear, increases in operating leverage are often planned, and often come with expected future actions by the group, such as capital injections or future transactions that may reduce risk. On the other hand, decreases in capital sometimes are not expected, and may not result in immediate action, but it is possible that they may lead the group to contemplate future actions to take. Therefore, these discussions would allow these potential actions to be better understood by the analyst and documented.

Procedure Step 5c contemplates assessing if the group has the ability and resources to either reduce its risks or to raise additional capital. See the section below for further considerations of the group's capacity to raise capital. This procedure is not intended to suggest the analyst has the capacity to make this determination on their own, but rather to question the reasonableness of the possibility. Further, the GCC and related provisions in Model #440 and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group's GCC; regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

Procedure Step 5d contemplates that the group or legal entity may believe no action is necessary because it believes current capital is adequate to meet its business plan, which is more likely to be the case when a one-time reduction of capital as opposed to a growth in leverage that may continue. Procedure 5e is for the rare situation where the legal entity insurers have been strained or face impending pressure contemplated within the *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (#385)* that would suggest one or more of the insurers may be in a hazardous financial condition. Procedure Step 5f is designed to suggest the analyst bring the collective supervisors of the legal entity insurers together for a supervisory college to fully understand what is occurring and the identified legal entity's plans for addressing the underlying issues. Procedure Step 5g is an extension of Procedure Step 5f as it contemplates the regulators discussing whether the proposed actions from the legal entity(is) in the group are adequate. This action could represent something either informally done before an insurer is in a regulatory action level, or formally once an insurer is in a regulatory action level. Procedure Step 5h is similar to the other actions contemplated within a supervisory college or, for example, to address a troubled insurance company under accreditation requirements regarding communication with other states.

ADDITIONAL PROCEDURES – BUSINESS PLANS

While there is a multitude of possibilities that are beyond the scope of this guidance to address, the following provides some of the related issues that may be helpful to the analyst to consider.

Group's Business Plan (or collective legal entities):

Planning Process

- Understand the overall planning process (who is involved, how frequently it occurs, etc.) and how the overall initiatives are determined.
- Understand the estimate of the impact of the proposed actions on financial results.
- Review the plan's assumptions for reasonableness. Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results.
    - Consider subcategories of changes including:

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- Overall potential changes in investment strategy.
- Overall potential changes in underwriting strategy or risk concentrations.
- Overall impact on financing matters (e.g., debt, requirements, etc.).
- Overall impact on derivatives to mitigate economic conditions.
- Overall changes in governance or risk management procedures.
- Increased ceded reinsurance transactions (common approach to reducing risk/increasing surplus):
    - Details regarding the revised strategy.
    - Specifics on types of coverage such as assumption reinsurance, loss portfolio transfers.
    - Transfer of risk considerations.

Variances to Projections

- Consider the history of explanations regarding variances in projected financial results and the insurer's actual results. If analysts determine the goals of the business plan are not attainable and/or projections are unreasonable, a revised business plan may be requested.
- Identify any internal or external issues not considered in the plan that may affect future financial results. Examples of such issues include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company's product designs; or 3) the loss of key marketing personnel.

Evaluating a Business Plan

Analysts should consider further detail where necessary in evaluating the proposed revised business plan but also monitor, on a periodic basis, the insurer's progress in achieving the initiatives included in the group's plan. Assuming that the analyst has determined that a decline in the GCC is material and considered a negative event, i.e., it was not the result of capital management and planning to more efficiently utilize capital while staying within sound levels to achieve ERM objectives, the goal of the plan would then be to address the underlying causes that led to the issues and an improvement in subsequent GCC ratio results. Detail considerations for improving the plan may include the following (where considered inadequate):

- Trending comparative measures of targeted risk exposures including (where applicable):
    - Asset mix by detailed types.
    - Credit risk by detailed types.
    - Business writings/ratios by detailed product.
- Impacts on financing items:
    - Projected cash flow movements for ongoing principal and interest payments on debt.
    - Impact on debt interest coverage ratio, other debt covenants, and rating agency ratings.
    - Discussion of impact on parental guarantees and/or capital maintenance agreements.
    - Expected source and form of liquidity should guarantees be called upon.
- Impact of reasonable possible stress scenarios
- How the individual legal entities' capital will be maintained at required levels.

Consultation with Other Regulators

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- Consult with members of the supervisory college (if applicable) or other domestic states for input in evaluating the revised business plan.

CONSIDERATIONS REGARDING ABILITY OF THE ENTITIES IN THE GROUP TO RAISE CAPITAL

The following is designed simply as a reminder of considerations the lead state would contemplate when discussing the group system response to the issues identified in this section. More specifically, in most situations a group will first consider ways to reduce risk. In limited situations, it may consider trying to raise additional capital. While this is typically not an option for a group that is currently not performing as it anticipated, in some situations, alternative sources of capital may be raised if the holders of the newly issued equity securities are given rights that are attractive to the holder. In addition, in some cases, the group may have the ability to issue other forms of capital (e.g., debt), which can be used to inject into the insurance subsidiaries. While these facts are not unique to the utilization of the group capital calculation, they are worth a reminder along with relevant other related details.

New Equity Considerations

Public Holding Company

While no two groups are the same, issuing public stock may be limited for the reasons previously identified. In addition, regulators are reminded that a public holding company may be obligated to pay dividends in order to maintain the expectations of their shareholders, making the reduction of risk a more viable action under the circumstances.

Private Holding Company

While no two groups are alike, a private company has some of the same characteristics as a public company in terms of owners' expectations, but usually such expectations differ from a public company, and it may be more feasible for a private company given their access to specific individuals that may have a higher interest in additional capital rights.

Mutual Insurance Company

A mutual insurer is limited in terms of its access to capital because it cannot issue new stock, but it can issue surplus notes.

Mutual Holding Company

Because mutual holding companies have characteristics of both public companies and mutual companies, there are implications of how such a structure affects its operations.

Non-profit Health Company

Insurers that are non-profits are generally charitable organizations, and it is not uncommon for some types of insurers, particularly those that provide health insurance, to have some history as a non-profit. It may be helpful to understand these types of dynamics when considering a group structure.

Fraternal Associations

Regulators often find similarities between a fraternal benefit society and a mutual insurer because both can be limited in terms of their ability to raise additional funds, but they can issue surplus notes. If allowed within state law and the charter, the fraternal could assess members or adjust members policy values.

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Reciprocal Exchanges

Regulators often find similarities between reciprocal exchanges and fraternal benefit societies and mutual insurers because they can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the group system, there is generally much more that must be understood because in some cases, the reciprocal may be able to assess policies that can serve a similar purpose as raising capital.

New Debt Considerations

Through discussions with the group, understand the potential impact of any new debt on the group system, including specifically the extent of future additional reliance on the insurance operations and whether those insurers have the capacity for such. Also consider an updated review of the following:

- Total debt service requirements.
- Revenue streams expected to be utilized to service the debt.
- Any new guarantees for the benefit of affiliates.
- Any new pledge of assets for the benefit of affiliates.
- Any new contingent liabilities on behalf of affiliates.

GENERAL HOLDING COMPANY CONSIDERATIONS

International Holding Company Structure

This section is applicable only to those international groups that are required to complete the GCC, which may be relatively few considering many international holding companies have a non-U.S. groupwide supervisor and are exempt from the GCC. Those foreign groups that are required to complete the GCC will generally file a "subgroup" GCC that includes insurance entities that are part of the group's U.S. operations. In those situations, the analysts should understand the structure to determine if it has any impact on this analysis. Analysts should direct any regulatory concerns to the appropriate organization contact to ensure a prompt reply or resolution. In some organizations, the appropriate organization contact will often be associated with the U.S. insurance operations, while in others, an advisory board may have been established to communicate with regulators.

Capital/Operational Commitment to U.S. Operations

Some holding companies may consider their U.S. insurance enterprises non-core and may be less invested in their ongoing business operations or financial support. Analysts should be aware of a holding company's stated commitment to ensure the continued stability of U.S. insurance operations. This commitment may include a written or verbal parental guarantee.

PRIMER ON THE GROUP CAPITAL CALCULATION FORMULA

The National Association of Insurance Commissioners (NAIC) began development of the GCC in late 2015 following extensive deliberation on potential measurement models and methodologies. The GCC uses a bottom-up aggregation approach, accounting for all available capital/financial resources, and the required regulatory capital based on the measurement of assets and liabilities of the various corporate entities, including insurers, other financial entities, and non-financial businesses.

The Group Capital Calculation Aggregation Methodology

As illustrated in the sample tables above, the proposed GCC is an aggregation or grouping of the available financial resources and calculated capital of all legal entities that potentially could pose material risk to the insurers in the group. The GCC allows some discretion in determining what entities are under common control but outside of the

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defined insurance group may be excluded from the scope of application in the GCC. When reviewing a group's choice of entities to be excluded from application of the GCC, the following points should be considered:

- The regulatory evaluation should be based on the criteria for material risk (e.g., structural separation, no history of cross subsidies, or other criteria as defined in the GCC instructions).
- Group requests for reducing the scope of application of the base GCC should be based on supporting information and a rationale provided by the group.
- Information on excluded entities should be made available upon request from the analyst.

The GCC includes the following types of entities (listed with the general approach of calculated capital toward each):

U.S. Insurers – The available capital of U.S. domiciled insurers is determined by Statutory Accounting Principles (SAP) as defined by state law and the NAIC Accounting Practices and Procedures Manual, which defines assets, liabilities, and net available capital/financial resources, sometimes referred to as policyholder surplus. The calculated capital for these insurers is subject to state law that requires these insurers to maintain minimum capital based on the applicable NAIC RBC formula at 200% x Authorized Control Level.

Non-U.S. insurers – Similar to the available capital and calculated required capital of U.S. insurers, the available and calculated capital of non-U.S. insurers is determined by reference to the home jurisdiction's basis of accounting and capital requirements converted to U.S. dollars. While most non-U.S. jurisdictions do not possess the same level of industry specific technical guidance as included in the NAIC AP&P Manual, all jurisdictions have established accounting standards that insurers are required to follow to determine available capital/financial resources. In some cases, this represents local Generally Accepted Accounting Principles (GAAP), which may or may not be consistent with International Financial Reporting Standards (IFRS).

> ***DRAFTING NOTE:*** While the GCC utilizes the available capital and home jurisdictions' capital requirement, for jurisdictions where data is available, the use of appropriate scalars is currently being explored to produce more comparable measures for risk that can be aggregated into the group-wide measure. One such scaling methodology is included as part of a sensitivity analysis in the GCC template. That scalar methodology uses aggregated data from the U.S. and other jurisdictions at the first intervention level to recognize that (for example) state regulators often have much higher reserve requirements, incorporating amounts that are required to be carried as capital in other jurisdictions. For jurisdictions where the data is not available, the full jurisdictional requirement at the first intervention level is used.

U.S. Insurers Not Subject to RBC – Some types of U.S. insurers are not subject to an RBC formula (e.g., Financial Guaranty Insurers, Title Insurers). For these entities, the available capital/financial resources are determined by reference to state law and the NAIC AP&P Manual. However, since an RBC formula does not exist, calculated capital is determined by reference to the minimum capital requirements set out in state law (or 300% of reserves for Title insurers). For U.S. captive insurers, available capital is determined based upon the states accounting requirements, but the calculated capital is required to be calculated using the applicable RBC formula even if RBC does not apply to that entity in its state of domicile.

Banking or Other Financial Service Operations Subject to Regulatory Capital Requirements – Non-insurers such as banks are subject to their own regulatory valuation methods (typically GAAP with tiering of available capital) and their own regulatory capital requirements (e.g., Office of the Comptroller of the Currency (OCC), Federal Reserve, Federal Deposit Insurance Corporation (FDIC), or other requirements for banks). These regulatory values are used for the GCC.

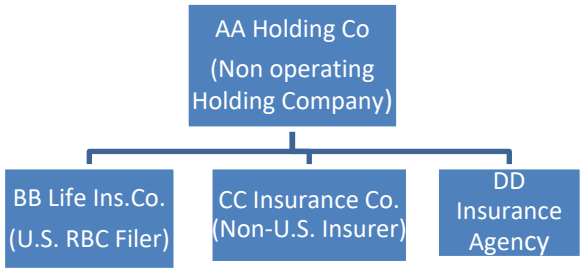
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- Financial and non-financial operations not subject to regulatory capital requirements – In general, financial entities (as defined in the GCC instructions) are subject to a higher capital charge in the GCC than the non-financial entities. However, the GCC does require available capital/financial resources and calculated capital to be gathered for all such entities that pose a material risk to insurers. In both cases, the GCC will utilize the valuation used by such legal entities (typically U.S. GAAP) and a calculated capital based upon a risk factor. All entities within the defined insurance group (definition included in GCC instructions) must be included.
- All financial entities (definition included in GCC instructions) must be included.
- The level of risk (low/medium/high) and associated capital calculation assigned to a financial entity will be selected by the group and evaluated by the lead -state reviewer.
- Non-financial entities that are subsidiaries of U.S. insurers, foreign insurers, or banks where a capital charge for the non-financial entity is included in the regulated parent's capital formula will remain with the Parent and will not be inventoried. Regulators already have access to the financials of these entities if needed (if causing unrealized losses within the insurer).

Eliminations – The GCC uses an aggregation and elimination approach, where each of the above legal entities' available capital/financial resources and calculated capital are combined, and then eliminations are utilized to prevent any double counting of available capital/financial resources or calculated capital. The following example illustrates the use of eliminations for both available capital/financial resources and calculated capital. However, in practice, the GCC only requires the foreign insurers and other financial entities owned by an insurance company to be "de-stacked", so if AA Holding Company was a U.S. insurer (e.g., AA Insurance Company), the capital required and calculated capital for DD Insurance Agency as a nonfinancial entity would remain in the values of AA Insurance Company and not be de-stacked.

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EE Insurance Group (EEIG)



EEIG Financial Information

Entity	Total Available Capital	Minimum Regulatory Capital
AA Holding Company	50.0 million	0[2]
BB Life Insurance Company	30.0 million	3.0 million[3]
CC Insurance Company	6.0 million[1]	1.6 million[3]
DD Insurance Agency	2.0 million[1]	0[2]

Calculation of ARC

Entity	TAC	Less: Subs' TAC	Adjusted TAC
AA Holding Co.	50.0M	(38.0M)[1]	12.0M
BB Life Insurance Co.	30.0M	0	30.0M
CC Insurance Co.	6.0M	0	6.0M
DD Ins. Agency	2.0M	0	2.0M
ARC (EEIG Group Total)			**50.0M**

[1] Amount of TAC for Subs as follows: (30.0M + 6.0M + 2.0M)

[1] For non-RBC filers this is regulatory available capital or stockholder equity
[2] There is no regulatory capital for these entities when owned by a non-regulated entity. Calculated capital is added @ 10.5% x stand-alone ARC
[3] Authorized Control Level (ACL) RBC or Prescribed Capital Requirement for non-U.S. insurers

Calculation of MRC

Entity	ACL or Calculated Capital[1]	Less: Subs' Calculated Capital	Adjusted Calculated Capital	Multiply by 2.0[3]	MRC
AA Holding Co.	6.07M	(4.81M)[2]	1.26M	NA	1.26M
BB Life Ins. Co.	3.0M	0	3.0M	6.0M	6.0M
CC Insurance Co.	1.6M	0	1.60M	NA	1.6M
DD Ins. Agency	0.21M	0	.21M	NA	0.21M
MRC Total					**9.07M**

[1] Estimated post covariance factor of 10.5% @ CAL x ARC per GCC added for AA Holding Co. and DD Ins. Agency
[2] Amount of Calculated Capital for Subs as follows: (3.0M +1.6M + .21M)
[3] Applies to U.S. insurer only to increase level to Company Action Level (CAL) RBC

In the above example, available capital/financial resources are referred to as available regulatory capital (ARC) and total authorized capital (TAC1), and minimum calculated capital is referred to as minimum regulatory capital (MRC) and authorized control level (ACL2). The GCC will allow non-insurance/non-financial entities owned by RBC filers in the group to remain within the available capital and calculated capital of the parent, so no eliminations are required for these entities. As shown, since AA Holding Company owns each of the other business entities in the organizational chart, $38 million (which is the amount of available capital/financial resources in the subsidiaries of AA) is eliminated from the TAC column since accounting methods include those as an asset on AA Insurance Company's balance sheet. Also, the GCC includes capital calculations for AA Holding Company and DD Insurance Agency as part of the MRC in addition to the regulatory capital already included for the insurance subsidiaries. The MRC of the subsidiaries is eliminated from the parent's (AA Holding Company) calculated capital. Therefore, in this example, $4.81 million of calculated capital is eliminated from the MRC. Finally, the MRC of U.S. insurance subsidiary is multiplied by 2 in order to reflect Company Action Level (CAL) RBC as required in the GCC.

[1] Terminology used in RBC for available capital/financial resources.
[2] Terminology used in RBC for calculated regulatory capital.

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Debt – It is important to note that the available capital used in deriving the GCC recognizes a portion of the group's senior and hybrid debt as capital. This allowance recognizes that debt that is not already recognized as available capital/financial resources under all known accounting principles (SAP, U.S. GAAP, or IFRS) may have some value to the group under the U.S. insurance regulatory requirements where debt proceeds are contributed down to the insurance companies and where extraordinary dividends must be approved by the state. Qualifying debt along with limitations thereon are described in the GCC instructions as is the calculation for the additional available capital. In addition to looking at the group's debt leverage, consideration should be given to how the allowance for additional capital from debt interacts with changes in available capital and capital requirements from year to year. The impact of procyclical changes in the allowance for debt as capital should be assessed.

Other Information Included in the GCC – The_GCC includes selected financial information (net income, premiums, liabilities, debt, etc.) that is captured in Schedule 1 and in the "Analytics" tabs of the GCC, which is meant to be used to help isolate potential strengths and weaknesses of the group and more specifically where such exist among the entities in the group. Some important information related to other features in the GCC also should be considered and are discussed below. Schedule 1, a simplified version of the Inventory tab, and most analytics are required in the case of a limited filing. However, data is not required for the Capital Instruments, Sensitivity Analysis, and Other Information tabs in a limited filing.

Grouping - The GCC separately allows certain financial entities (e.g., asset managers) and non-financial entities included in the GCC to have their values and capital calculation combined (grouped) for more efficient reporting and analysis. Although the GCC instructions set parameters for such grouping, the general expectation is that regulators will work with each applicable GCC filer in determining where grouping is and is not appropriate outside of what is allowed within the GCC instructions. Grouping should be viewed in the context of materiality. A single entity conducting a given activity may not be material, but when all entities conducting the same activity are combined, they may then be material.

Excluded Entities – The GCC provides two mechanisms for the exclusion of non-financial entities in Schedule 1 and in the Inventory tab at the discretion of the lead state. State regulators should consider whether any of the information collected in the GCC template should be collected for an entity or group of similar entities that would otherwise be excluded from the GCC ratio calculation. Regulators should separately monitor increases in the level of activity of an "excluded" entity or group of similar entities for purposes of materiality and potential subsequent inclusion in the GCC.

Sensitivity Analysis – A tab devoted to sensitivity analysis is included in the GCC. These informational items provide the regulator with impact of discretion in excluding listed entities and alternative perspectives on risk charges for non-financial entities and foreign insurers. Monitoring these items can help the regulator identify areas where the GCC may be improved, or where capital calculations may be adjusted in the future. One item included in the sensitivity analysis is a "sensitivity test" that increases the overall calibration of the calculated capital in the GCC from its normal 200% x ACL RBC calibration to 300% x ACL RBC.

Accounting Adjustments - The impact of accounting adjustments and related detailed information is collected in the GCC template in the Inventory tab and in the Other Information tab, respectively. Such adjustments can be material during the de-stacking process. For example, a consolidated holding company may include GAAP values for entities that would otherwise be valued under regulatory accounting rules (e.g., SAP) on a stand-alone basis. When the regulated entity is de-stacked the difference between the GAAP values and SAP values will be removed from the group's available capital. These "lost" values can result in a material reduction in the inventoried available capital compared to consolidated available capital. Understanding the impact and the components of this adjustment can help the regulator when considering the impact of issuing new debt or when evaluating the allowance for debt as capital calculated in the GCC template.

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Intangible Assets – Acquisitions, mergers, and reorganization often can create significant intangible assets at a holding company level or possibly at an operating company (other than a regulated entity) level. The GCC template collects information on intangible assets held by inventoried entities in the Other Information tab. The available capital associated with the value of entities whose assets are materially comprised of intangible assets should be evaluated in the context of fungible resources and in assessing the adequacy of the capital calculation assessed on such entities.

Dividend Pass-Thru (Gross View of Dividends) – Schedule 1D collects information on dividends paid and received within the group. It also includes a column that indicates whether dividends were declared but not yet paid, as well as cases where dividends received were retained or "passed through" to another affiliate or paid out in dividends to shareholders. This information will assist the regulator in evaluating the movement of capital within the group to fund strategic insurance and non-insurance operations or activities (e.g., expansion of activities) or to fund entity specific capital shortfalls. It also provides a window to capital leaving the group (e.g., debt repayment, stock repurchase, or dividends to shareholders).

Considerations When Exempting Groups – As stated elsewhere within this guidance, the GCC and its related provisions in the Model #440 and Model #450 are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group's GCC. Rather, the GCC is intended to be a tool to better understand the risks of the group, mostly through the trending of the financial information in the "Input 4-Analytics" tab. However, specific to the provisions of the Model #440 and Model #450, the Group Capital Calculation (E) Working Group did believe that the GCC might be more helpful for some groups and not as much for others when it developed criteria within Model #440 and Model #450 for exemptions. On this point, the Working Group believed that in general the GCC would be more helpful for those groups that had 1) non-U.S. insurers within the group; 2) a bank within the group, or 3) a more material degree of non-insurers. Specific to the point regarding non-U.S. insurers or banks, the GCC is based upon the premise that the most relevant measure of capital is the actual legal entity requirements of capital from the applicable regulator. On this point, the required capital, as well as the trending of information on these particular legal entities might be the most valuable, particularly if the relative operations and assets of these entities compared to the U.S. RBC filers is material. Similarly, while the calculated capital on the non-insurance entities may not be as relevant as required capital on regulated insurers or banks, if the operations and assets of non-insurers relative to those of U.S. RBC filers are material, the GCC may provide greater value to such types of groups.

To these points, Model #440 and Model #450 contain possible exemptions for groups that have less than $1 billion in premium and that do not possess any of the three characteristics just described. The possible exemptions exist after the GCC has been filed once, because without seeing the completed GCC at least once for a group, it may be difficult for the lead state to determine if the GCC has value. However, it should also be understood that these three criteria of non-U.S. insurer, bank, or non-material non-insurers are not the only situations where the GCC would be valuable to the lead-state. As a reminder, all states are required to assess the sufficiency of capital within the holding company structure; prior to the GCC, this was done using various methods (e.g., debt to equity ratios, interest coverage ratios, existing RBC ratios and relative size of insurance). The GCC is expected to enhance a state's ability to make this assessment more easily. Therefore, in deciding if a group should be exempted, the lead state will need to consider a number of factors, including how easily it can make this assessment without the GCC. For small groups where the U.S. RBC operations and assets are much larger than the non-insurance operations, it is likely the GCC would provide a smaller degree of value and exempting from the GCC may be appropriate. However, the analyst should also consider the fact that the simpler the holding company structure, the more easily the GCC can be completed. Specifically, given all of the data included in the GCC is existing data and, therefore, readily available to the company, a smaller and simple structured group should be able to accumulate into the GCC template in a short period of time. Also worth considering is that if such operations are contained within a number of different U.S. insurers where it is difficult to determine the degree of double counting of capital, the GCC may provide more value.

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To be clear, these are not the only situations where the GCC might be helpful even with a relatively small group. This is because the value may come from figures the GCC requires that the state may have otherwise not been aware of. Specifically, the GCC may identify non-RBC filers who may be experiencing some level of financial difficulties. This possible identification of information the lead state was not otherwise aware of is the primary reason the Working Group suggested the GCC be filed once before deciding on whether a group should be exempted. While the NAIC Accreditation program may not require a state to have such authority to have the GCC filed once before exempting, this background information provided herein is intended to encourage the state to consider such possibilities before deciding on exempting a group, particularly since it may be difficult to stop an exemption in any given year once it is provided.

In summary, as with everything else described in this documentation, the GCC requires judgement on behalf of the analyst and the lead state based upon multiple factors including the lead-state's existing knowledge of the group. The same applies when considering whether a group should be exempt.

Special Consideration for Risk Retention Groups When Exempting Groups

Risk retention groups (RRGs) often have unique structures that impact how they are regulated, how risks are assessed, and their potential sources of capital. For RRGs in a holding company system, the type of entities in the group, as well as the amount of information readily available for the other entities in the group, play a key role in regulatory oversight, including granting exemptions from the GCC calculation.

The following are some examples of unique circumstances/structures and related procedures that should be considered for RRGs when granting exemptions from the GCC. There may be other examples when evaluating RRGs, and the regulator should clearly document the justification if an exemption is granted.

- RRG is affiliated with a commercial carrier, and the RRG is not the controlling entity in the holding company:
  - The lead state of the commercial carrier will determine whether the GCC is required.
  - The commercial carrier will prepare GCC, which will include RRG results.

- Closely held RRG:
  - Obtain and review the sponsoring organization's audited financial statements to assess the ability to infuse capital if needed and consider any other impacts to the RRG.
  - Check the sponsoring organization's website and/or perform internet research for news headlines to learn of any current changes to the sponsor structure, such as mergers, acquisitions, or any other significant occurrences that could impact the RRG. This would be done periodically/quarterly to anticipate changes requiring a Form D filing.
  - Review the RRG's balance sheet for the asset receivable from parent, subsidiaries, and affiliates, as well as the liability payable to parent, subsidiaries, and affiliates to determine whether there are concerns with the level of affiliated receivables/payables.

- RRG with affiliated offshore reinsurer:
  - Obtain and review the most recent audited financials for the affiliated reinsurer.
  - Ensure compliance with credit for reinsurance requirements.

- RRG itself is the ultimate controlling entity, has one or more non-insurance subsidiaries, and no one policyholder owns or controls 10% or more of the RRG:
  - Through review of RRG policies and procedures, corporate documents, subscription agreements, and policy provisions, determine the RRG's access to capital in the event a capital infusion would be needed. Consider the need to obtain financial information of policyholders. However, where no one policyholder

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owns or controls 10% or more of the RRG, it is not contemplated that the state would routinely collect financial information of the RRG's individual policyholders.

- Obtain and review the most recent financials for the subsidiaries.

In addition to structure, factors consistent with the above guidance for all holding company groups should be considered when exempting an RRG from the GCC. Factors to consider include how easily the information necessary to understand the group's capital situation can be obtained without the GCC and whether the state already has a process to obtain and review the information needed to easily assess the sufficiency of capital within the holding company system.

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Special Note: The following procedures do not supersede state regulation but are merely additional guidance an analyst may consider useful.

The following is intended to demonstrate the type of potential questions a lead state may want to consider when it conducts a periodic meeting with the group. To the extent a lead state chooses to consider asking particular questions, as opposed to simply engaging in a conversation, it is recommended that these NOT be used in a checklist manner and instead be tailored to fit the situation of the group. Tailoring should be based on sophistication, complexity and overall financial position of the group. Again, this list is intended to simply demonstrate the type of questions that may be appropriate.

FINANCIAL PERFORMANCE AND RELATED INDICATORS

Suggested Items for Discussion

1. Group's most recent profitability results by comparing such results (e.g., return on equity (ROE), return on revenue (ROR) or other internal (group) measures against the prior year plan, and the adequacy of the group's results over a five-year period compared to the industry as a whole, peers and shareholder/other stakeholder expectations over the same time period.
2. The drivers of weaknesses within the profitability results and the action the company is taking to improve the results either on a short-term basis in terms of specific products/investments, or a long-term basis in terms of any movement to new products/investments. Discuss the time frame for such actions and when either is expected to affect future trends.
3. Actions being taken by the group to capitalize on strengths in the profitability results and trends such a position. Discuss any risks to such approaches and any risk management techniques the group is using to minimize the downside risk. Are any of these actions expected to put any strain on the group's leverage or overall capital position?
4. Impact of the current year results on the group's overall financial position. Include in that discussion a request to address: 1) the current equity levels of the group compared to the prior year plan, and long-term plan; 2) its adequacy in relation to the group's internal targets; 3) any external targets for the current business plan from rating agencies, banks, or other lenders.
5. The extent to which the current year equity levels are sufficient to absorb any material spike in losses that may have been experienced by the insurance operations, or a particular non-insurance segment or entity.
6. Internal measures used by the group to measure leverage and consider the extent to which such measures are increasing or decreasing over the past five years.
7. The extent the group has introduced any new products, or has become subject to any new obligations, discuss the basics of such products/obligations and any measures taken by the group to mitigate any material downside risk.
8. Changes in the group's liquidity program and the internal measures used by the group to measure such adequacy.
9. Changes in the group's investment strategy or any market changes that are shifting the group's general approach.

OTHER GROUP RISKS

Suggested Items for Discussion

10. Top five to 10 risks the Chief Financial Officer (CFO) and/or Chief Risk Officer (CRO) have identified within the group and how such risks are mitigated.

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11. Group's non-insurance entities, as well as any risks they originate and could pose to the group.
12. Group's use of derivatives and other instruments to mitigate risk and how the group measures any risk that such programs pose to the group.
13. Group's most recent results/position compared to any corresponding covenants the group is required to meet.
14. Impact that the current economic environment is having on the ability to execute the group's business plan both on a short-term basis and a long-term basis.
15. Strategy for meeting any short-term debt or other similar material non-insurance company payments (source of cash and anticipated movement within the group structure).
16. Group's capital allocation methodology including specific levels of capital that are maintained within specific companies and the basis for such allocation (multiple of RBC, multiple of rating agency capital, etc.) and the extent to which excess capital is fungible throughout the group.
17. Internal discussion the group has had with respect to any potential rating agency downgrades and the impact that such a downgrade could have on the group's financial flexibility.
18. Any proposed acquisitions that the group is pursuing, and/or a current strategy associated with acquisitions that meet a particular need. Similarly, discuss whether there are any proposed divestures or operations that may be discontinued and any current strategy the group is considering for possible future transactions.
19. Group's approach for managing its non-insurance entities, as well as the non-uniform requirements of regulated entities and the impact these two distinct variations have on the management of the group's financial condition.
20. Any other events that are affecting the group's strategy or ability to execute its strategy.

SUMMARY, CONCLUSION AND RECOMMENDED FOLLOW-UP

- ❑ Develop and document an overall summary and conclusion regarding the periodic meeting.
- ❑ Analysts may want to consider documenting any questions that were asked during the meeting.
- ❑ Analysts should communicate to the examiner-in-charge (EIC) any prospective risks identified.
- ❑ Provide a copy of such questions and answers to the examiner to help prevent any duplication of questions. However, in some cases, asking some of the same questions on an examination may be helpful to provide an update on particular issues, and would often be used in an examination year to replace the periodic meeting with the group.
- ❑ Analysts should update the Insurance Holding Company System Analysis, Branded Risk Assessments and Supervisory Plan in the Group Profile Summary for risk and other information obtained through meetings with the group.

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Special Note: The following procedures do not supersede state regulation but are merely additional guidance an analyst may consider useful.

The following provides examples of potential risk areas where the lead state, or group-wide supervisor for internationally active insurance groups (IAIGs), may want to perform certain limited examination procedures as part of the continual risk assessment process. However, analysts should be aware that in some years, it is highly possible that no risks or changes in risks rise to the level of requiring a specific targeted examination. In addition, certain risks and examination procedures may not be deemed urgent enough to warrant a targeted or limited-scope examination and could therefore be deferred until the next scheduled examination of the group.

The general purpose of a targeted on-site examination is to focus resources on a particular risk. Such procedures would generally be driven by any change in risks or any weaknesses or concerns. Performing such procedures through an on-site inspection can provide assurances that cannot be provided through off-site monitoring. In some cases, such procedures will focus on collecting information that will provide assurances that the risks that have been portrayed by the group can be relied upon. On-site examinations can also be more effective in understanding the risks of a group that are not easily understood with a regulatory filing, be it through a physical inspection of the group's process or through inspection of supporting documentation. The following provides examples of different risk areas where such assurances can be provided through tailored procedures. However, these are only examples and, again, what should be considered more than anything is the risk or changes in risk of the group and the assurances that can be provided through such an on-site inspection relative to such risks.

PROSPECTIVE RISKS

See Exhibit V – Overarching Prospective Risk Assessment of the Financial Condition Examiners Handbook for a more detailed listing of examples.

1. New products, or recently developed products that have become more material or that create unique risks to the group. Consider reviewing the process to develop and price the product, as well as monitor its results compared to pricing.
2. New investment vehicle either recently acquired or that recently became more material to the portfolio. Consider reviewing the process by which the investment vehicle became available, the diligence performed to consider its risks, and the process to monitor its results before more monies are invested into the strategy.
3. Risk arising from the group's governance. (See Section VI.D. Corporate Governance Disclosures Procedures for a detail of such procedures) or risk management process (see Section VI.E. Enterprise Risk Management Process Risks Guidance for a detail of procedures to apply to groups submitting an Own Risk and Solvency Assessment (ORSA)).

INFORMATION OBTAINED FROM FILINGS, ETC.

4. Information that supports representations regarding significant investors' expectations.
5. Current and historical consolidating financial statements used to validate information obtained regarding non-insurers.
6. Internal management reports that provide product detail on operations that, when accumulated are supported in total by audited statements.
7. Supporting documentation of internal and external equity target levels, including information from rating

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agencies, banks or other lenders.

8. Copy of the most recent liquidity strategy and walkthrough of daily monitoring process.
9. Copy of the most recent investment strategy and walkthrough of recent acquisitions or sales made in connection with strategy.
10. Documentation supporting risk management strategy as presented to internal risk committee or board of directors.
11. Copy of group derivatives use plan and walkthrough of daily monitoring process.
12. Copy of debt covenants and internal quarterly calculations.
13. Copy and walkthrough of projected future capital management plans.
14. Copy of any due diligence work performed on potential acquisition and key metrics for the board's consideration.

INTERNATIONALLY ACTIVE INSURANCE GROUP CONSIDERATIONS

(See Additional Discussion in Financial Condition Examiners Handbook Section 1.I.F)

15. Risks arising from the holding company's status as an IAIG, including evaluations of the head of the IAIG's corporate governance (see Section VI.D. Corporate Governance Disclosure Procedures), risk management (see Section VI.E. Enterprise Risk Management Process Risks Guidance), and/or internal control (see Section VI.C. Insurance Holding Company System Analysis Guidance) frameworks.

SUMMARY AND CONCLUSION

- ❑ Develop and document an overall summary and conclusion regarding the targeted examination.
- ❑ Analysts should update the Insurance Holding Company System Analysis and Supervisory Plan in the Group Profile Summary.

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Special Note: The following procedures do not supersede state regulation but are intended to provide guidance and best practices for Supervisory Colleges; but also, to identify some specific minimum procedures to be used by all U.S. lead states and/or group-wide supervisors when leading a Supervisory College.

OVERVIEW

Background Information

A Supervisory College is a mechanism that intends to foster cooperation, promote common understanding, communication and information exchange, and facilitate coordination for group-wide supervision. Potential benefits of Supervisory Colleges include:

- ❑ Improving all the relevant regulators' understanding of the group and its risks
- ❑ Building relationships between relevant regulators, sharing regulatory approaches, and promoting cooperation and consensus
- ❑ Interacting more effectively with a group's management to gain insights into the group and to reinforce regulatory messages

As the business of insurance has expanded globally, insurance regulators worldwide have determined that increased levels of communication, coordination and cooperation among regulators at Supervisory Colleges is vital to understanding risk trends that could adversely impact policyholder protection and solvency oversight in an increasing global insurance market. As a result, the overall objective is to further information exchange, cooperation and coordination amongst relevant regulators as a key component for enhancing the supervision of cross-border financial institutions.[i]

In the U.S., the *Insurance Holding Company System Regulatory Act* (#440) provides the commissioner with the authority to participate in a Supervisory College for any domestic insurer that is part of an insurance holding company system with international operations. The powers of the commissioner with respect to supervisory colleges include, but are not limited to, the following:

- Initiating the establishment of a Supervisory College.
- Clarifying the membership and participation of other supervisors in the Supervisory College.
- Clarifying the functions of the Supervisory College and the role of other state insurance regulators, including the establishment of a group-wide supervisor.
- Coordinating the ongoing activities of the Supervisory College, including planning meetings, supervisory activities, and processes for information sharing.
- Establishing a crisis management plan.

[i] The statement from the G-20 Summit on Financial Markets and the World Economy, held in Washington, DC, in November 2008, states the following: "Supervisors should collaborate to establish Supervisory Colleges for all major cross-border financial institutions, as part of efforts to strengthen the surveillance of cross-border firms."

[ii] "Report of the Financial Stability Forum on Enhancing Market and Institutional Resilience," Financial Stability Forum, April 2008.

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In addition to U.S. guidance, the International Association of Insurance Supervisors (IAIS) has developed guidance for state insurance regulators in conducting and participating in Supervisory Colleges, which are primarily presented in Insurance Core Principle (ICP) 25 – Supervisory Cooperation and Communication, as well as additional considerations and best practices in the IAIS's Application Paper on Supervisory Colleges.[ii] Information from these sources has been utilized in developing this chapter, and state insurance regulators are encouraged to reference the source documents, as necessary, to gather additional insight. However, IAIS materials are not deemed authoritative and should not be viewed as official NAIC guidance if they are not directly incorporated into this chapter.

ICP 25 provides among other things, the following guidance related to Supervisory Colleges that is hereby incorporated into this chapter:

- "Supervisors of the different insurance legal entities within an insurance group with cross-border activities should coordinate and cooperate in the supervision of the insurance group as a whole."
- "Supervisors may draw upon several supervisory practices to facilitate cross-border cooperation and coordination. These practices include the identification of a group-wide supervisor and the use of coordination arrangements, including supervisory colleges."
- "The procedures for systematic or ad hoc information exchange should be agreed with the other involved supervisors. The sharing of information by the group-wide supervisor and the other involved supervisors should be subject to confidentiality requirements."
- "Once identified, the group-wide supervisor should be responsible for coordinating the input of insurance legal entity supervisors in undertaking group-wide supervision as a supplement to the existing insurance legal entity supervision. Responsibilities of the group-wide supervisor should include chairing of the supervisory college (where one exists) or consider establishing one if not in place yet."
- "The group-wide supervisor, in cooperation and coordination with other involved supervisors, should consider establishing a supervisory college where, for instance: the nature, scale and complexity of the cross-border activities or intra-group transactions are significant and associated risks are high; group activities or their cessation could have an impact on the overall stability of the insurance markets in which the insurer operates; and the insurance group has significant market share in more than one jurisdiction."
- "The group-wide supervisor sets out the coordination arrangements in a written coordination agreement and puts such arrangements in place."
- "A written coordination agreement should cover activities including information flows between involved supervisors; communication with the head of the group; convening periodic meetings of involved supervisors; conduct of a comprehensive assessment of the group, including the objectives and process used for such an assessment and supervisory cooperation during a crisis."

STRUCTURE

The guidance contained in this, and the following sections apply generally to all Supervisory Colleges of insurance groups involving foreign jurisdictions. Additionally, colleges for insurance groups that meet the IAIG criteria are subject to additional expectations that are separately outlined towards the end of the chapter.

Organizational Procedures Performed Before Conducting a Supervisory College

Although there is no international legislation that provides that the group-wide supervisor has any authority over the sovereign authority of the jurisdiction, insurance regulators across the world have agreed that having one

[ii] Located on the IAIS website: https://www.iaisweb.org/home

group-wide supervisor that is responsible for coordination and communication among supervisors within the group strengthens the global insurance regulatory system.

Supervisory College Membership

Supervisory College members are generally the states/jurisdictions where the largest insurance entities within a group are domiciled, premium underwritten and key corporate decision-makers in the organization are located. However, also worth considering is the materiality that the group has for a particular jurisdiction. The group-wide supervisor or U.S. Lead State should consider who the appropriate invitees to the college should be; recognizing that determining the materiality of a group to a particular jurisdiction may be difficult. Ultimately, it is the responsibility of the group-wide supervisor, in cooperation with other involved supervisors, to determine which jurisdictions participate in the college and to review membership on a regular basis to reflect changing circumstances in the insurance group.

While there is a need to include as many members as possible, it must be balanced with the need to maintain a manageable, operational Supervisory College. In this regard, it may be appropriate to establish a tiered membership approach. This approach suggests that regulators that attend a Supervisory College be referred to as "Tier 1 or Tier 2" jurisdiction. If jurisdictions have primary authority (e.g., state/country of domicile) for insurers that have direct or gross premium greater than 5 percent of the entire group it may be appropriate for this tier 1 cutoff. The state insurance regulator should also consider requesting feedback from the insurance group regarding who it believes should be included in the "Tier 1," because they will have more specific data on the premiums written in each jurisdiction. In most cases, this type of approach will limit the number of jurisdictions involved. However, it may also be appropriate to place a limit on the total number of individuals participating from each jurisdiction. Some state insurance regulators suggest a maximum of 75 regulators attending a Supervisory College and believe that 50 is a more manageable number to maximize the effectiveness of the college.

In some cases, trying to maintain a specific size may result in some smaller jurisdictions that may be small to the group, but whose market is materially impacted by the group, being excluded from the actual college meeting. However, the group-wide supervisor must determine a means for such jurisdictions to be involved with the college through other means (e.g., follow up correspondence with all jurisdictions after a college meeting has taken place which could include the use of different secure IT tools).

States that are group-wide supervisors should consider developing, or requesting the group to develop, a map of all of the entities within the group and the corresponding jurisdiction for each entity. This mapping can be further enhanced by providing additional information that identifies the actual primary contact for each jurisdiction, as well as other participants from the same jurisdiction, and various contact information. When developing such a list, it's important to consider branches or other aspects of the group that may not be included on an organizational chart. All of this information should be kept up to date at all times, and made available through correspondence to all college members, and may be more easily distributed through a secure IT tool.

The use of such tools is becoming more common, and in addition to requiring confidentiality of data and controls around the sharing and updating of information, they must also allow for the permanent storage of data, and they must be efficient to administer. Similar issues may exist as it pertains to other forms of communication, such as conference calls.

Coordination and Information-Sharing Agreements

One of the most critical and lengthy tasks undertaken by the group-wide supervisor is drafting, distributing, and obtaining executed coordination and information-sharing agreements from the participating supervisory college membership. U.S. group-wide supervisors have experienced significant delays in getting information-sharing agreements drafted and completed with college members, which can span a period of months. Therefore, sufficient lead time is absolutely critical to ensuring that all agreements are obtained prior to the distribution of any materials for the college meeting. Consequently, this activity should be initiated at the outset of planning and organizing a supervisory college.

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A written coordination agreement should cover activities including:

- Information flows between involved supervisors.
- Communication with the head of the group.
- Convening periodic meetings of involved supervisors.
- The conduct of a comprehensive assessment of the group, including the objectives and process used for such an assessment.
- Supervisory cooperation during a crisis.

In addition, the coordination agreement may also include information on membership of the college, the process for appointing a supervisor to chair, the roles and functions of the college and its members, the frequency and location of meetings, and the scope of activities of the college.

The group-wide supervisor is responsible for the regular information collected by the Supervisory College and any notifications that should be made to it (from supervisors and the group). The Supervisory College should agree to the frequency of which information is provided and any information gathering should be coordinated in a way so as to avoid duplicative requests and to reduce the burden on a group. State insurance regulators should understand the difficulty and the amount of time it may take to get these agreements in place. This difficulty can lead to significant delays in beginning a new Supervisory College; therefore, state insurance regulators should take action to complete these information sharing agreements as soon as possible. The group-wide supervisor must recognize however that such agreement is needed not only for college meetings, but also correspondence that may be made available to all college members (sometimes a wider group than the jurisdictions attending the meetings) subsequent to a meeting.

A written information-sharing and confidentiality agreement between the involved supervisors must be agreed upon and entered into by all parties prior to participating in the Supervisory College, which may be covered through a broader coordination agreement. This information-sharing and confidentiality agreement can be achieved in various ways, such as: 1) through bilateral memorandums of understanding (MOU) among all of the jurisdictions involved; 2) through a Supervisory College-specific agreement; or 3) through the IAIS multilateral memorandum of understanding (MMOU), which establishes a formal basis for cross-border cooperation and information exchange amongst supervisors around the world to enhance supervision of internationally active insurance groups (IAIGs). The Department should note that in selecting the best agreement to utilize, while the NAIC Master Information-Sharing and Confidentiality Agreement (Master Agreement) addresses the sharing of information between state insurance departments, it does not include information sharing with other functional regulators, such as federal or international regulators, that may be participating in Supervisory Colleges.

The objective of the Mamou is for a signatory authority[iiii] to be able to request from and provide to any other signatory authority having a legitimate interest, information on all issues relevant to regulated insurance companies (including licensing, ongoing supervision and winding-up where necessary) and to other regulated entities such as insurance intermediaries, where appropriate. The MMoU is essentially designed as an alternative vehicle for having every jurisdiction sign a bilateral confidentiality agreement with every other jurisdiction. Further, it facilitates the exchange of confidential information in the Supervisory College context. If all members of a Supervisory College are also signatory authorities of the IAIS MMoU, it would effectively eliminate the need for every Supervisory College member to enter into a bilateral agreement with every other Supervisory College member and/or the drafting of a Supervisory College specific agreement in order to ensure that confidential

[iii] A "signatory authority" is defined in the IAIS MMOU Article 2 as "any insurance industry supervisor who is an IAIS member or is represented by an IAIS member [reference made here to the NAIC per the IAIS Bylaws Article 6 No. 2(b)] and following a successful qualification procedure has acceded to the MMOU by its signature." Each U.S. state insurance regulator, as an IAIS member or represented by an IAIS member (the NAIC), is eligible to be a signatory authority.

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information can be freely exchanged between Supervisory College members. This mechanism has the potential to significantly improve and expedite the cross-border exchange of information between supervisors. The execution of a memorandum of understanding on either a bi-lateral or multi-lateral basis does not supersede state or federal law governing disclosure of information. The legal obligations and regulatory requirements concerning information sharing and disclosure placed on state insurance regulators remain in effect.

Chairing the Supervisory College/other Supervisory Duties

As previously noted, it is generally expected that the group-wide supervisor will serve as the chair of all Supervisory Colleges. In addition to serving as the leader for the college, the chair is expected to complete a number of activities prior to and subsequent to each college. The following lists some of these activities:

- Set the date for the meeting.
- Conduct a group-wide supervisory review of the IAIG, including a group-wide risk assessment, and communicate the results to members of the Supervisory College and, as appropriate, concerns or areas of focus to the head of the IAIG to assist in college planning.
- Set the agenda for the meeting in coordination with other involved supervisors and distribute it in advance. The potential list of agenda topics and company presenters should be discussed with the insurer for input to help maximize the effectiveness of the college.
- Record outcomes that are achieved at each meeting including points arising from the meeting (specifically, the individual to whom each task is assigned and the deadline when an action should be complete) to allow the college to track individual items to make sure that the necessary action has been carried out.
- Liaison with insurer's designated college coordinator in obtaining information, their participation in the college and any related correspondence.
- Develop a preliminary crisis management plan.
- Consider for larger colleges preparing and updating a coordinated work plan. Consider using U.S. Supervisory Plan as starting point.
- Prepare, update, and circulate as changes occur, a contact list of members.
- Require a periodic self-assessment of the effectiveness of the college.
- In addition to these items, it is important to recognize that other expectations may exist from regulators and the US state should determine how to address such expectations. The following may be common examples of such other expectations of the group-wide supervisor:
- Set reporting requirements for the college, including specifying frequency (e.g., annual, quarterly, etc.) and type (technical provisions, issues raised as a result of on-site inspections, intra-group transactions, outsourced activities)
- Analyze data received from the group.
- Promote willingness to work together with other regulators.
- Provide guidance to other regulators on particular issues.
- Improve college effectiveness not within the group-wide supervisor's purview. Therefore, it may be appropriate to encourage maximum participation from all members of the college.
- Allow college members to submit written comments prior to the college meeting if they are unable to attend due to resource constraints, timing of the meetings, language barriers, or any other reason, even though regulators of entities that are significant to the group are generally expected to attend.
- Draft minutes or action points for approval by the members

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- Circulate presentations and other materials for the meeting once information sharing-agreements are obtained from all college participants.

Key Functions of the Supervisory College Including Coordination Agreements/Terms of Reference and Work Plan

One of the primary purposes of Supervisory Colleges is to facilitate coordination and communication between regulators. Consequently, one of the key functions of the college is to create the means to facilitate communication. Making this happen begins with the actions of the group-wide supervisor. As previously stated, state insurance regulators should be aware that other regulators may have other expectations when it comes to the group-wide supervisor. Specifically, Article 248 of the *European Union Solvency II Directive* indicates that the group-wide supervisor has a significant planning and coordination role, but also a more defined supervision review and assessment role and significantly more decision-making capacity. State insurance regulators should understand and be aware of these possible differences and seek to establish agreed upon expectations with the other involved supervisors. Understanding the specific expectations may be communicated through conference calls by the college members. These expectations once documented are often referred to as a "Coordination Agreement" or "Terms of Reference." A Coordination Agreement can serve as defining the expectations of the members of the purpose of the college and can include clarification on why a particular supervisor was determined to be the lead supervisor(s), group membership, agreement on frequency and location of meetings and finally, the role and responsibilities of the group-wide supervisor.

Different Approaches to College Structures

In general, the majority of colleges that states attend and lead are known as inclusive colleges. Under an inclusive college, there are no differences for the group-wide supervisor and other college members regarding participation in college work or access to information. More specifically, under this approach, the college would not use sub-colleges (e.g., regional colleges) or topical colleges where only certain members are invited to participate. This approach does not preclude the use of joint examinations between jurisdictions where two or more jurisdictions believe that they have a similar issue that applies to their legal entities. Other approaches can include a tiered approach, where there may be a US regional college, or a European college, or some other regional, with a separate world college. In these situations, the group-wide supervisor may be expected to attend each of these, or at least that has become the practice. Consequently, this may be more demanding. Finally, in some cases there may be core colleges that only involve the college members most significant to the business of the group. These may be useful in targeting discussions but may also create additional work for communicating the results back to other members of the world college. States should also be careful to consider the ramifications of these types of approaches on the existing information sharing agreements, as they may require additional more inclusive agreements if jurisdictions carry that opinion.

COLLEGE EXPECTATIONS – AS THE GROUP-WIDE SUPERVISOR

College Requirements for U.S. States Determined to be the Group-Wide Supervisor

The following sets forth examples of regulatory procedures to be used by U.S. lead states when leading a Supervisory College. States that act as group-wide supervisors are encouraged to develop additional internal processes for meeting planning and logistics to supplement these procedures.

Initial College Procedures (most likely not applicable after first college meeting)

- ❑ Begin to plan all of the relevant logistical items that are important to a successful college, including considering the schedule of other Supervisory Colleges as posted to the Supervisory College Calendar on iSITE+.

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- ❑ Identify the entities that would fall within the scope of the group, either based upon information from annual holding company filings or through direct communication with the group, or both.
- ❑ Determine through various means if your jurisdiction may be considered the group-wide supervisor and proceed under this assumption.
- ❑ Make initial contact with other regulators that may also be considered the group-wide supervisor and informally suggest your state may be the group-wide supervisor. If there are no objections, proceed to planning the first Supervisory College.
- ❑ Develop and execute information sharing agreements necessary for the protection of confidential information that will be shared among college members Acceptance of the wording of these agreements and the protections they provide are key to the insurer releasing college materials.
    - Consider establishing and maintaining a confidential information-sharing tool or portal, with an appropriate level of access controls and monitoring in place, to collect and share information among college members that have entered into a Coordination/Information-Sharing Agreement.
- ❑ At the college, present an initial Coordination Agreements/Terms of Reference document that summarizes various important aspects of the college collected prior to the college meeting, then discuss and adjust as deemed appropriate by members.
- ❑ At the college, present an initial Crisis Management Plan for discussion then adjust as deemed appropriate by members.
- ❑ At the college, direct a short discussion by each jurisdiction of their respective legal entity(ies), and the impact it (they) may have on the group. This type of discussion is not to be repeated after the initial meeting unless the impact is material, or if it is from the perspective of what is driving particular performance for the group as a whole.
- ❑ Develop a preliminary Supervisory Work Plan based on information gathered at the college with input from the college members.

Initial and Ongoing College Meetings

- ❑ Send to all of the appropriate jurisdictions, initial information regarding the potential for a Supervisory College meeting approximately six to nine months before the intended date (two to three months each conference calls) and modify the date to fit the needs of as many regulators as possible. Use of conference calls to discuss specific issues raised regarding the insurer will enable the regulator-to-regulator meeting immediately preceding the college meeting to be more efficient.
- ❑ Develop a tentative agenda and distribute it eight weeks before the college to all other regulators who plan to attend, asking for changes in order to ensure each jurisdiction's needs are met. Refine the agenda as needed and redistribute to all regulators four weeks prior to the college.
    - The agenda should be focused on a regulator shared view of the primary risks of the group. At the end of the meeting, college members should reach consensus upon the updated shared view of the primary risks of the group.
        - The primary risks of the group will vary but will require the same general understanding of the group's business strategy, risk management and governance processes, in addition to its financial, legal, and regulatory position. Therefore, initial colleges should have an agenda that develops this same general understanding of each of these items. Primary risks can be determined prior to such an understanding, but such a list is expected to be modified over time as the college gathers more information each meeting.

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- The agenda should include presentations from the group regarding those topics selected by the regulators when voting on the agenda (either to the entire group, or breakout sessions on more specific topics). This can include things such as the following:
    - Strategic and financial overview
    - Material changes to the group since last meeting
    - Material plans and projects for the coming year
    - Governance and risk management
    - Identification of key risks
    - Capital planning and management
    - Stress testing
    - Interconnectivity
    - Non-regulated entities
    - Succession planning
- The meeting should include targeted discussions on the primary risks of the group, or trends that suggest a modification to such a list. The group-wide supervisor should consider utilizing a Group Profile Summary, or a similar document to meet this objective and summarize the results of their group-wide risk assessments. This specifically includes a document that would focus on the branded risk classifications of the group.
    - Exchange/discuss qualitative and quantitative information and data either prepared by the regulator or by the group. The information shared should be based upon the regulators shared view of the primary risks of the group, including any evolving or new potential material risks identified by any member. Discuss at each college if the information is adequate or if further information is appropriate for ongoing review of the group.
    - The group should present on the implications and readiness of the group for work adopted within various jurisdictions (e.g., ORSA, reporting or model development for Solvency II, etc.)

❑ After the agenda topics/insurer presenters are identified by the college participants, contact the insurer's designated college coordinator to make certain the key personnel are available for the appropriate portions of the college meeting before finalizing the date.

❑ Discuss and agree on feedback to the group and where appropriate, solo/legal entities.

❑ Update and reach consensus upon a modified Coordination Agreements/Terms of Reference document.

❑ Update and reach consensus upon a modified Crisis Management Plan.

❑ Update and agree upon a modified Supervisory Work Plan including updates to risks and identification of individuals and the jurisdiction to whom each task is assigned and the deadline or frequency when an action should be completed. The updated Supervisory Work Plan should be updated and distributed to all members of the college.

❑ Record a summary of each meeting, documenting decisions that were reached. Distribute the summary to the participants following each college meeting.

❑ Distribute an updated contact list of members following each college meeting, or something more flexible if that is agreeable to college members.

❑ Have each member of the college meeting discuss the effectiveness of the college and the need for any changes, and have each member complete a survey of its effectiveness.

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With regard to agendas, the above tries to capture the need for agendas that are focused on the risks of the group, which can be different from one group to the next. However, as Supervisory Colleges are intended to employ best practices because participating members are expected to attend other colleges, emphasis should be placed on asking all jurisdictions to provide suggestions to draft agendas.

Group Risks Perspective from Each Supervisory College Member

As discussed previously, the Coordination Plan/Terms of Reference document is intended to capture the specific expectations of each member of the Supervisory College. Understanding each member's expectation is critical to having a successful college. In order to meet the majority members expectations, it is suggested that the group-wide supervisor requests input from other college members, as necessary, to identify group risk exposures and tailor the college agenda and supervisory workplan, as necessary, to address concerns.

Crisis Management Plan

Note: Sample Plan is available within iSITE+ – FAH Report Links

Many regulators believe that Supervisory Colleges are most effective when mutual cooperation and mutual trust is achieved. This attribute proves most beneficial and perhaps needed in times of financial difficulties or financial distress for the company. Although regulators take steps to encourage companies to avoid financial trouble and distress, they must all be prepared for such situations to occur. To that end, the Supervisory College should engage in a conversation about the issue and how the college will work in these situations. The intent is for these discussions to occur at the inception of the college itself, and then be documented and approved formally as early as possible. Such plans should attempt to be flexible and should consider the need to adapt to the particular individual company situation

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COLLEGE EXPECTATIONS – AS THE LEAD STATE BUT NOT THE GROUP-WIDE SUPERVISOR

The following are suggestions relating to the role of the U.S. lead state to function as the U.S. contact for parent holding companies domiciled in other countries.

- Communicate on a consistent basis with applicable international regulators
- Attend Supervisory Colleges and for informal conference calls
- Provide consistency in who participates in the Supervisory College for continued building of international relationships

The U.S. lead state plays a key role in coordinating communication to and from the international holding companies to the non-lead states.

The U.S. lead state also provides a financial review of the international holding companies, and must:

- Have a good understanding of the holding company organizational structure
- Keep current of the financial review of the ultimate controlling person's financial statements and those of key subsidiaries
- Keep current of the significant events that impact the holding company system (e.g., financial, market, stock, catastrophic, etc.)
- Maintain contact with the international holding companies and the international regulators
- Coordinate the sharing and requesting of information where appropriate

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After participating in a Supervisory College session, the U.S. lead state is encouraged to:

- ❑ Develop and document an overall summary and conclusion regarding the college
- ❑ Describe structure of college, attendees, key risks identified, etc.
- ❑ Identify key observations and risk noted during the Supervisory College
- ❑ Coordinate and communicate follow-up on key takeaways to relevant regulators, including in-house state departments (such as examination, actuarial, rates and forms, etc.)
- ❑ Update the Holding Company System Analysis if there are observations from the college that have a material impact on the view of the group.
- ❑ Update the Group Profile Summary and Supervisory Plan if there are observations from the college that have a material impact on the view of the group.

U.S.-BASED INTERNATIONALLY ACTIVE INSURANCE GROUP CONSIDERATIONS

While the guidance included in this chapter is generally applicable to all Supervisory Colleges, there are some specific considerations and requirements for IAIG Supervisory Colleges that should be followed by U.S. group-wide supervisors, as summarized below. For additional background information and best practice suggestions, please see ICP 25.

- **Frequency of College Sessions** – IAIG college sessions are expected to be conducted at least annually, in-person or via conference/video call, with the first session taking place in a timely manner after the identification of the IAIG.
- **Initial College Session** – Priorities for the initial Supervisory College meeting should include:
  - Confirming the group-wide supervisor and the structure of the Supervisory College.
  - Describing the scope of group-wide supervision, including an explanation from the group-wide supervisor on the scope of group supervision and any entities excluded.
  - Discussing proposed coordination agreements.
- **Ongoing College Sessions** – The group-wide supervisor should ensure that the IAIG's Supervisory College discusses the most relevant elements of the group-wide supervisory process and the supervisory plan by coordinating with other involved supervisors. The agenda set by the group-wide supervisor should provide for discussion of at least the IAIG's:
  - Corporate governance framework.
  - Enterprise risk management (ERM).
  - Main risks and intra-group transactions.
  - Financial position.
  - Regulatory capital adequacy and compliance with supervisory requirements.
  - Coordination of ongoing supervisory oversight activities and examinations, if appropriate.
- **Communication and Information Exchange** – The members of the IAIG's Supervisory College should communicate and exchange information on an ongoing basis—i.e., in conjunction with and outside of formal college sessions—in accordance with information-sharing and confidentiality agreements.
- **Review and Assessment of Group Capital** – The members of the IAIG's Supervisory College should obtain, discuss, and assess group capital information from the IAIG, including information provided in the group

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capital calculation (GCC) and ORSA Summary Report. In addition, a discussion of group capital may include information provided through the Aggregation Method (AM), or the Reference Insurance Capital Standard (ICS) as reported to the IAIS, if applicable and available.

- The discussion by group-wide supervisors and Supervisory Colleges could include: 1) a comparison of GCCs, current or under development, to the Reference ICS; 2) the extent to which material risks of the IAIG are captured; 3) the appropriateness and practicality of the calculations required; and 4) any difficulties in implementing the GCCs by the IAIG or the group-wide supervisor.

- **Crisis Management Group**[iv] – The group-wide supervisor establishes a crisis management group (CMG) for the IAIG, with the objective of enhancing preparedness for, and facilitating the recovery and resolution of, the IAIG[v].
  - There should be clear membership conditions, and members should include the group-wide supervisor, other relevant involved supervisors, and relevant resolution authorities, if possible.
  - The CMG should keep under active review the process for sharing information within the CMG and with host resolution authorities not represented, the processes for recovery and resolution planning for the IAIG, and the resolvability of the IAIG.
  - The role, priorities, and approach of any CMG should be proportional to the group's organization, capital structure, characteristics, and financial condition.
  - As stated in the *ORSA Guidance Manual*[vi], "the ORSA Summary Report should discuss at a high level the severe stresses that could trigger a recovery plan measures and the recovery options available." In the US, the information provided in the ORSA Summary Report or other ERM reporting should generally satisfy the requirement to develop a recovery plan for an IAIG.[vii] However, the U.S. group-wide supervisor, in consultation with the CMG, should determine through an activities-based approach, whether or not to require a stand-alone recovery plan that is in addition to the recovery information provided through ERM/ORSA.
    - A recovery plan[viii] establishes in advance the options to restore the financial position and viability of the IAIG in a crisis, as well as how and when the plan should be updated on an ongoing basis.
    - The recovery plan should be utilized by the CMG and the IAIG to take actions for recovery if the IAIG comes under severe stress.
    - It is recommended that the group-wide supervisor consider the IAIG's nature, scale, and complexity when setting recovery plan requirements, including the form, content, and detail of the recovery plan and the frequency for reviewing and updating the plan.
    - The head of the IAIG should ensure that the IAIG's management information systems are able to produce, on a timely basis, information that is relevant to the recovery plan (as determined—see above.) and necessary for the execution of recovery actions[ix]. Similarly, management information

[iv] For additional guidance, refer to the *Receiver's Handbook for Insurance Company Insolvencies* [insert chapter/appendix reference] and the *Troubled Insurance Company Handbook* (regulator only publication) [insert chapter/appendix reference].
[v] Refer to ICP CF 25.7.a.
[vi] 2022 *ORSA Guidance Manual*, page 14. https://content.naic.org/sites/default/files/publication-orsa-guidance-manual.pdf
[vii] ICP CF 16.15.a requires recovery plans for IAIGs. In the U.S., existing available recovery information is considered first in determining a recovery plan requirement.
[viii] Refer to ICP CF 16.15.a and the IAIS Application Paper on Recovery Planning for more background information and possible best practice guidance regarding governance, monitoring, updating the recovery plan, and key elements of a recovery plan (e.g, stress scenarios, trigger frameworks to identify emerging risks, recovery options, communication strategies, and governance). (https://www.iaisweb.org/home)
[ix] Refer to ICP CF 16.15.b, ICP CF 16.15.b.1 and ICP CF 16.15.b.2

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systems should be able to produce information on a timely basis for resolution authorities, for purposes of preparing for resolution and taking resolution actions[x]. The group-wide supervisor should ensure that the management information systems are capable of being operated effectively by the receiver, if receivership becomes necessary.

- With regard to resolution plans[xi] the group-wide supervisor and/or resolution authority, in consultation with the CMG, should have a process to regularly determine whether a resolution plan is necessary, including consideration of factors such as the size, risks, activities and complexity of the IAIG[xii] .
- Where a resolution plan is required, the group-wide supervisor and/or resolution authority, in coordination with the IAIG CMG[xiii]:
  - Ensures that the plan covers at least the group's material entities.
  - Requires relevant legal entities within the IAIG to submit necessary information for the development of resolution plan.
  - Regularly undertakes resolvability assessments to evaluate the feasibility and credibility of resolution strategies, in light of the possible impact of the IAIG's failure on policyholders and the financial system and real economy in the jurisdictions in which the IAIG operates.
  - Requires the IAIG to take adequate actions to actions to improve its resolvability, where impediments to resolution are identified in a resolvability assessment.
- The group-wide supervisor puts in place a written coordination agreement[xiv] between the members of the IAIG CMG, which covers the following:
  - Roles and responsibilities of the respective members of the IAIG CMG.
  - The process for coordination and cooperation, including information sharing among members of the IAIG CMG.

[x] Refer to ICP CF 12.3.a

[xi] Refer to ICP 12.4, ICP CF 12.4.a and the Application Paper on Resolution Powers and Planning for more background information and possible best practice guidance, including the approach to determining if resolution plans are needed and key elements of a plan (e.g., resolution strategies, financial stability impacts, governance, communication, and impact on guaranty fund systems). (https://www.iaisweb.org/home)

[xii] Per ICP CF 12.4.a.1, factors to be considered are set out in ICP 12.4

[xiii] Refer to ICP CF 12.4.b

[xiv] Refer to ICP CF 25.7b and to the IAIS Application Paper on Supervisory Colleges, Nov. 2021, and the Application Paper on Resolution Powers and Planning, June 2021.

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Schedule A
(Supervisory College Members)

as a part of the

Terms of Reference
for the COMPANY Supervisory College

Tier I Members:

1. COUNTRY
2. COUNTRY
3. UNITED STATES – STATE
4. UNITED STATES - STATE

Tier II Members:

1. COUNTRY
2. UNITED STATES - STATE

Tier III Members:

1. COUNTRY
2. UNITED STATES - STATE

EXAMPLE

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The following guidance on assignment of group code was adopted by Financial Condition (E) Committee in 2014.

- NAIC Group Codes are assigned by NAIC staff to add efficiency and effectiveness to the oversight functions performed by NAIC members and their financial regulatory staff. Similar to the concept of statutory accounting and reporting which is designed to meet the needs of regulators but is also used by non-regulators, the NAIC Group Code is designed for regulatory needs but is available to non-regulators. The NAIC Group Code allows for quick and easy identification of related companies, their electronic statutory financial statement results in the NAIC Financial Data Repository (FDR) database, and their automated prioritization and analysis tool results that are generated from the electronic statutory financial statement filings and provided to regulators through iSite+.
    - These benefits are useful to regulators in all states in which the particular insurer or insurers in a specific insurance holding company system are licensed and writing business, not just the domiciliary state(s).
- To respond to mergers, acquisitions and dispositions, NAIC staff will make changes in existing NAIC Group Codes based upon information received from insurance groups and their regulators. However, if any questions or disagreements arise for a particular change in the NAIC Group Code, NAIC staff will seek direction from the collective states which are expected to make their decisions as to which US based insurers should be included in an NAIC Group Code based upon the definitions of "Insurance Holding Company System," "Control," "Affiliate," "Subsidiary," and "Person" from the NAIC *Insurance Holding Company System Regulatory Act* (#440).
    - The "Control" concept in Model #440 includes a process whereby presumption of control (presumed to exist with ownership/control of 10% or more of the voting securities of an entity) can be rebutted (Section 4.K.). Per this section, a "disclaimer of affiliation" must "fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation."
    - Similarly, the "Control" concept in Model #440 establishes the authority for the commissioner to determine control exists, "after furnishing all persons in interest notice and opportunity to be heard," even when a presumption of control does not exist (Section 1.C.).
- For these issues, all states in which the subject insurer is currently licensed, as well as the domiciliary states of affiliates of the subject insurer, are the collective states able to raise questions or disagreements with any proposed change to the NAIC Group Code.
- Upon receipt of a question or disagreement, NAIC staff will work with the domiciliary state regulator of the subject legal entity insurer to set up a call with these states, and any applicable international supervisors and/or sectoral regulators, to discuss the question or disagreement. As a best practice, the subject legal entity insurer should communicate with the collective states to facilitate this process.
- The NAIC Group Code will be changed based upon the consensus view of the domiciliary states of the subject legal entity insurer and its affiliates. If a consensus view is not reached, NAIC staff will pursue direction from the NAIC Financial Condition (E) Committee. NAIC staff will formally notify the Chief Financial Regulators, and any applicable international supervisors/sectoral regulators, of the change in the FDR database and its effective date.

As stated above, the collective domestic states decide which U.S based insurers should be included or excluded in an NAIC Group Code. The following are a few best practices and considerations for establishing a change in the Group Code.

- Group Code changes should not be impacted by insurance companies within the respective group.
- Group Code decisions should not be based on intentions that results in allowing groups to avoid U.S. state, federal or international regulation (e.g., ORSA group premium criteria).

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- If a decision is made to exclude an insurer from a group code, regulators should consider whether any interconnectedness between the insurer and the group will still be transparent in public disclosures.

The following examples provide unique organizational situations that may require analysts to gain a clearer understanding of the group relationships during the review of group code changes or during subsequent holding company analysis.

- Attorney-in-fact: The amount of fee charged to the insurer for services provided by the attorney-in-fact and the overall financial impact on the insurer.
- Limited Partnerships & Hedge Funds:
  - A Master Limited Partnership (LP) where the only management and employees in the LP consist of two individuals who were appointed and paid by a hedge fund.
  - Hedge funds that own stakes in several insurance groups or serve as asset managers for the insurance groups.
- Family Ownership Structures: Family members collectively own the largest percentage shares in multiple insurers.
- Boards of Directors: Common and multiple seats on Boards of Directors of different insurance groups, however the common board members do not have voting rights on the Board, therefore under SEC rules there is no control.

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