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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Date: January 4, 2017
To: Users of the NAIC’s Financial Analysis Handbook
From: NAIC Staff

This edition of the NAIC Financial Analysis Handbook is to be used in conjunction with the 2016 Annual and 2017 Quarterly Financial Statements. The following summarizes the most significant changes since the prior edition:

Level 1—All Statements
In the reference guide, in a new section titled “Understanding the Insurer in Risk-focused Financial Analysis”, additional guidance was added to encourage analysts to review existing sources of information already available to the insurance department and make inquiries to the lead state prior to requesting additional information from the insurer for certain risk areas.

Level 2—Investments
Additional guidance and procedures were added to assist in determining whether concerns exist regarding the insurer’s exposure to certain classes of BA assets, specifically hedge fund and private equity funds, and the insurer’s level of expertise in investing in alternative investments.

Level 2 – Property/Casualty Reinsurance
Additional guidance and procedures were added to assist in determining whether there is a trend of commutations and if it has a favorable/unfavorable impact on the insurer.

Supplemental Procedures – Management Considerations
Additional guidance and a procedure were added to assist the analyst in evaluating the insurer’s human capital and succession planning.

Group-wide Supervision – Lead State Insurance Holding Company System Analysis
Guidance and procedures were updated to assist the analyst in the lead state analysis process. In order to eliminate redundant guidance and clarify lead state guidance, three chapters from Group-wide Supervision were combined into two chapters and clarifying edits were made.

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, or Rodney Good, Property/Casualty Financial Analysis Manager at (816) 786-8430, rgood@naic.org, or Bill Rivers, Health Financial Analysis Program Manager at (816) 783-8142, wrivers@naic.org.
## Financial Analysis Handbook Proposed Revision Form

### Instructions

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

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### Handbook Sections To Which Proposal Applies

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### 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 Handbook (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, 2017. They will be reviewed by the Working Group and considered for adoption and implementation in the next Handbook edition. Send proposals via email to Ralph Villegas, Life/Health Financial Analysis Manager, rvillegas@naic.org, or fax to 816-460-7563; or send to Rodney Good, Property/Casualty Financial Analysis Manager, rgood@naic.org, or fax to 816-460-0176. 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.

Any member of a state insurance department is welcome to submit a Proposed Revision Form. The forms will be regarded as submitted on behalf of insurance departments rather than individuals.

Proposed Procedure 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 of procedures. This analysis encompasses the effectiveness of ratio limits as well as the language of procedures. Additionally, the general usefulness of procedures is considered. Specific proposals from states relative to procedures are welcome and should include detailed analysis.

Proposed Revisions for Annual Statement Changes
The Financial Analysis & Examination Unit also studies adopted changes to the Annual Statements and provides revision proposals to the Working Group. The Financial Analysis & Examination Unit automatically makes changes to the Handbook for minor changes, such as for page and line numbers. Specific proposals are welcome. Additionally, please alert the Financial Analysis & Examination Unit to any overlooked minor annual statement changes.

Proposed Software Revisions
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.
Preface

The NAIC Financial Analysis Handbook (Handbook) was developed and released by the Financial Analysis Handbook Working Group of the Examination Oversight (E) Task Force in 1997 for Property/Casualty and Life/A&H, and in 2004 for Health. The purpose of the Handbook is to provide a uniform risk-focused analysis approach for insurance departments to more accurately identify insurers and/or holding company systems experiencing financial problems or to identify prospective risks that pose the greatest potential for developing financial problems. The Handbook includes both quantitative and qualitative procedures. The overall goal of the Handbook is to assist regulators to evaluate and understand insurer’s risks better in order to develop appropriate corrective action plans sooner; thus, potentially decreasing the frequency and severity of insurance company insolvencies.

The Handbook does not include state-specific information or regulations, and does not establish guidelines that insurance companies and departments must follow. Parameters or benchmarks utilized are not regulatory requirements to be complied with by insurance companies. The accreditation standards indicate that the analyst should utilize procedures developed by their Department or procedures within the Handbook.

The Handbook contains the following:

**Introductory Chapters**
A general overview concerning regulatory organization, communication, and prioritization is covered within these chapters.

**Financial Analysis Framework**
This chapter discusses resources utilized throughout the insurer review process. In addition, the steps of the review process are presented through various flowcharts.

**Analysis Procedures**
There are two levels of procedures within the Handbook. In Level 1, the analyst performs an overall review of the insurer. If there is any area of concern, procedures from Level 2 should be completed. Level 2 Procedures focus on specific financial areas that assist the analyst in conducting a thorough financial analysis. The analyst may perform additional procedures that are available at the end of each of the Level 2 Procedures if continued concerns exist. These additional procedures are intended to address qualitative issues of an insurer. The Handbook Supplemental Procedures assist the analyst in reviewing additional filings from the insurer such as the Audited Financial Report, Statement of Actuarial Opinion, Management’s Discussion & Analysis, Management Considerations, Holding Company System Analysis, and Captives and/or Insurers Filing on a U.S. GAAP Basis (P/C Only). There are also quarterly Level 1 and 2 Procedures including Level 1 Procedures for non-troubled insurers.

**Analyst Reference Guide**
The Analyst Reference Guide should be utilized with the Level 1, 2 and Supplemental Procedures for both annual and quarterly periods. The Analyst Reference Guide provides discussion on the procedures that could be performed during an analysis of an insurer.

**Group-wide Supervision Procedures and Analyst Reference Guide**
The new guidance provides guidelines for gaining an understanding of the holding company system and monitoring the financial condition of a group through a coordinated process with other state regulators to understand the various risks of the group and how the group is managing those risks.
Preface

Guidance for Notes to Financial Statements
The guidance provides guidelines to assist the analyst in further understanding the reporting requirements of an insurer, which will aid the analyst during the review of the Notes to Financial Statements.

Health Insurance Industry
This narrative discussion section provides an overview of health insurance industry topics and terminology.

Appendix – References
This document provides references to other NAIC publications and NAIC Model Laws and Regulations that are applicable to the analysis process.
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F. Captives and/or Insurers Filing on a U.S. GAAP Basis
   (P/C Only)
Special Note: It may not be necessary to complete all procedures within this chapter. Procedures completed are based on the level of concern an analyst may have with management performance and the driving forces behind operations.

In performing analysis of management considerations, the analyst should utilize the risk-focused surveillance examination work that has been most recently completed related to these risk areas. Where applicable, the analyst should follow up on the work performed by the examiners including any comments or recommendations made by the examiners.

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. As of the date of this publication, most states had not adopted such legislation. The corporate governance and compliance procedures in chapter “V. Group-Wide Supervision – D. Corporate Governance Disclosure Procedures” are applicable to only those states that have adopted such legislation. This Management Consideration chapter may also be used in addition to the Corporate Governance Risks procedures by an analyst of a state that has obtained the disclosure for an insurer or insurance group subject to the aforementioned corporate governance disclosure. However, the analyst should not request information related to the Management Considerations procedures which has already been provided by the insurer or insurance group from the corporate governance disclosure.

Corporate Governance—Board of Directors

1. Review and follow up on any issues noted in the department’s documentation of corporate governance in the most recent examination reports, other examination documentation or summaries, communication with the examiner-in-charge, or the most recent communication with the insurer. Note any observations or follow-up analysis performed.

2. Does the board of directors and management provide a sufficient level of oversight and support? Explain.

3. Obtain a copy of and review the most recent board of directors’ meeting minutes. Has the board of directors 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?

4. Request information on any changes in the membership of the board of directors.
   a. Are new board of directors members sufficiently independent from management?
   b. Do new directors have adequate knowledge and applicable industry experience, and are new directors engaged in performing their duties?

5. If further concerns exist regarding the board of directors, consider reviewing internal resources on file related to the following, and if not on file, request the following information from the insurer:
   a. 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.
IV. Supplemental Procedures – A. Management Considerations

b. 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.

c. Financial expertise or statutory accounting principles expertise of the audit committee.

d. Reporting structure of the internal audit function.

e. Copy of company’s by-laws currently in effect.

f. If part of a holding company system, discussion on the level of oversight the parent company maintains over the insurer.

g. Discussion of compliance with corporate governance statutes.

h. Discussion of compensation policies, bonus/incentive programs, and management performance and assessment programs.

i. Discussion of board of directors’ and management’s responsibilities and authority.

Corporate Governance—Changes in Management or Organizational Structure

6. Review the changes in officers, directors or trustees and any concerns noted in the analyst’s review of biographical affidavits.

a. Do new executives in charge have the required knowledge, experience and training to perform their duties? Document any concerns.

b. Has there been significant turnover in management in the current year or a pattern of turnover in the past five years? If so, document the reasons.

c. Have new members of management 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: 1) was placed in supervision, conservation, rehabilitation or liquidation; 2) was enjoined from, or ordered to cease and desist from, violating any securities or insurance law or regulation; or 3) suffered the suspension or revocation of its certificate of authority or license to do business in any state? If so, explain.

d. Summarize the insurer’s policies and procedures regarding performance of background checks on new management.

7. Have there been any changes in the organization’s structure? If so, request from the insurer the reasons for the changes and the impact on future business plans.

8. Have there 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?

9. If the insurer was a party to a merger or consolidation (Level One Procedure #3), were any concerns or follow-up issues noted in the review and approval of Form A? If so, note any observations and follow-up analysis performed.
Compliance with State Statutes, Accounting and Reporting

10. Has 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?

11. If the insurer failed to comply with the state’s statutes and regulations enacted during the period:
   a. Describe the nature of the non-compliance.
   b. Describe the impact to the insurer’s financial position and reporting.
   c. Describe the outcome of any department communication with the insurer regarding the non-compliance issues.
   d. Have the non-compliance issues been resolved? If no, discuss the insurer’s plans for resolving the issues.

12. 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:
   a. Describe the nature of the suspension or revocation.
   b. Review the reason(s) stated for the revocation or suspension, noting any observations.
   c. Describe the outcome of any department communication with the insurer and/or with the other regulatory authority who issued the revocation or suspension.
   d. Has the revocation or suspension been resolved? If not, discuss the insurer’s plans to resolve the issues.

13. Has the insurer been issued any consent orders or agreements by other regulators/jurisdictions? If so:
   a. Request a copy of the consent order or agreement from the other regulator/jurisdiction.
   b. Review the reason(s) stated for the consent order or agreement.
   c. Discuss the outcome of any department communication with the insurer and/or with the other regulatory authority.
   d. Have the issues in the consent order or agreement been resolved? If not, discuss the insurer’s plans to resolve the issues.

Reputational Risk

14. If concerns exist regarding a poor financial strength or credit rating, 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). If concerns exist, consider:
   a. Requesting information from the insurer on the impact to the insurer and/or group’s operations.
b. Requesting information from the insurer on the efforts to restore its rating.

c. Requesting a revised business plan.

15. 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 operations or financial solvency. If concerns exist, consider:

a. Requesting information from the insurer regarding:

   i. The financial impact to the insurer and/or group’s operations and surplus.

   ii. Disclosures of financial impact to the public and agent distribution force.

   iii. The insurer’s efforts to mitigate any impact of the risk.

   iv. Policies and procedures in place to mitigate adverse publicity.

   v. Revised business plan.

b. Performing additional non-routine procedures where applicable; for example, survey or questionnaire, stress testing, etc.

Legal/Fraud

16. In order to gain an understanding of the legal risk, consider requesting information regarding:

a. How the insurer assesses its legal risk and reports it to senior management.

b. The involvement of legal counsel in changes to existing products and development of new products.

c. The degree to which compliance programs are utilized to control, monitor and report legal risk.

17. Upon review of the Annual Financial Statement, Notes to Financial Statements, was the insurer a party to any significant litigation not in the normal course of business? If so:

a. Describe the litigation.

b. Describe any contingent liabilities for accrued legal expenses.

   c. Request information from the insurer regarding the potential risk of:

      i. Negative financial impact on the insurer and/or group should the litigation not be ruled in favor of the insurer.

      ii. Negative reputational impact to the insurer and/or group.

      iii. Negative impact to shareholders and/or policyholders.

18. In order to gain an understanding of potential fraudulent activities within the insurer, consider:

a. Requesting information from the insurer regarding:

   i. Any known fraudulent activity within the insurance operations.

   ii. Issues regarding compliance with federal anti-money-laundering requirements.

   iii. Antifraud initiatives established by the insurer.
b. Communicating with other state insurance regulators or other regulatory authorities, or through other information sources to identify any areas for potential fraud occurring in or with affiliates that may result in a financial impact to the insurer (e.g., other regulators that may have identified risks from audits of non-insurance entities).

Strategic Business Plans, Financial Projections and Other Operating Considerations

19. Regarding the insurer’s information technology (IT) functions:
   a. Describe any issues the insurer reported or issues the department is aware of regarding significant IT related problems (e.g., market analysis of IT related claims handling issues).
   b. Describe any new IT systems implemented or any new outsourcing arrangements.
   c. Discuss any procedures the insurer has in place to analyze and assess the accuracy and timeliness of IT systems.

20. If market conduct information is unusual and indicates potential financial risks, perform the following procedures:
   a. Describe and document the findings of the most recent market conduct examination and analysis and communication with the insurance department’s market conduct staff.
   b. 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.
   c. Describe the actual or projected financial impact of any settlements, fines, or remediation to operations and surplus.

21. Review the most recent business plan and financial projections, if available, from recent surveillance activity and if considered necessary based on the insurer’s priority designation and financial condition, determine the following:
   a. Have significant changes in business plan or philosophy occurred? If so, explain.
   b. Assess if initiatives outlined in the business plan have been accomplished.
   c. Compare actual with projected financial results. Are actual results consistent with management’s expectations? If not, explain.
   d. If actual results vary significantly from planned:
      i. 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.
      ii. Request a revised business plan.
   e. 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.
IV. Supplemental Procedures – A. Management Considerations

22. Review the new current strategic business plan received, note any areas of concern and if necessary, request additional explanations from the insurer.
   a. Does the new business plan reflect significant changes in the strategic goals or philosophies compared to the prior plan? If so, explain.
   b. Describe the insurer’s strategic and annual planning process.
   c. Describe the board of directors’ involvement in developing and implementing the business plan.
   d. Assess the insurer’s ability to attain the expectations of the business plan and projections. Does the business plan reflect changes that appear unrealistic for the current market environment, financial position of the insurer or other circumstances? If so, explain.
      i. Reasonableness of underwriting assumptions.
      ii. Current and anticipated interest rate and economic environment.
      iii. Growth objectives.
      iv. Stability of capital and ability to access additional capital, if needed.
      v. Quality and sources of earnings (trends and stability).
      vi. Dividends and dividend payout policy.

23. Review and evaluate the insurer’s human capital and succession planning processes and controls.
   a. Evaluate the insurer’s management and personnel to identify directors, executives, or key employees that may be approaching retirement.
      i. For these identified individuals, discuss the steps taken by the company to plan for succession.
   b. Determine whether the insurer is overly reliant on any one individual to produce its business or manage its operations.
      i. For these key individuals, discuss the steps taken by the company to plan for succession.
   c. Describe the insurer’s processes to identify, appoint, train, evaluate, and compensate directors, executives, and key members of personnel.

Risk Management

24. Does the company prepare an Enterprise Risk Management assessment or similar risk assessment program? If so, request a copy. If not, request an explanation of how the insurer identifies risk.

25. Review and follow up on the work performed by the examiners regarding assessment of risk management and assess any changes in the following or other areas:
   a. The risk-management culture demonstrated throughout the organization.
   b. The importance of risk management to the organization.
c. How risk tolerances and “appetites” are defined and communicated throughout the organization.

d. How existing risks are identified, tracked, assessed and mitigated.

e. How emerging and/or prospective risks are identified, tracked, assessed and managed.

f. How the organization uses the risk information to determine capital needs.

g. Whether internal models are utilized and regularly updated to ensure appropriate risk-management decisions.

h. How responsibilities for risk-management functions are delegated and monitored.

i. The level of involvement of the board of directors in the risk management function.

**Summary and Conclusion**

Develop and document an overall summary and conclusion regarding management assessment. In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating management under the specific circumstances involved.

Recommendations for further action, if any, based on the overall conclusion above:

- Contact insurer seeking explanations or additional information from the insurer
- Obtain the insurer’s business plan
- Require additional interim reporting from the insurer
- Refer concerns to the examination section for target examination
- Meet with the insurer’s management
- Obtain a corrective plan from the insurer
- Other (explain)

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

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 the analyst determines 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 director 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
- Review of examination workpapers
- 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;
IV. Analyst Reference Guide – A. Management Considerations

- 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.

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,” the analyst 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:

1. Active board and senior management oversight;
2. Adequate risk identification, monitoring and management processes;
3. Adequate and clear policies, authorization limits and procedures;
4. Comprehensive and effective internal controls; and
5. 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; and
- 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)*;
IV. Analyst Reference Guide – A. Management Considerations

- 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; and
- 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, the analyst should utilize the risk-focused surveillance examination work that has been most recently completed related to these risk areas. Where applicable, the analyst 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.

Discussion of the Supplemental Procedures

The Supplemental Procedures included in the Management Consideration section are designed to identify potential areas of concern. The purpose of these procedures is to give guidance to the analyst as he/she considers and assesses the insurer’s corporate governance (which includes the assessment of the risk environment) in order to identify current or prospective solvency concerns, oversight provided by the board of directors, and the effectiveness of management, including the code of conduct established by the board of directors.

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures.

Procedures #1-5 are intended to assist the analyst in assessing corporate governance pertaining to boards of directors. It is critical that the analyst get a sense for corporate governance already in place. This review provides for an understanding of the direction and intention of the group and insurance entities.
Board of director meetings typically initiate change that will ultimately have an impact on not only the insurer but many times the entire group. A historical understanding of the board of directors is important in assessing its level of competence, which may lead to a more in-depth review due to concerns.

Procedures #6-9 are intended to assist the analyst in assessing corporate governance as it pertains to management, changes in senior management, and changes in organizational structure or operations. At times it is impossible to avoid management turnover. Whether the change is a result of performance, promotion, or termination, the end result is a new individual that requires an independent assessment by the analyst. The new management member’s level of relevant experience is key in understanding the potential prospective risk that may result. New management history is critical in determining concerns going forward. New management may institute change 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). It is also important to recognize significant staff turnover as a potential issue related to top level management directives and the potential overall impact to the operations of the insurer.

Procedure #10 asks the analyst to identify through the I-SITE Validation Exceptions tool and through any corrections of reporting errors potential issues with the reliability of financial reporting that may require follow-up discussions with the insurer. 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.

Procedure #11 offers follow-up analysis and actions the analyst may consider if the insurer is in violation of any state statutes or regulations. It is critical that the analyst determine the extent of the non-compliance and document the issue, resolution, communication by the insurer, and the outcome. The analyst should complete a detailed written explanation of the violation to ensure proper documentation should non-compliance issues recur.

Procedures #12 and 13 offers follow-up analysis and actions the analyst may consider if the insurer has had a certificate of authority, license, or registration suspended or revoked by any government entity during the period or if the insurer has been issued a consent order or agreement. If the action was taken by another state or regulatory body, the analyst should contact that regulator for details regarding the action.

Procedures #14 and 15 directs the analyst to assess the level of reputational risk the insurer faces with respect to its credit and financial strength ratings or any potential reports or news releases reported on the insurer or the group. Some insurers depend heavily on the credit and financial strength ratings to produce its premiums. If a downgrade occurs the analyst should assess the potential impact by communicating concerns with the insurer and determining the mitigating steps the insurer will implement to ensure a reasonable outcome. The analyst should secure a revised business plan should the impact of any rating change be considered long-term. The analyst should track the plan versus actual financial results and request explanations and resolutions on significant variances. If concerns exist with respect to a potentially damaging report issued on the insurer or group, the analyst should inquire about the overall financial impact on the insurer and the steps the insurer plans to implement to mitigate the circumstances.

Procedure #16 assists the analyst in assessing the degree to which legal risk is tracked and documented by the insurer. The analyst should ensure that the legal counsel is engaged with the insurer when entering uncharted territory, such as new lines of business or programs or geographic changes in writings. The analyst should ensure an understanding of management’s chain of command when entering new contracts, the documentation process by the insurer, and how the information is shared with interested parties.
IV. Analyst Reference Guide – A. Management Considerations

*Procedure #17* guides the analyst through the assessment of any legal risk the insurer or group may have. The analyst should ensure a thorough understanding of the litigation and that any potential financial impact is documented. Further, the analyst should communicate with the insurer’s management regarding the impact of reputational risk on continuing operations. The analyst should understand the insurer’s plan to address the reputational risk and track the progress.

*Procedure #18* directs the analyst in determining the degree to which the insurer is exposed to fraudulent activity. The analyst should communicate with the examiner regarding any exposure to fraud. Any exposure should be documented detailing any financial impact that could threaten the financial solvency of the insurer. To the extent possible, the analyst should understand the legal consequences of the fraud as well as any details available from other regulators, such as the FBI or state attorneys general. The analyst should communicate with the insurer to determine how the issue will be addressed and whether revised business plans will be drafted.

*Procedure #19* helps the analyst understand any issues the insurer may be facing with regard to its information technology (IT) functions and the potential impact on operations. The analyst should communicate with the insurer regarding any system changes that could impact any aspect of operations. When new IT processes are implemented or any portion of in-house operations are outsourced, the analyst should determine the financial impact on the insurer.

*Procedure #20* alerts the analyst to review any communication from the state’s market analysis unit, including the results of any market regulation examination and any information drawn from the market analysis tools available on I-SITE, such as the 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 Complaints Database System (CDS). Analysts should review any market conduct issues identified by the market analysis staff (such as the market analysis chief or the collaborative action designee) or I-SITE tools and consider the financial implications those issues may have on the insurer, e.g., 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 that may have a material impact on the financial solvency of the insurer.

*Procedure #21* assists the analyst in determining if the insurer is meeting its expectations outlined in the business plan. Following the review of the business plan the analyst should have a firm understanding of any changes from the previous plan. The analyst should assess whether the current management team has the expertise to attain the goals of the business plan. Through communication with the insurer, the analyst should document any detailed explanations regarding variances in projected financial results and the insurer’s intended plan to address variances. If the analyst determines the goals of the business plan are not attainable and/or projections are unreasonable, a revised business plan may be requested.

*Procedure #22* aids the analyst in reviewing the insurer’s strategic business plan. The analyst should determine whether any changes have been made in the business goals or philosophies. The analyst might consider discussing with the insurer, the overall planning process and how the overall initiatives are determined. In addition, the analyst may consider discussing with the insurer any assumptions used in establishing the goals.

*Procedure #23* is intended to assist the analyst in evaluating the insurer’s human capital and succession planning. Human capital can be defined as the collective skills, knowledge, or other intangible assets of employees and directors that can be used to create economic value for an organization. Insurer’s face a number of wide-ranging threats to the quality of their human capital including aging directors/executives,
over-reliance on key individuals in an increasingly competitive employment market and the lack of a workforce possessing insurance knowledge and skills. Insurers may be able to mitigate its risk in this areas by implementing effective succession planning, recognizing and rewarding outstanding performance and developing effective training, coaching and performance evaluation processes.

Procedures #24 and 25 assist the analyst in determining the risk appetite in determining strategies employed by the insurer and the methods utilized in managing those risks. The analyst should be aware of risk response, risk avoidance, and risk sharing. Further the analyst should be familiar with the insurer’s plans to reduce unplanned operational risk. By determining the risk position, the analyst should have an understanding of overall capital needs of the insurer. As part of the examination, several key areas are considered when reviewing the risk management function. Where applicable, the analyst should review and follow-up on work performed by the examiner including any comments or recommendations by the examiner and assess any changes in these or other areas of risk management: 1) the organizations risk management culture; 2) the importance of risk management to the organization; 3) how risk tolerances and “appetites” are defined and communicated; 4) how existing risks are identified, tracked, assessed, and mitigated; 5) how emerging and/or prospective risks are identified, tracked, assessed, and managed; 6) how the organization uses the risk information it gathers to determine capital needs; 7) whether internal models are utilized and regularly updated to ensure appropriate risk-management decisions; 8) how responsibilities for risk-management functions are delegated and monitored; and 9) the level of involvement of the board of directors in the risk-management function.

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. The following areas should be considered in conducting a review of enterprise risk management:

- Type of risk management culture
- Risk tolerances and “appetites” 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 risk information is used to determine capital needs
- How responsibilities for risk management functions are delegated and monitored
- Involvement of the board of directors in the risk management function
PART I — Audited Financial Report

1. Were the financial statements included in the Audited Financial Report prepared based on statutory accounting practices?

2. Were the financial statements included in the Audited Financial Report specific to the insurer rather than on a consolidated or combined basis?

3. If the financial statements included in the Audited Financial Report were prepared on a consolidated or combined basis, answer the following questions:
   a. Was this basis approved by the domiciliary commissioner upon application by the insurer due to a pooling or a 100 percent reinsurance agreement with affiliates?
   b. Was a consolidating or combining worksheet included with the financial statements that:
      i. Shows amounts separately for each insurer (non-insurance operations may be shown on a combined or individual basis)?
      ii. Provides explanations for consolidating and eliminating entries?
      iii. Includes a reconciliation of any differences between the amounts shown for an individual insurer and the amounts per the insurer’s Annual Financial Statement?

4. What type of opinion was issued by the certified public accountant (CPA)?
   - Unmodified
   - Modified
     - Qualified
     - Adverse
     - Disclaimer of opinion

5. If the opinion was modified, note which type of opinion was issued and comment on the reasons for the deviation.

6. Review the Financial Statements included in the Audited Financial Report. Do total assets, net income, and surplus per the Audited Financial Report agree with the amounts per the insurer’s Annual Financial Statement?

7. If total assets, net income, and/or surplus do not agree with the amounts per the Annual Financial Statement, review the reconciliation of differences and comment on the differences and the reasons based on the Notes to Financial Statements. 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 on the Annual Financial Statement information.

8. Review the Notes to Financial Statements and comment on items of significance including, but not limited to: investments, other assets, reserves, reinsurance, transactions with affiliates, contingent liabilities, and the summary of ownership and relationships with affiliated companies. Also consider the impact, if any, of the information in the Notes to Financial Statements on the conclusions reached as a result of the analysis of the Annual Financial Statement, and consider the need to perform additional analysis on the Annual Financial Statement information.
9. Review the Supplemental Schedules included in the Audited Financial Report and note anything unusual or any items that differ from what was reported in the Annual Financial Statement.

10. If affiliated transactions are significant, consider comparing information regarding affiliated relationships and affiliated transactions per the Audited Financial Report to information reported by the insurer in the Annual Financial Statement and in the various holding company filings, and comment on any discrepancies noted.

11. If further concerns exist, consider additional procedures that may include, but not limited to, requesting and reviewing the following:
   a. Letter of Representation
   b. A schedule of all recorded and unrecorded audit adjustments
   c. Internal control related presentation materials including Management’s Comment Letter
   d. Any other audit workpapers deemed appropriate or necessary, i.e., Statement on Auditing Standards (SAS) 99 Fraud and Legal Representation Letters

**CPA’s Letter of Qualifications**

This section of the Audited Financial Report should be completed whenever there has been a change in the independent CPA from the prior year and may be completed annually whether or not there has been a change in the independent CPA.

12. Confirm that the CPA’s Letter of Qualifications includes the following:
   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 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 workpapers prepared in the conduct of the audit and any communications between the CPA and the insurer related to the audit.

   ii. Retain the audit workpapers 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 workpapers to be made and retained by the domiciliary state insurance department examiners.

13. Comment on any deviations between the statements in the CPA’s Letter of Qualifications and the required statements per Model #205 for insurers as summarized in step 1 above.

**Change in CPA**

14. 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?

15. If the CPA who issued the opinion on the insurer’s financial statements this year is different from the CPA in the prior year:

   a. Was the domiciliary state insurance department notified of the change?

   b. 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 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?

   c. 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?

d. With regard to the letter referred to in procedure #15c, 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?

16. Comment on any disagreements noted in the letters from either the insurer or the former CPA.

Audit Committee

17. Every insurer is required to have designated an Audit Committee, a percentage of whose members should be independent from the insurer depending upon premium volumes.

   a. Has the insurer established an Audit Committee in compliance with the domiciliary state insurance laws? If not, review Annual Financial Statement, General Interrogatory – Part 1, #10.6 for an explanation.

   b. Does the Audit Committee membership meet independence requirements of the domiciliary state insurance laws?


Summary and Conclusion — PART I

Develop and document an overall summary and conclusion regarding the Audited Financial Report. In developing a conclusion, consider the above procedures as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the Audited Financial Report under the specific circumstances involved. In documenting the conclusion, comment specifically on the reasons for anything but a standard unmodified opinion.

Recommendations for further action, if any, based on the overall conclusion above:

- Contact the insurer seeking explanations or additional information from the insurer or the independent CPA
- Obtain the insurer’s business plan
- Require additional interim reporting from the insurer
- Refer concerns to the examination section for target examination
- Meet with the insurer’s management
- Obtain a corrective plan from the insurer
- Other (explain)

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer _______________ Date ________
PART II — 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.

1. 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.


3. 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:
   a. Assess the internal control weaknesses impact on key processes (e.g., the accuracy of financial reporting, reserve valuation, claims processing, or investment practices, etc.)
   b. 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, consider additional holding company system analysis procedures be performed
   c. 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

4. 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.

Summary and Conclusion – PART II

Develop and document an overall summary and conclusion regarding the Reports on Internal Controls. In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the Reports under the specific circumstances involved. In documenting the conclusion comment specifically on the reasons for anything but a standard unmodified opinion.

Recommendations for further action, if any, based on the overall conclusion above:

- Contact insurer seeking explanations or additional information from the insurer or the independent CPA
- Obtain the insurer’s business plan
- Require additional interim reporting from the insurer
- Refer concerns to the examination section for target examination
- Meet with the insurer’s management

- Obtain a corrective plan from the insurer
- Other (explain)

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________

Overview

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 the analyst 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.

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 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 Procedures are designed to assist the analyst 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. In addition, the procedures of the Audited Financial Reports include 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.

**Procedures Related to the Level 1 Annual Procedures**

Generally, the Audited Financial Report will not be available at the time of the Annual Financial Statement review. There is one question within the Level 1 Annual Procedures that is used to identify if any unusual items were noted in the Audited Financial Report, if received. However, an analyst should consider performing a review of information related to the potential filing of an Audited Financial Report that is available within the Annual Financial Statement itself. Any unusual responses at this preliminary stage should be noted within the Level 1 Annual Procedures. The Annual Financial Statement Supplemental Exhibits and Schedules Interrogatories ask whether the insurer will file an Audited Financial Report by June 1, and require an explanation if one will not be filed. Every insurer required to file an Annual Financial Statement is also required to file an Audited Financial Report by an independent CPA as a supplemental filing to the Annual Financial Statement on or before June 1. However, there are two exemptions to this requirement:
1. Insurers having direct premiums written that total less than $1 million nationwide in the calendar year and fewer than 1,000 policyholders or certificate-holders of directly written policies nationwide at the end of the calendar year shall be exempt from this requirement for that year (unless the domiciliary commissioner makes a specific finding that compliance is necessary in order to carry out statutory responsibilities), except that insurers having assumed premiums written pursuant to contracts and/or treaties of reinsurance totaling $1 million or more will not be so exempt.

2. The domiciliary commissioner may grant an exemption from compliance with this requirement upon written application from an insurer if the domiciliary commissioner finds that compliance with this requirement would constitute a financial or organizational hardship for the insurer.

**Discussion of the Supplemental Procedures**

The analysis of the Audited Financial Report is documented on the separate Audited Financial Report Supplemental Procedures rather than the Annual Financial Statement Supplemental Procedures due to its significance and due to the timing of the receipt of the Audited Financial Reports on June 1 rather than on March 1 with the Annual Financial Statement. The Audited Financial Report Supplemental Procedures are broken down into five parts: 1) review of the Audited Financial Report; 2) review of the CPA’s Letter of Qualifications; 3) change in CPA, including the letter regarding any disagreements with the former CPA in the event of a change in CPA; 4) audit committee; and 5) review of internal controls and report of significant deficiencies.

**PART I — Audited Financial Report**

*Procedure #1* assists the analyst in determining whether the financial statements included in the Audited Financial Report have been prepared in conformity with statutory accounting practices prescribed or otherwise permitted by the domiciliary state insurance department.

*Procedure #2* assists the analyst in determining whether the financial statements included in the Audited Financial Report are those of the insurer on a separate company stand-alone basis. While most insurers are required to file audited financial statements on a separate company stand-alone basis, an insurer may make 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-percent reinsurance agreement that affects the solvency and integrity of the insurer’s reserves and the insurer cedes all of its direct and assumed business to the pool.

*Procedure #3* should be completed in those instances where audited consolidated or combined financial statements are filed. This procedure assists the analyst in determining whether the domiciliary commissioner approved the insurer’s application to file on a consolidated or combined basis due to a pooling or 100-percent reinsurance agreement, and that a consolidating or combining worksheet has been included with the financial statements. This worksheet shows amounts for each insurer separately, includes explanations for consolidating and eliminating entries, and has reconciliation for any differences between the amounts shown for an individual insurer and the amounts per the insurer’s Annual Financial Statement. This allows the analyst to reconcile from the audited consolidated or combined financial statements to the Annual Financial Statement filed by the individual insurer being analyzed.

*Procedure #4* assists the analyst in determining the type of audit opinion that was issued by the independent 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. Following is a discussion of each of the audit opinions:
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:

Qualified Opinion

The auditor should express a qualified opinion when:

1. 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

2. 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.

Adverse Opinion

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.

Disclaimer of Opinion

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.

Procedure #5 should be completed in those instances where the independent CPA’s audit opinion is other than an unmodified opinion. The analyst should document the reason(s) for the deviation. The comments should be as detailed as possible based on information in the audit opinion and in the Notes to Financial Statements, and should include the effect of the cause of the deviation, if applicable, on the insurer’s financial position.

Procedure #6 assists the analyst in determining that total assets, net income, and surplus per the Audited Financial Report agree with the amounts per the insurer’s Annual Financial Statement that has previously been analyzed. 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.

Procedure #7 should be completed in those instances where differences exist between the Audited Financial Report and the Annual Financial Statement. This procedure requires the analyst to 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.

Procedure #8 assists the analyst in reviewing the Notes to Financial Statements included in the Audited Financial Report and noting any items of significance including, but not limited to, investments (i.e., fair value and duration/maturity of bonds and realized and unrealized gains and losses); reserves (i.e., variability of reserves, the impact of any estimated salvage and subrogation, and/or discounting); reinsurance (i.e., reserve credits taken, recoverables, transfer of risk, and collectability); affiliated transactions (i.e., pooling, administrative agreements and fees, dividends, and transfers); and contingent liabilities (i.e., litigation and assessments). The information included in the Notes to Financial Statements is an integral part of the information included in the Audited Financial Report and should be closely scrutinized by the analyst. The comments included by the analyst in this procedure should focus on all significant items noted and not just those with a negative impact on the insurer’s current financial position.

Procedure #9 requires the analyst to document any unusual items or differences identified in the review of the supplemental schedules, including the Supplemental Schedule of Assets and Liabilities, Supplemental Summary Investment Schedule and Supplemental Investment Risk Interrogatories. Any differences between what is reported in these schedules and what is reported in the Annual Financial Statement should be documented as well as the reasons for the differences.

Procedure #10 should be completed in those instances where transactions with affiliates are significant. This procedure suggests that the analyst consider comparing information regarding affiliated relationships and transactions per the Audited Financial Report to information reported by the insurer in the Annual Financial Statement and in the various holding company filings (Form B—Annual Registration Statement, Form C—Summary of Registration Statement, Form D—Prior Notice of a Transaction, Form E—Pre-Acquisition Notification Regarding Potential Competitive Impact of a Proposed Merger or Acquisition, and Extraordinary Dividend/Distribution) to verify the information in these other filings and to determine that all appropriate filings were made by the insurer.

Procedure #11 may be considered if further concerns exist. This procedure may include, but is not limited to, the following:

a. 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 if there are representations that would impact the insurer’s solvency.

b. 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.

c. 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.

d. 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’s Letter of Qualifications

This section of the Audited Financial Report Supplemental Procedures should be completed whenever there has been a change in the independent CPA from the prior year and may be completed annually whether or not there has been a change in independent CPA.

Procedure #12 should be completed in order to determine if the independent CPA must also furnish 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. The analyst should verify that the independent CPA included all of the statements in the Letter of Qualifications (especially those included in Procedures #12b, 12c, and 12f). 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.

Procedure #13 assists the analyst in documenting any deviations or omissions from the required statements in the independent CPA’s Letter of Qualifications. In addition, if the analyst has concerns regarding the independent CPA’s qualifications, these concerns should also be documented as a part of this procedure.

Change in CPA

Procedure #14 assists the analyst in determining whether the independent CPA who issued the opinion on the insurer’s financial statements is the same CPA who issued the opinion in the prior year. 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.

Procedure #15 is to be completed in those instances where the CPA who issued the opinion on the insurer’s financial statements in the current year is different from the CPA in the prior year. This procedure assists the analyst in determining whether the domiciliary state insurance department was notified of the change and whether the letters from the insurer and the former CPA regarding any disagreements were filed.
Procedure #16 should be completed in those instances where disagreements were noted in the letter from either the insurer or the former CPA. This procedure directs the analyst to comment on the disagreements noted. In commenting on the disagreements noted, the analyst should consider the impact of the disagreements on any other analysis of the insurer performed by the analyst.

Audit Committee

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.

Procedure #17 is intended to verify that the insurer has established an audit committee. The procedures also ask the analyst to verify that audit committee membership meets domiciliary state requirements.

Procedure #18 is intended to alert the analyst to any exemptions that have been granted under sections 7H, 14H or 17A of the Model Audit Rule. Section 7H pertains to prohibited non-audit services provided by the certified independent public accountant. Section 14H relates to the audit committee requirements. Section 17A relates to other requirements of the Model Audit Rule as allowed for in Section 17A, or substantially similar state law or regulation. If exemptions have been granted the analyst should review the Annual Financial Statement, General Interrogatories—Part 1, lines 10.1 through 10.4 for information related to the exemption and communicate with internal staff who were involved in the review and approval of the exemption in order to gain an understanding of the reasons for the exemption.

PART II — 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 whether material weaknesses have been identified. In those instances where material weaknesses were 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.

Procedure #1 assists the analyst in documenting the review of the Report of Significant Deficiencies, if applicable. In addition to commenting on any weaknesses noted, the analyst should also comment on the adequacy of the remediation’s made or proposed by the insurer to correct the weaknesses.

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 as well as disclosure of any unremediated material weaknesses in internal control over financial reporting.

Procedure #2 suggests that the analyst review Management’s Report of Internal Controls Over Financial Reporting process and note any unpremeditated material weaknesses that may have been disclosed in the report.
Procedures #3 and 4 provide the analyst with additional steps the analyst may consider taking if internal control weaknesses are noted and are material.
A. Actuarial Opinion

General

1. Was a Statement of Actuarial Opinion filed with the Annual Financial Statement? (Note that the Annual Financial Statement is also referred to as the Annual Statement within these procedures.)

2. Determine whether any exemptions for filing the Statement of Actuarial Opinion were granted.
   a. Did the insurer receive an exemption from the requirement to file a Statement of Actuarial Opinion?
   b. If the answer to 2a is “yes,” was the exemption attached to the Annual Financial Statement?
   c. Reason for exemption:
      - Small company
      - Under supervision or conservatorship
      - Nature of business
      - Financial hardship
      - Other (_______________________)

Identification

3. Name of appointed actuary (Exhibit B, Item #1):

4. Relationship of appointed actuary to insurer (Exhibit B, Item #2):
   - Officer/employee of insurer or group (E)
   - Consultant (C)

5. The appointed actuary is a qualified actuary based upon what qualification? Check the same qualifying actuarial designation shown on Exhibit B, Item #3:
   - Is a Fellow of the Casualty Actuarial Society (F)
   - Is an Associate of the Casualty Actuarial Society (A)
   - Is not a member of the Casualty Actuarial Society, but a Member of the American Academy of Actuaries approved by the Casualty Practice Council, as documented with the approval level attached to the Opinion (M)
   - Other (O)

6. 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 Opinion was rendered?

7. Is this the same actuary who was appointed for the previous Opinion?
   a. If “no,” did the insurer notify the domiciliary state insurance regulator within 5 days of the replacement?
b. Within 10 business days of the above notification, did the insurer also provide an additional letter stating whether or not there were any disagreements with the former actuary and also in writing request the former actuary for a letter of agreement?

c. Did the Company furnish the former actuary’s letter of agreement?

8. Is the Company a member of an intercompany pooling arrangement? (This can be verified by Reviewing Note #26 of the Notes to the Financial Statements.)

a. If “yes,” did the actuary include a description of the pool and identify the lead company?

b. Is a list of all pool members, their states of domicile and their respective pooling percentages disclosed?

c. Do Exhibits A and B appear to represent the company’s share of the pool and reconcile to the company’s respective financial statement?

9. If the Company is a member of a pool and has a 0% share, does the Opinion adhere to the following;

a. Does it read similar to that provided for the lead company?

b. Are responses to Exhibit B, Items #5 and #6, $0 and “not applicable,” respectively?

c. Are Exhibits A and B of the lead company attached?

Scope

10. Is Exhibit A attached to or made part of the Opinion? Exhibit A should list those items and amounts with respect to which the Appointed Actuary is expressing an opinion.

11. Does the Scope paragraph contain a sentence such as one of the following?

- "I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 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 December 31, 20xx and reviewed information provided to me through xxx date.”

- Other or none (provide comments).

12. Exhibit A lists amounts for specific items, these amounts should match the corresponding Annual Financial Statement references. The analyst should document whether the items in Exhibit A match, do not match, are not listed, or any other concerns or unusual findings.

13. Exhibit A may also list premium or other items on which the Appointed Actuary is expressing an Opinion. The analyst should document any concerns with these items and in particular for any of the following items that contain premium amounts.

a. Reserve for direct and assumed unearned premiums for long duration contracts.
IV. Supplemental Procedures – C.1. Statement of Actuarial Opinion (Property/Casualty and Title) &
Actuarial Opinion Summary (Property/Casualty only)

b. Reserve for net unearned premiums for long duration contracts.
c. Other premium reserve items such as premium deficiency reserves (list and discuss).

14. Does the Scope paragraph contain statements regarding the formation of the actuary’s opinion on
the loss and LAE reserves that includes the following:
a. The individual(s) (company officer(s)) that was relied upon for data preparation.
b. The actuary evaluated that data for reasonableness and consistency.
c. The actuary reconciled or reviewed the reconciliation of that data to Schedule P, Part 1 of
the company’s current Annual Financial Statement. If the data was not reconciled, the
analyst should document any reasons provided by the 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 actuary as to why the
data did not reconcile.
d. The actuary’s examination included a review of the actuarial assumptions and methods
used and tests of the calculations as considered necessary.

Opinion

15. Does the Opinion state that the amounts shown in Exhibit A meet the requirements of the
insurance laws of the state of domicile? The analyst should document any reasons provided by
the actuary as to why the amounts did not meet the requirements.

16. Does the Opinion state that the 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…”?

17. Does the Opinion state that the amounts shown in Exhibit A make a reasonable provision (carried
reserve is within the 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? (See also Exhibit B,
Item #4)
a. If “no,” does the appointed actuary state that the amounts in Exhibit A are:
   □ Deficient or Inadequate (carried reserve is less than the minimum amount needed
to be considered reasonable).
   □ Redundant or Excessive (carried reserve is greater than the maximum amount
needed to be considered reasonable).
   □ Qualified (carried reserve amount makes a reasonable provision for the liabilities
associated with the specified reserves, except for the item, or items in question
and cannot be reasonably estimated or the actuary is unable to render an opinion
on those items).
   □ No Opinion (the actuary cannot reach a conclusion due to deficiencies or
limitations in the data, analysis, assumptions, or related information).

If applicable, comment on the reasons why the Opinion states the reserves do not make a
reasonable provision for unpaid loss and LAE obligations. Include a discussion of (1) the
differences between the actuary’s indicated reserves (or range of reasonable reserves) and those
carried by the insurer, (2) the impact of the differences on the insurer’s policyholders’ surplus and/or, (3) the reasons why a Qualified Opinion or No Opinion was given. Consider the impact of the differences on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis on the Annual Financial Statement, such as additional supplemental procedures for the item impacted.

b. If the appointed actuary issues a Qualified Opinion, does the actuary disclose the item(s) to which the qualification relates and the amounts of such items. Does the actuary also state whether the reserves make a reasonable provision for the liabilities, except for the item(s) to which the qualification relates? The analyst should provide comments on the reserves, e.g., what amount of reserves could not be estimated and why? Are these reserves material?

18. If the Scope section includes material unearned premium reserves for long duration contracts, does the Opinion state that the amount shown in Exhibit A makes a reasonable provision for the unearned premium reserves for long duration contracts? The analyst should comment on the reasons why the Opinion states the reserves do not make a reasonable provision for material long duration contracts (See Procedure #17b for types of appropriate comments). (Note that this procedure is not applicable to Title insurers.)

19. Does the appointed actuary make use of the work or Actuarial Opinion of another actuary?

a. If “yes,” for what segment of the reserves?
   - Pools
   - Subsidiary
   - Special line of business
   - Other

b. If stated in the Opinion, what percentage of the total reserves are the segmented reserves?

c. If for a material portion of the reserves, are the name(s) and affiliations of actuary(ies) disclosed?

d. Does the actuary disclose: 1. whether he/she reviewed the other actuary’s analysis, and 2. if a review was performed, the extent of the review?

### Relevant Comments and Exhibit B: Disclosures

20. Risk of Material Adverse Deviation:

a. Does the Opinion list the Materiality Standard in Exhibit B (Item #5)?

b. If “no,” inquire why; otherwise, describe the standard (e.g., “X” percent of surplus).

c. What is the actuary’s basis for establishing this standard?

d. Does the actuary believe that there are significant risks or uncertainties that could result in material adverse deviation (Exhibit B Item #6)?

e. Note any risk factors or explanations discussed by the actuary. Regardless of whether the answer to Exhibit B, Item #6 is “Yes” or “No,” explanation of risk factors should be disclosed.
Bright Line Indicator Test: This test is only applicable if the Company is subject to Risk-Based Capital. This indicator is triggered if 10 percent of the insurer’s net reserves (Liabilities, Surplus and Other Funds page, sum of Losses and Loss adjustment expenses) are greater than the difference between the Total Adjusted Capital (Five-Year Historical Data page) and Company Action Level RBC (twice the authorized control level risk-based capital amount in the Five-Year Historical Data page). Is the Bright Line Indicator triggered? If “yes,” comments from the actuary should be pursued if the actuary does not believe a risk of material adverse deviation exists.

A special report is located on StateNet under the Financial Analysis link.

21. Exhibit B lists the amounts for the following items; these amounts should match the corresponding Annual Financial Statement references. Also, the actuary should include paragraphs describing the significance of these disclosure items in the Opinion narrative if necessary. Provide comments below each item, including a summary of the actuary’s comments if necessary.

a. For Property/Casualty insurers, items in Exhibit B are:
   i. Statutory Surplus (Item #7)
   ii. Anticipated net salvage and subrogation (Item #8)
   iii. Non-tabular discount (Item #9.1)
   iv. Tabular discount (Item #9.2)
   v. Voluntary and involuntary pools and associations (Item #10)
   vi. Net asbestos (Item #11.1) and environmental (Item #11.2) reserves
   vii. Extended loss and expense reserves (Item #12.1 and #12.2)
   viii. Other items on which actuary is providing relevant comment (Item #13)

b. For Title insurers, items in Exhibit B are:
   i. Statutory Surplus (Item #7)
   ii. Known Claims Reserve (Item #8)
   iii. Statutory Premium Reserve (Item #9)
   iv. Aggregate of Other Reserves as Required by Law (Item #10)
   v. Supplemental Reserve (Item #11)
   vi. Anticipated net salvage and subrogation (Item #12)
   vii. Discount (Item #13)
   viii. Other items on which the Appointed Actuary is providing Relevant Comment (Item #14)
22. Reinsurance
   a. Does the insurer have retroactive reinsurance? (Review the Annual Financial Statement, Liabilities, Surplus and Other Funds page for write-in items and Notes to Financial Statements.)
      i. Does the actuary discuss retroactive reinsurance? The analyst should document any concerns.
   b. Does the insurer have financial reinsurance? (Review the Management’s Discussion and Analysis, Reinsurance Attestation Supplement, Notes to Financial Statements, and the General Interrogatories for any possible information).
      i. Does the actuary discuss financial reinsurance? The analyst should document any concerns.
   c. Does the insurer have reinsurance collectibility issues? (Review the Annual Financial Statement, Schedule F and Notes to Financial Statements).
      i. Does the actuary discuss reinsurance collectibility? Check all that apply.
         - No
         - Yes, with little comment
         - Actuary solicited information from management
         - Actuary reviewed ratings of reinsurers
         - Actuary reviewed the Annual Financial Statement, Schedule F

23. The insurer failed the following IRIS ratios (check all that apply):
   - None.
   - One-year development (Annual Financial Statement, Schedule P, Part 2) divided by prior year’s Surplus (Five-Year Historical Data).
   - Two-year development (Annual Financial Statement, Schedule P, Part 2) divided by two-prior year’s Surplus (Five-Year Historical Data).
   - Estimated current reserve deficiency to policyholders’ surplus cannot be easily calculated but can be found on I-SITE along with the other IRIS ratios.

   a. Did the actuary discuss any exceptional values? The analyst should document any concerns.
   b. Note that for Title insurers, IRIS ratios do not apply; however, the actuary is required to discuss exceptional reserve development, where exceptional reserve development is calculated the same as the one- two-year development for property/casualty insurers. The same 20 percent threshold applies.

24. Does the actuary indicate that there has been a material change in the actuarial assumptions and/or methods from those previously employed in determining the amounts of the insurer’s reserves, if applicable? The analyst should document any comments or concerns.

25. Does the actuary comment on any other topics (e.g., lack of historical data for a line of business) if applicable? The analyst should document any comments or concerns.
Conclusions/Recommendations

26. Does the Opinion conclude with the signature, the printed name, the employer’s name, the address, the telephone number, and the email address of the appointed actuary, and the date the Opinion was rendered?

27. Does the actuary indicate that an Actuarial Report has been prepared, which supports the findings expressed in the Opinion and that this report will be maintained at the company and available for regulatory examination for seven years?

28. For a small number of cases, the analyst may consider requesting a copy of the Actuarial Report (particularly if the Opinion is unusual in some way). The Actuarial Report should be consistent with the documentation and disclosure requirements of Actuarial Standards of Practice #41.

Answer this question if a Report was provided. Indicate whether the Actuarial Report includes the following required elements:

a. Narrative component (should provide sufficient detail to clearly explain the actuary’s findings and conclusions, as well as their significance).

b. Technical component - actuarial exhibits (should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work; must show the analysis from the basic data, e.g. loss triangles, to the conclusions).

c. A description of the appointed actuary’s relationship to the company with clear presentation of the actuary’s role in advising the board and/or management regarding the carried reserves. The Report should identify how and when the appointed actuary presents the analysis to the board and, where applicable, to the officer(s) of the company responsible for determining the carried reserves.

d. An exhibit which ties to the Annual Statement and compares the actuary’s conclusions to the carried amounts consistent with the segmentation of exposure or liability groupings used in the analysis. The actuary’s conclusions include the actuary’s point estimate(s), range(s) or reasonable estimates, or both.

e. An exhibit that reconciles and maps the data used by the actuary, consistent with the segmentation of exposure or liability groupings used in their analysis, to the Annual Financial Statement Schedule P line of business reporting.

f. An exhibit or appendix showing the change in the estimates from the prior Actuarial Report, including extended discussion of factors underlying any material changes.

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

h. Extended comments on factors that led to unusual reserve development and how these factors were addressed in current and prior year analyses.

i. For Title insurers: Documentation of interviews, questionnaires, correspondence or other meetings with company management or officers that influenced the actuary’s conclusions, reliances or opinions.
Additionally, the analyst should review the narrative and indicate any significant issues which affected the actuary’s interpretation of the data and the resulting Opinion issued. Provide any additional comments regarding the Actuarial Report.

B. Actuarial Opinion Summary (not applicable to Title insurers)

1. Does the domiciliary state insurance regulator require a confidential Statement of Actuarial Opinion Summary (Summary)?
   If “yes,” was the Actuarial Opinion Summary submitted by March 15 or the date requested by the regulator and signed by the same actuary who provided the Statement of Actuarial Opinion?

2. Is the company a member of an intercompany pooling arrangement?
   If “yes,” is the percentage of the company’s share of the pool disclosed? For non-0% companies, the point or range comparison should be after the company’s share of the pool has been applied. For 0% pool participants, the information provided should be that of the lead company.

3. Are the company’s carried loss and loss adjustment expense reserves in the Summary consistent with the corresponding reserves presented in Exhibit A of the Opinion and the Annual Financial Statement?

4. Did the actuary provide a comparison of the carried reserves to a point estimate, a range estimate, or both?
   If the carried reserves are below the actuary’s point estimate or below the midpoint of the 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 position?
   • Is the difference greater or less than the material adverse deviation standard?

   The analyst should judge the relative materiality of the difference and document any concerns. Please refer to the Analyst Reference Guide for more information on how to address this situation.

5. Is the Summary consistent with the Opinion’s conclusion that the amounts shown in Exhibit A are Reasonable, Deficient or Inadequate, Redundant or Excessive, Qualified, or No Opinion?

   Consistency is defined by the following situations:
   • Opinion conclusion is “Reasonable”; carried reserves are at or near the actuary’s point estimate and/or within the actuary’s range
   • Opinion conclusion is “Deficient”; carried reserves are materially below the actuary’s point estimate and/or below the low end of the actuary’s range
   • Opinion conclusion is “Redundant”; carried reserves are materially above the actuary’s point estimate and/or above the high end of the actuary’s range

   If the carried reserves are deficient and/or the Summary is not consistent with the Opinion, document any concerns.
IV. Supplemental Procedures – C.1. Statement of Actuarial Opinion (Property/Casualty and Title) &
Actuarial Opinion Summary (Property/Casualty only)

6. Did the company experience one-year development in excess of 5 percent of prior year’s surplus
as measured by the Annual Financial Statement, Schedule P, Part 2 Summary in at least three of
the last five calendar years? (Review 5 Year Historical page.)

If “yes,” did the actuary provide explicit discussion of reserve elements and/or management
decisions that were the reasons for such consistent adverse development? Because the Summary
is a confidential document, regulators expect appointed actuaries to provide more detailed
discussion here, than in the public Opinion. The analyst should look for more discussion in the
Summary, versus the Opinion, in the presence of current year IRIS failures 11, 12, or 13. Note
that merely stating that the development was due to “reserve strengthening” is insufficient. The
analyst should document any concerns.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the Opinion. In developing a
conclusion, consider the above procedures as well as any other procedures that, in the analyst’s judgment,
are relevant to evaluating the actuarial opinion. This includes reviewing the Summary, a confidential
supplemental filing, if required. The Summary supplemental procedures should be performed before
taking any further action as recommended below.

Recommendations for further action, if any, based on the overall conclusion above:
- Consult with the regulatory P/C actuary, if available
- Obtain the insurer’s business plan
- Require additional interim reporting from the insurer
- Refer concerns to examination section for targeted examination
- Consult with the appointed actuary
- Engage an independent actuary to review insurer’s reserves
- Meet with the insurer’s management
- Obtain a corrective plan from the insurer
- Contact the insurer
- Obtain the Actuarial Report
- Develop a corrective plan
- Other (explain)

Analyst __________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

A. Actuarial Opinion

The Statement of Actuarial Opinion (Opinion) can be a valuable piece of information in determining whether the insurer requires further regulatory attention.

While the Annual Statement Instructions (Instructions) as a whole are directed to the insurer, Section 1 identifies the specific responsibilities of the insurer regarding appointment of a qualified actuary, the definition of a qualified actuary, required notification to regulators and exemptions from the requirement. Most of this is straightforward. The Casualty Actuarial and Statistical (C) Task Force has defined a qualified actuary with consideration of Actuarial Standards of Practice and a Code of Professional Conduct that bind members of identified professional organizations. With respect to filing exemptions, it should be noted that a commissioner is not obligated to grant an exemption merely due to the presence of one or more conditions. Consideration of an exemption request should include the size and uncertainty in the reserves, both the direct and assumed as well as the net.

The 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.)

The remainder of the Instructions provides guidance to company management and its appointed actuary regarding regulatory expectations around the reported information. Section 2 states that the Opinion should contain four clearly designated sections: Identification, Scope, Opinion, and Relevant Comments. While illustrative language is presented in the Instructions, specific language is not required, provided the information is clearly conveyed by the appointed actuary.

Section 3 (Identification) is self-explanatory. The actuary is rendering his or her opinion as an individual, not the firm or insurer the actuary represents.

Section 4 (Scope) is self-explanatory. Required reserve amounts upon which the Opinion is based are consolidated and presented in Exhibit A. Additional related disclosures and dollar amounts are consolidated and presented in Exhibit B. The exhibit structure lends itself to easier identification of zero and non-zero amounts and allows for comparisons to amounts in the Annual Statement.

Section 4 requires the actuary to disclose the name and affiliation of the person(s) upon whom the actuary relied upon for the data used in the reserve analysis. This reliance is expected to be based on an individual(s) from the company, that has 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, the analyst should request the insurer to provide a clarifying amendment.

Section 5 (Opinion) presents the first opportunity for the regulator to identify a need for immediate attention. The actuary is required to explicitly state his or her opinion using one of five Opinion types. The illustrative language provided in the Instructions is based on the most commonly rendered opinion—that the carried reserves make a reasonable provision. Should any other type of opinion be presented, the opinion calls for immediate further attention and determination of the need for follow-up action.
Section 6 (Relevant Comments) identifies specific areas in which the actuary is required to comment. The purpose of this requirement is to provide the regulator with information that numbers alone cannot convey. The most important relevant comment relates to the Risks of Material Adverse Deviation (RMAD). The appointed actuary should provide explanation of the major risk factors affecting the company. The actuary must then explicitly state whether or not he or she reasonably believes those significant risks and uncertainties could result in material adverse deviation. The actuary must also identify the materiality standard and the basis for establishing it.

Actuaries often choose a materiality standard as a percentage of surplus or reserves, but other standards may also be appropriate. The standard chosen helps to quantify the degree of risk the appointed actuary believes to be present in the company’s carried reserves. 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 contains excellent guidance regarding the selection of a materiality threshold. Based on this guidance, an actuary for two companies with comparable business and comparable reserves could have different RMAD statements. For example, an insurer with a Risk Based Capital (RBC) ratio of 205 percent could possibly need only a small change in reserves to put it in Company Action Level, whereas a similar insurer with an RBC ratio of 600 percent may be viewed as having little or no RMAD.

If the Company is subject to RBC reporting requirements, the following calculation is suggested for use as a Bright Line Indicator regarding the need for an RMAD statement:

\[
\text{If } 10\% \text{ of the insurer’s net loss and loss adjustment expense (LAE) reserves is greater than the difference between the Total Adjusted capital and Company Action Level capital, the appointed actuary should be asked to explain why they do not feel there is an RMAD.}
\]

A similar comparison could be made between 10 percent of the insurer’s net reserves and the size of their underwriting or operating income. It should be noted that the RMAD might increase with more volatile exposures such as asbestos and environmental, excess casualty, and/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 actuary. The disclosures in Exhibit B are required to ensure that the actuary acknowledges consideration of certain items in reaching his or her opinion.

Section 7 (the Actuarial Report) provides guidance for both the actuary (regarding required content of the report) and for the regulator (regarding what to expect from the report if more information is desired). The NAIC places a high level of trust in the work of a qualified actuary. The presumption is that professional qualifications and adherence to the Actuarial Standards of Practice and Code of Professional Conduct promulgated by the American Academy of Actuaries result in a work product that assists the regulator in understanding a balance sheet entry that is management’s best estimate, which is an estimate that can have considerable uncertainty. That trust is only justified if the actuary can readily provide support for the opinion provided. That support should be available in the Actuarial Report.

Section 8 (Signature) is self-explanatory.

Section 9 (Error Correction) addresses infrequent events or corrections that occur at a later date. No action is necessary as part of Opinion review. Should an appointed actuary provide such notification, the analyst should immediately determine if additional regulatory action is needed.
Requirements for Pooled Companies

These requirements are also identified in section 1C of the Annual Statement Instructions and apply only to insurers who are participants to intercompany pooling agreements.

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 actuary is directed to write an 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 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 the analyst. The Instructions include specific answers for the Exhibit B questions regarding materiality and the RMAD.

Note the distinction between pooling with a 100 percent lead company with no retrocession and ceding 100 percent 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 their operating platform.

B. Actuarial Opinion Summary (not applicable to Title insurers)

The Actuarial Opinion Summary (Summary) is a confidential document that provides valuable insight to an appointed actuary’s conclusion regarding the reasonability of the carried reserves. Nearly all Opinions submitted provide a qualitative statement that the carried reserves are “reasonable.” The Summary provides quantitative information to more clearly show the analyst how the appointed actuary reached that conclusion. With the additional information provided in the Summary, the analyst can make a judgment regarding the need for further regulatory attention.

As with the Opinion, the Annual Statement Instructions for the Summary are directed to the insurer.

Section 1 of Supplemental Instructions 23-1 (Actuarial Opinion Summary Supplement) identifies the specific responsibilities of the insurer regarding this document. The analyst should first determine if the domiciliary state requires the Summary. If so, the Summary should be reviewed in tandem with the Opinion and factored into the decision for further regulatory attention.

Section 2 restates regulatory expectations that the Summary is consistent with professional standards that guide a “qualified actuary” as defined in the Opinion Instructions.

Section 3 restates exemption considerations.

Section 4 addresses confidentiality. As noted above, the analyst should have advanced knowledge of the state’s requirements for submission of the Summary.

Section 5 provides guidance to the company and its appointed actuary regarding the specific content that is expected in the Summary. This is the quantitative information that the analyst should focus on in order to develop a recommendation for further regulatory action.

Section 5, Subsections A, B, C and D in combination 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.

Subsections A and B require the actuary to compare their point estimate and/or range of estimates (whatever is calculated), to the carried loss and loss adjustment expense reserves. The 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 Opinion and the Annual Statement. The analyst should note that the amounts provided in the Summary are commonly presented as combined Loss & Loss Adjustment Expense amounts (Exhibit A Lines 1 & 2 for Net; Lines 3 & 4 for Direct & 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. Regardless of the source of the error, it is an indication of a lapse in communication between the appointed actuary and the company and requires follow up.

The comparisons will likely result in one of the following situations. The tables in these illustrations show both point and range estimates by the actuary. The actuary is not required to calculate both, but regulators expect actuaries to report whatever is calculated. A small percentage of appointed actuaries calculate a range only.

**Situation 1: Actuary’s Point Estimate or Range Midpoint = Carried Reserves**

<table>
<thead>
<tr>
<th></th>
<th>Net Loss + LAE Reserves</th>
<th>Direct &amp; Assumed Loss + LAE Reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Point</td>
</tr>
<tr>
<td>B. Actuary’s Estimates</td>
<td>17,000</td>
<td>20,000</td>
</tr>
<tr>
<td>C. Company Carried Reserves</td>
<td>20,000</td>
<td></td>
</tr>
<tr>
<td>D. Difference</td>
<td>3,000</td>
<td>0</td>
</tr>
</tbody>
</table>

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 actuary’s estimate and the carried amount. There may be small variations from this scenario in which the actuary’s estimate is “close to” the company carried reserves. The analyst needs 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 actuary’s estimate. If the carried reserves are higher than the actuary’s estimate, then surplus is more conservatively stated. Further action is generally not necessary.

**Situation 2: Actuary’s Point Estimate or Range Midpoint < Carried Reserves**

<table>
<thead>
<tr>
<th></th>
<th>Net Loss + LAE Reserves</th>
<th>Direct &amp; Assumed Loss + LAE Reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Point</td>
</tr>
<tr>
<td>B. Actuary’s Point Estimates</td>
<td>17,000</td>
<td>20,000</td>
</tr>
<tr>
<td>C. Company Carried Reserves</td>
<td>21,000</td>
<td></td>
</tr>
<tr>
<td>D. Difference</td>
<td>4,000</td>
<td>1,000</td>
</tr>
</tbody>
</table>

In this case, the company is carrying a reserve amount greater than the actuary’s point estimate or is carrying reserves in the higher end of the actuary’s range. From a solvency perspective, surplus is more conservatively stated, and the analyst should apply judgment about whether to follow up with the company.
Situation 3: Actuary’s Point Estimate or Range Midpoint > Carried Reserves

<table>
<thead>
<tr>
<th></th>
<th>Net Loss + LAE Reserves</th>
<th>Direct &amp; Assumed Loss + LAE Reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Point</td>
</tr>
<tr>
<td>B. Actuary’s Point Estimates</td>
<td>17,000</td>
<td>20,000</td>
</tr>
<tr>
<td>C. Company Carried Reserves</td>
<td>17,100</td>
<td>22,000</td>
</tr>
<tr>
<td>D. Difference</td>
<td>100</td>
<td>(3,000)</td>
</tr>
</tbody>
</table>

When the carried reserves are less than the 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 the analyst to evaluate. The analyst should focus on the difference between the carried reserves and the point estimate or range midpoint. If the actuary has issued a “Reasonable” opinion, the analyst should consider the following factors in how to accept this difference and/or to seek more information:

- The difference as a percent of surplus
- The difference as a percent of carried loss + loss adjustment expense reserves
- The company’s risk-based capital position
- The actuary’s response to items A & B of the Opinion paragraph

At this point, the analyst might consider an alternate question: “If the company had carried the 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 the analyst should consider requesting management’s rationale and documentation to support the lower carried reserve amount(s). In addition, the analyst might require the company to have their appointed actuary provide additional information regarding the range of estimates, if calculated. The actuary’s description of the range should also be documented in the Actuarial Report supporting the Opinion.

As a rule of thumb, it is concerning if carried reserves are more than 5 percent (of surplus) below the actuary’s point estimate or range midpoint, even if the reserves still lie within the actuary’s range. The 5 percent (of surplus) is a common examiner materiality starting selection.

Next, consider the Summary in the context of RMAD as addressed in the Opinion. If a range is provided, is the materiality standard less than the difference between the carried reserves and the high end of the actuary’s range? This implies that the actuary’s range of reasonable reserve estimates encompasses the amount the actuary considers to be a material adverse deviation. Does the actuary conclude “yes” in Exhibit B as to whether there is significant risk of material adverse deviation and provide extensive discussion of risks and uncertainties? The analyst should document any comments or concerns.

Most Opinions issued are “Reasonable, which means that the carried reserve amounts are within the actuary’s range of reasonable reserve estimates. Thus, 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 the analyst. 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 very rare, presents a challenge for the analyst. 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, the analyst should evaluate the materiality of the deficiency in light of surplus, the company’s RBC position, net income, and other factors. The analyst 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 the implied deficiency can be evaluated.

Regardless of the analyst’s 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, the analyst should direct initial questions to company management for rationale and documentation of decisions regarding the carried reserves.

Section 5, subsection E 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 percent of surplus as measured by Schedule P, Part 2, in at least three of the past five calendar years, the appointed actuary must provide explicit discussion of the causes or actions that contributed to adverse development. The calculation of the one-year adverse development ratio can be found in the Five-Year Historical Data exhibit of the Annual Statement.

In the discussion of persistent adverse development, the appointed actuary is encouraged to address common questions that regulators have, such as:

- Is the development concentrated in one or two exposure segments, or is it broad across all segments?
- How does the development in the carried reserve compare to the change in the actuary’s estimates?
- Is the development related to specific and identifiable situations that are unique to the company?
- Is the development judged to be random fluctuation attributable to loss emergence?
- Do either the development or the reasons for development differ depending on the individual calendar or accident years?

The analyst should also consider the following situations:

Situation A: Prior Summaries indicate that the company relies on the actuary’s estimates. If persistent adverse development occurs, the analyst might infer that the actuary’s methods and assumptions have a bias toward underestimation.

Situation B: Prior Summaries indicate that the company regularly carries amounts lower than the actuarial point estimate or low in the actuary’s range. If persistent adverse development occurs, the analyst might infer that management takes a more optimistic view of its liabilities, regardless of what the appointed actuary calculates.

Considerations

The Opinion and/or the Summary 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 through correspondence or conversation.

**Initial Steps**

The Statement of Actuarial Opinion Supplemental Procedures and the Actuarial Opinion Summary Supplemental Procedures provide guidance for a reviewing analyst. The procedures should be supplemented with comments and questions as needed. Both the Opinion and the Summary should be reviewed and considered together before any action is taken. At the completion of the review procedures, the analyst should conclude what, if any, further action is needed.

**Consult with the regulatory property/casualty actuary, if available**

If the insurance department has a regulatory property/casualty actuary on staff, the analyst may consult him or her with any questions or concerns.

**Contact the insurer**

The analyst 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 method for determining the carried loss and LAE reserves, or other risk items noted in the Relevant Comments section as having the potential to result in material adverse deviation. Typically, items of a general nature, such as the risk from a change in the legal or regulatory environment, would not require further investigation.

The analyst may need to contact the insurer when the insurer has provided coverage for certain classes of business that affect the type of liabilities that arise. Asbestos, environmental, pollution or 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 insurer loss history has limited predictability. The results from these models often have a wide range in estimates for loss and LAE reserves and thus a high degree of uncertainty. Construction defect claims have a 10-year reporting period in some states, making their liabilities particularly difficult to estimate. The analyst should consider submitting a request for additional information from the insurer if an RMAD from these types of claims is identified.

Collectability of reinsurance can be a concern when noted in the Relevant Comments section. 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 the company 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.

A change in the method for determining the loss and LAE reserves could also be identified by the actuary in the Relevant Comments section. If an insurer has recently implemented loss reserve discounting or if the discount rate used to determine the reserves has changed, then the impact on the reserve estimates arising from these changes should be ascertained by the analyst. The impact of any changes in the reserving methodology should be investigated, particularly with regard to its effect on the provision for material adverse deviation and its potential impact on RBC levels.
For property/casualty insurers, the appointed actuary must include comments on the factors that led to exceptional values for IRIS ratios #11, #12, and #13 in the Opinion. An explanation that identifies risk elements that are part of the insurer’s operations rather than a one-time occurrence would merit further investigation by the analyst. It is generally not sufficient to explain an exceptional value by simply stating the insurer has strengthened reserves. Specific detail regarding lines of business, accident years, or changes in operations should be requested if the actuary has not provided that explanation for the specific IRIS ratio. Similarly for title insurers, exceptional reserve development as defined by the Instructions 6D should be explained in the Opinion.

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, reviewing the Actuarial Report supporting the Opinion can give the analyst insights about the nature and severity of the risks identified. If one or more portions of the carried reserves are excluded from the Opinion, the Actuarial Report may give the analyst insight as to the relative amount of any excluded items and the reasons why those items were excluded from the Opinion.

If the analyst requests the Actuarial Report, the analyst might start reviewing the narrative component first. The narrative should contain the summary exhibits and the appointed actuary’s point estimate and/or range, and is often referred to as the Executive Summary. 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 an evaluation of the carried reserves by an actuary.

If the relevant comments or RMAD paragraphs mention the use of loss portfolio transfers or financial reinsurance as a potential source for subsequent adverse impact, then the analyst needs to understand how these agreements may affect the insurer’s financial position. The Actuarial Report may include information about the impact of these contracts under various scenarios or consider the possible range of outcomes under different circumstances.

Any items in the insurer’s carried reserves that were identified in the Opinion as not quantifiable require further investigation. The particular reasons or circumstances given can provide guidance on how to proceed. The analyst should consult with the appointed actuary to find out why there was not an opinion rendered on a portion of the reserves.

Consult with the appointed actuary

The analyst may contact the appointed actuary regarding any issues noted in the Opinion or the Summary, regardless of where the appointed actuary is employed. The analyst should use discretion in informing company management while communicating with the appointed actuary.

Next Steps

Engage an independent actuary to review the insurer’s reserves

For items that were not quantified in the Opinion or any liability items for which there is significant concern, the analyst 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.
Meet with the insurer’s management

The analyst 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. This 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 financial report. 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.

Refer the insurer to the examination section for a target examination

The analyst may recommend a target examination if, after obtaining further information, there is still concern about the financial risk of the insurer. The target examination should determine if the insurer is taking proper steps to mitigate the adverse impact arising from the risks identified in the Opinion.

Discussion of the Supplemental Procedures

A. Actuarial Opinion

The analysis of the Opinion, although filed with the Annual Statement, is documented separately from the Annual Procedures because of its significance.

GENERAL and IDENTIFICATION

Procedures #1 through 9 assist the analyst in determining whether, (1) an Opinion was filed and prepared by a qualified actuary who was appointed by the insurer’s board of directors prior to December 31 of the year for which the Opinion pertains, (2) the insurer has an exemption from filing the Opinion that was approved by the domiciliary state insurance department and (3) the insurer is a member of an intercompany pooling arrangement. Pool members’ financial results may need to be evaluated differently than insurers who operate independently.

SCOPE

Procedures #10 through 14 assist the analyst in determining whether the Scope paragraph of the Opinion contains verbiage that covers the reserves and premium amounts required to be reviewed (as shown in Exhibit A) according to the Annual Statement Instructions Property/Casualty, and whether the reserve amounts included in the Opinion agree with the amounts reported in the Annual Statement. If the reserve amounts included in the Opinion do not agree with the amounts per the Annual Statement, the analyst should (1) comment on the reasons for the differences, (2) consider the impact of the differences on the conclusions reached as a result of the analysis of the Annual Statement, and (3) consider the need to perform additional analysis on the Annual Statement.

Procedure #14 assists the analyst in determining whether the actuary indicated that the data used in forming his or her opinion on the loss and LAE reserves were 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 CPA as a part of the audit of the insurer. These procedures were designed to prevent the problem of the actuary relying on unaudited data in analyzing the insurer’s reserves. For title insurers, data is reconciled to the Annual Financial Statement, Schedule P, Parts 1 and 2.

IV. Analyst Reference Guide – C.I. Statement of Actuarial Opinion (Property/Casualty and Title Insurers) & Actuarial Opinion Summary (Property/Casualty only)

OPINION

Procedures #15 through 19 assist the analyst in determining whether the 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, 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 Opinion. If the Opinion deviates from these statements or if any portion of the insurer’s reserves are excluded from the Opinion (e.g., pools and associations, reserves for asbestos or environmental exposures, etc.), the analyst should (1) comment on the deviations or exclusions, (2) consider their impact on the conclusions reached as a result of the analysis of the Annual Statement, and (3) consider the need to perform additional analysis on the Annual Statement. Procedure #18 is not applicable to Title insurers.

RELEVANT COMMENTS AND EXHIBIT B DISCLOSURES

Procedures #20 through 25 assist the analyst in determining whether the actuary commented on various topics and issues in Exhibit B of the Opinion (including the materiality standard, discounting, salvage and subrogation, asbestos and environmental, reinsurance collectability, etc.) as required by the Annual Statement Instructions Property/Casualty and Annual Statement Instructions Title. For property/casualty insurers, the Opinion should also indicate if the insurer failed the reserving IRIS ratios and discuss any exceptional values.

For Title insurers IRIS ratios do not apply. However, the Title Opinion should also indicate if the insurer had exceptional reserve development as defined in the Title Instructions. The analyst should summarize any pertinent comments made by the actuary and consider the impact, if any, of the actuary’s comments on the conclusions reached as a result of the analysis of the Annual Statement and determine the need to perform additional analysis on the Annual Statement.

CONCLUSIONS/RECOMMENDATIONS

Procedures #26 through 28 assist the analyst in determining whether the actuary indicated that an Actuarial Report has been prepared which supports the findings expressed in the Opinion. In some cases, the analyst may consider obtaining a copy of the Actuarial Report. The Actuarial Report is a confidential document that describes the sources of data, material assumptions, 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/ or reinsurance. While not required to be filed with the Opinion, the Actuarial Report is required to be retained by the insurer for a period of seven years and available for regulatory examination.

B. Actuarial Opinion Summary (not applicable to Title insurers)

The Actuarial Opinion Summary Supplemental Procedures provide a guide for a reviewing analyst. The procedures should be supplemented with comments and questions as needed. The Summary is not required to be prepared for title insurers.

Procedure #1 verifies the regulatory requirements for filing the Summary and the company’s compliance with the requirement.
Procedure #2 verifies if the insurer is a member of an intercompany pooling arrangement and if such applicable pooling percentages are disclosed.

Procedure #3 verifies consistency between the Summary and the Opinion with respect to the carried reserves of the company. Inconsistencies in reported values indicate weak controls within the company.

Procedure #4 identifies the type of comparison that the actuary presents (carried reserves to the actuary’s point estimate and/or carried reserves to the actuary’s range). The analyst should note concerns regarding carried amounts that appear significantly low relative to the actuary’s estimate(s). See the Analysts Reference Guide for guidance on evaluating the comparison.

Procedure #5 verifies consistency between the appointed actuary’s opinion found in the Opinion and the comparison presented in the Summary.

Procedure #6 verifies compliance with the Summary reporting requirement regarding persistent adverse development. The analyst should note concerns regarding the nature of historical adverse development. See the above discussion for guidance on evaluating the comments provided by the appointed actuary.
Statement of Actuarial Opinion Based on an Asset Adequacy Analysis

1. Is this actuary the same actuary who was appointed for the previous Opinion?
   a. If “no”, did the insurers notify the domiciliary state insurance regulator within 5 days of the replacement?
   b. Within 10 days of above notification, did the insurer provide an additional letter stating whether or not there were any disagreements with former actuary and also in writing request the former actuary for a letter agreement?
   c. Did the insurer furnish the former actuary’s responsive letter?

2. Do the reserve amounts included in the Statement of Actuarial Opinion agree (SAO) with the amounts per the Annual Financial Statement?

3. Has 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 does such notice state that the person meets the definition of a qualified actuary?

4. Does the SAO cover 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)?

5. Does the SAO include a table that indicates those reserves that have been analyzed for asset adequacy, including the method of analysis, and indicate that any additional actuarial reserves must be established?

6. Review Annual Financial Statement, Exhibits 5, 6 and 7. Were the additional actuarial reserves properly established as a result of the asset/liability analysis?

7. Does the SAO state that the reserves:
   a. Are computed in accordance with those presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles?
   b. 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?
   c. 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?
   d. 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)?
   e. Include provisions for all actuarial reserves and related statement items that ought to be established?

Regulatory Asset Adequacy Issues Summary (RAAIS)

8. Did the RAAIS include the following?
   a. Descriptions of scenarios tested
   b. Extent to which assumptions used are materially different from assumptions in the previous asset adequacy analysis
   c. 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
   d. Comments on results that may be of significant concern to the appointed actuary
   e. Methods used to recognize the impact of reinsurance on cash flows under each scenario tested
   f. 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

9. 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:
   a. Did the company book additional reserves for any scenario 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?
      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.

Actuarial Memorandum

10. Did the qualified actuary conduct an asset adequacy test on at least 95 percent of the insurer’s total reserves?

11. Based upon the judgment of the analyst and after reviewing the SAO and RAAIS, should the actuarial memorandum be requested from the insurer? If “no,” skip to the summary and conclusion.
Summary (Life/A&H and Fraternal)

12. Does the Actuarial Memorandum including an asset adequacy analysis include the following? (Note that the items required to be included may vary from state to state.)

a. For reserves:
   i. Product descriptions
   ii. Source of liability in-force
   iii. Reserve method and basis
   iv. Investment reserves
   v. Reinsurance arrangements
   vi. Persistency of in-force business
   vii. Identification of any guarantees made by the separate account in support of benefits provided through a separate account
   viii. Discussion of assumptions to test reserves

b. For assets:
   i. Portfolio descriptions
   ii. Investment and disinvestment assumptions
   iii. Source of asset data
   iv. Asset valuation bases
   v. Documentation of assumptions made

c. For the analysis basis:
   i. Methodology
   ii. Rationale for inclusion or 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 and method of treating reinsurance in the asset adequacy analysis

d. Summary of material changes

e. Summary of results

f. Conclusions

g. 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

h. Method for aggregating reserves and assets

i. Method for selecting and/or allocating assets supporting the Asset Valuation Reserve

j. Analysis of the effect of required interest rate scenarios
13. Document 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.

If additional concerns are noted based on the review of the RAAIS and/or Actuarial Memorandum, consider performing the following additional procedures [Note: Procedures 12.a. through 12.d. are applicable to insurers utilizing the New York 7 actuarial interest rate scenario tests. Procedure 12.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.

**Non-Guaranteed Elements Opinion (if applicable)**

14. Has 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 does such notice state that the person meets the definition of a qualified actuary?

15. Does the Statement of Actuarial Opinion include the following sections?
   a. Determination procedure section that defines the insurer’s policy in determining non-guaranteed elements, particularly the degree of discretion allowed by the insurer.
   b. Interrogatories section.
   c. Statement of Actuarial Opinion section that states that the non-guaranteed elements for individual life and annuities policies have been determined in accordance with generally accepted actuarial principles and practices.

16. Summarize any pertinent comments by the qualified actuary.

**Summary and Conclusion**

Develop and document an overall summary and conclusion regarding the SAO, and if applicable, the actuarial memorandum. In developing a conclusion, consider the above procedures, as well as any other
Summary (Life/A&H and Fraternal)

procedures that, in the analyst’s judgment, are relevant to evaluating the SAO and actuarial memorandum under the specific circumstances involved.

Recommendations for further action, if any, based on the overall conclusion above:

- Contact the insurer seeking explanations or additional information from the insurer or the qualified actuary
- Obtain the insurer’s business plan
- Require additional interim reporting from the insurer
- Refer concerns to the examination section for target examination
- Consult with the in-house actuary
- Engage an independent actuary to review insurer’s reserves
- Meet with the insurer’s management
- Obtain a corrective plan from the insurer
- Other (explain)

Analyst ________________ Date________

Comments as a result of supervisory review.

Reviewer _______________ Date________
Overview

Life insurers required to file an Annual Financial Statement are also required to file a Statement of Actuarial Opinion (SAO) as a supplement to the Annual Financial Statement. The specific requirements for the SAO are described in the NAIC Actuarial Opinion and Memorandum Regulation (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 regulation authorized by Section 3 of the Standard Valuation Law as amended by the NAIC in December 1990. 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 Regulatory Asset Adequacy Issues Summary (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 regulation authorized by Section 3 of the Standard Valuation Law as amended by the NAIC in December 1990. 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 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 accident and health 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 one in which the item amounts reviewed do not satisfy one or more of the six criteria listed in the opinion paragraph of the SAO.
Discussion of Level 1 Annual 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 Supplemental Annual Procedures 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 Level 1 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.

Every life insurer must file a SAO including an asset adequacy analysis.

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.

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 sufficient to pay future 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, the AOMR specified seven scenarios for cash flow testing (commonly referred to as the New York 7). The 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 percent of the total of life insurance reserves, annuity reserves and reserves for deposit-type contracts. This 95 percent threshold is included in procedure #9, but it is a recommendation and the standard of materiality may vary among actuaries.

Discussion of Supplemental Procedures

The analysis of the SAO, although filed with the Annual Financial Statement, is documented on the separate Supplemental Procedures for the SAO because of its significance. The Supplemental Procedures for the SAO are broken down into three parts: A) review of the SAO based on an asset adequacy analysis,
B) review of the RAAIS and the Actuarial Memorandum, and C) review of the non-guaranteed elements opinion (if applicable).

Statement of Actuarial Opinion Based on an Asset Adequacy Analysis

Procedures #1 and 2 assist the analyst in determining that the SAO was prepared by a qualified actuary and that the reserve amounts agree with the Annual Financial Statement.

Procedures #3-6 assist the analyst in determining 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.

Regulatory Asset Adequacy Issues Summary and Actuarial Memorandum

Procedures #7 and 8 request the analyst to 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 base 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.

Procedures #9-11 assist the analyst in reviewing 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.

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 three percent 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 a half percent (0.5%) per year and then level;
- Uniformity increasing at one percent per year over five years and then uniformly decreasing at one percent per year to the original level at the end of the 10 years and then level;
- An immediate increase of three percent and then level;
- Uniformly decreasing over 10 years at a half percent (0.5%) per year and then level;
- Uniformly decreasing at one percent per year over five years and then uniformly increasing at one percent per year to the original level at the end of 10 years and then level; and
- An immediate decrease of three percent and then level.

Procedure #12 asks the analyst to 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 12.a. through 12.d. are applicable to insurers utilizing the New York 7 actuarial interest rate scenario tests. Procedure 12.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 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.
Non-Guaranteed Elements Opinion (if applicable)

Procedure #13 assists the analyst in determining that a qualified actuary prepared the non-guaranteed elements opinion.

Procedures #14 and 15 assist the analyst in reviewing 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.

The instructions to the Health Annual Financial Statement require a Statement of Actuarial Opinion (SAO) to be attached to the Annual Financial Statement.

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 American Academy of Actuaries or a person recognized by the American Academy of Actuaries as qualified for such health actuarial valuation.

1. Does the SAO include a completed Table of Key Indicators?

2. Does the SAO state the actuary’s qualifications and affiliation?

3. 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.

4. Is this the same actuary who was appointed for the previous SAO?
   a. 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.)
   b. 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 request the former actuary a responsive letter as to whether the former actuary agrees or disagrees with the statements provided in the company’s letter?
   c. Did the company provide the responsive letter from the replaced actuary?

5. Do the reserve amounts included in the SAO agree with the amounts per the Annual Financial Statement?

6. 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?

7. The Health Annual Statement Instructions list A through H 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 Instructions:
   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.

Any examples of an item included in H above include the retrospective premium asset (Page 2, line 13.3):

If any of the above are “no,” what item(s) are missing?

8. Does the SAO state? “In my opinion, the amounts carried in the balance sheet on account of the items identified above”:
   A. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles?
   B. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared?
   C. 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. For each listed state a separate SAO was submitted to that state that complies with the requirements of that state?
   D. Make good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements?
   E. 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?
   F. Include appropriate provisions for all actuarial items that ought to be established?

9. Does the SAO state, “The Underwriting and Investment Exhibit – Part 2B was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice”?

10. Does the SAO state, “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”?

If an asset adequacy analysis was not required, do not proceed with the procedures for asset adequacy analysis (# 11, 12, & 13) and skip to the Summary and Conclusion.

11. If the SAO was based on an asset adequacy analysis, did the actuary determine that the reserves were sufficient in light of the assets held to meet future policy obligations?

12. If the SAO was based on an asset adequacy analysis, 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.

13. 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.

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.

Summary and Conclusion

Note any section where the Table of Key Indicators reflects that the actuary has not used the prescribed wording and summarize analysis performed. Summarize any pertinent comments by the qualified actuary. Develop and document an overall summary and conclusion regarding the SAO, and if applicable, the

actuarial memorandum. In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the SAO and actuarial memorandum under the specific circumstances involved. If there are serious inadequacies they should be reviewed with the actuary involved. If the inadequacies are not adequately explained, consider consulting the Actuarial Board of Counseling and Discipline, which provides guidance to the actuarial profession to improve the quality of actuarial activities.

Recommendations for further action, if any, based on the overall conclusion above:

- Contact the health entity seeking explanations or additional information from the health entity or the qualified actuary
- Obtain the health entity’s business plan
- Require additional interim reporting from the health entity
- Refer concerns to examination section for targeted examination
- Consult with the in-house actuary
- Engage an independent actuary to review health entity’s reserves
- Meet with the health entity’s management
- Obtain a corrective plan from the health entity.
- Other (explain)

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer _______________ Date ________

Overview

The Table of Key Indicators included in the Statement of Actuarial Opinion (SAO) notes where prescribed language has not been used, as well as if the Statement is other than unqualified. Generally the analyst can focus on the following four steps to compose much of the Level 1 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 Level 1 Procedures below, in most instances proper review and analysis of the (SAO) beyond Level 1 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 which provide instructions for the SAO which include 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, or a person recognized by the American Academy of Actuaries 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 December 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to December 31 of the same year if he or she deems the exemption inappropriate. A copy of the approved exemption must be approved 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.

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) one percent 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 which the exemption is sought; or

   b) three percent 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 SAO 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 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 (SAO 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 American Academy of Actuaries 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 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 & Health or Property & Casualty Annual Financial Statements and the Health Annual Financial Statement. Effective for 2003 Statutory Statements, companies with over 95 percent 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 Practice and Procedures Manual (AP&P Manual)* Appendix A-010 defines minimum health reserve requirements when there are no other state specific requirements. Although Appendix A-010 describes the separate minimum standard for each type of reserve separately, SSAP 54 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)

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1 The NAIC *Accounting Practices and Procedures Manual Appendix A-010* incorporates minimum reserve requirements from the Health Insurance Reserves Model Regulation.


D. Aggregate health policy reserves (Page 3, Line 4) including unearned premium 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)
   c. Reserve For Future Contingent Benefits (Underwriting and Investment Exhibit, Part 2D, Line 3)
   d. Reserve For Rate Credits or Experience Rated 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 & 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 Actuarial Standards Board 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. If required by either regulation or professional standards, the actuary should have included an opinion of the asset adequacy.¹ 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

In cases where the SAO is other than unqualified, the analyst 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 SAO 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.

**Discussion of Level 1 Annual Procedures**

In most instances proper review and analysis of the SAO and Actuarial Memorandum will require in-depth knowledge of actuarial science. In order to achieve this as a part of the financial review process, most SAOs will be reviewed in detail by actuarial staff members. Their review should encompass procedures discussed in the next section covering the Supplemental Procedures for the SAO.

¹ *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.
Soon after the Annual Financial Statement is received, a cursory review of the SAO should be performed to identify if any extraordinary item is detailed in the SAO. The primary goal of the Level 1 Procedures is to determine if a SAO was received and available for later review. And if so, was it a SAO which was unqualified, qualified, adverse, or inconclusive.

**Discussion of Supplemental Procedures**

The analysis of the SAO, although filed with the Annual Financial Statement, is documented on the separate Supplemental Procedures for the SAO because of its significance. The Supplemental Procedures are found in Section V of this Health Financial Analysis Handbook and are discussed as follows:

*Procedure #1* assists the analyst in determining that the Table of Key Indicators has been completed. The analyst should note that within each section of the Table, only one box should be checked. The Table assists the analyst in identifying those sections of the SAO for which it may be appropriate to perform additional analysis, specifically when “Prescribed Wording with Additional Writing” or “Revised Wording” has been checked.

*Procedures #2, 3, 4 and 5* assist the analyst in determining that the SAO was prepared by a qualified actuary and that the reserve amounts agree with the Annual Financial Statement.

*Procedure #6* assists the analyst in determining 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.

*Procedure #7* assists the analyst in determining if the health entity’s actuary has covered the required reserves.

*Procedure #8* assists the analyst in determining that the health entity’s actuary’s SAO on reserves is in accordance with the criteria found in the *Health Annual Financial Statement Instructions* paragraph #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. The analyst should also 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 the analyst.

*Procedure #9 and 10* is intended to assist the analyst in determining 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 #11, 12, and 13* are performed only in the situation where an asset adequacy test has been performed by the actuary. These procedures assist the analyst in reviewing 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. The analyst 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, which is filed with the Annual Financial Statement, assists the regulatory actuary in determining whether to request the actuarial memorandum. The Regulatory Asset Adequacy Issues Summary 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.

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.
Compliance and Review

1. Did the Management’s Discussion and Analysis (MD&A) filed in accordance with the Annual Financial Statement Instructions include the following overall content?
   a. Discussion of short and long-term analysis of the business of the insurer.
   b. Discussion of the two-year period covered by the Annual Financial Statement, including year-to-year comparisons.
   c. Reference to the Annual Financial Statement, Five-Year Historical Data exhibit and other exhibits or schedules where trend information is relevant.
   d. Explanation of accounting policies applied, judgments made in the insurer’s application, and any subsequent changes in assumptions or conditions that result in materially different reported results.
   e. Discussion of 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 condition.

2. Was the MD&A prepared on a non-consolidated basis? If “no,” does the domiciliary state permit audited consolidated financial statements or does the insurer cede substantially all of its direct and assumed business to a pool?

Results of Operations

3. Did the MD&A include a discussion regarding the insurer’s results of operations?
   a. Describe any unusual or infrequent events, transactions, or any significant economic changes that materially impact net income or other gains/losses in surplus, or any significant components of income.
   b. Describe any known trends or uncertainties that have had or are reasonably probable to have a material impact on premiums, net income, or other gains/losses in surplus.
   c. Discuss the extent to which material increases in premiums are attributable to increases in prices or volume of existing products or to the introduction of new products being sold.

Prospective Information

4. Did the MD&A include a discussion regarding prospective information?
   a. Discuss known trends or any known demands, commitments, events, or uncertainties that are reasonably likely to impact liquidity, capital resources, and the mix and cost of such resources.
   b. Discuss known trends or uncertainties that are reasonably likely to impact premiums, net income, and other gains/losses in surplus.

Material Changes

5. Did the MD&A include adequate disclosure of the reasons for material changes in line items, or discussion and quantification of the contribution of two or more factors to such material changes?
IV. Supplemental Procedures – D. Management’s Discussion and Analysis

Liquidity, Asset/Liability Matching and Capital Resources

6. Did the MD&A include a discussion on liquidity, asset/liability matching and capital resources?
   a. Indicate those balance sheet, income statement, or cash flow items that the insurer believes may be indicators of its liquidity condition.
   b. Discuss the nature and extent of restrictions on the ability of subsidiaries to transfer funds to the insurer and the impact such restrictions may have on the ability of the insurer to meet cash obligations.
   c. Identify any material expenditure, 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.
   d. Identify any known trends, demands, commitments, events, or uncertainties that are reasonably likely to result in material changes in the insurer’s liquidity. If any are identified, describe the course of action taken by the insurer to remedy deterioration in liquidity.
   e. Describe internal and external sources of capital available to improve liquidity and any material unused sources of liquid assets.
   f. Describe any material trends in the insurer’s capital resources, including any material changes in the mix or relative cost of such resources.
   g. Discuss cash flows from investing and financing.
   h. Discuss off-balance sheet financing if liquidity is dependent on such arrangements.
   i. Disclose circumstances that materially affect liquidity, such as market price changes, economic declines, defaults on guarantees, etc.

Loss Reserves

7. Did the MD&A include a discussion of those items that affect the volatility of loss reserves, including a description of those risks that contribute to the volatility?

Off-Balance Sheet Arrangements

8. Did the MD&A include a discussion on off-balance sheet arrangements?
   a. Discuss sources of liquidity and financing, including off-balance sheet arrangements and transactions with limited purpose entities.
   b. Describe the extent of the insurer’s reliance on off-balance sheet arrangements such as its business purposes and activities, economic substance, key terms and conditions of any commitments, initial and ongoing relationships, and the potential risk exposures resulting from the contractual or other commitments.
   c. Disclose uncertainties where contingencies inherent in the arrangements are reasonably likely to affect the continued availability of a material historical source of liquidity and finance.
Participation in High-Yield Financings, Highly-Leveraged Transactions or Non-Investment Grade Loans and Investments

9. Did the MD&A include a discussion on participation in high-yield financings, highly-leveraged transactions, or non-investment grade loans and investments?

   a. Identify transactions or investments and the nature and extent of the insurer’s involvement in such transactions or investments, if participation or involvement is reasonably likely to have a material effect on financial condition or results of operations.

   b. Describe additional risks to the insurer as well as associated fees and recognized losses.

   c. Describe the insurer’s judgment as to the material effect, if any, on the financial condition of the insurer.

Preliminary Merger/Acquisition Negotiations

10. Did the MD&A include a discussion on preliminary merger/acquisition negotiations, where disclosure is otherwise required or has been made by or on behalf of the insurer?

Assessment of Management’s Discussion and Analysis

11. In review of the MD&A, were any previously unknown and undocumented risks, concerns or unusual items noted in the information reported. Document any new risks, concerns and unusual items not already addressed for this company.

   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 (property/casualty only)

   h. Off-balance sheet arrangements

   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

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the MD&A. In developing a conclusion, consider the above procedures as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating MD&A under the specific circumstances involved.
Recommendations for further action, if any, based on the overall conclusion above:

- If any new risks, concerns or unusual items were noted in #11 above, consider performing additional Level 2 procedures, as applicable
- If the insurer’s MD&A is not sufficient, request that the insurer re-submit the MD&A with more disclosure
- Obtain the insurer’s business plan
- Require additional interim reporting from the insurer
- Refer concerns to the examination section for target examination
- Consult with the in-house actuary
- Meet with the insurer’s management
- Obtain a corrective plan from the insurer
- Other (explain)

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer _______________ Date ________
Overview

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 the analyst 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 the analyst’s 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.

Discussion of the Supplemental Procedures

The analysis of the MD&A is documented in the Supplemental Procedures rather than any level of procedures for the Annual Financial Statement, due to its significance, along with the filing due date of April 1 rather than on March 1 with the Annual Financial Statement.

Compliance and Review

Procedure #1 assists the analyst in evaluating the overall completeness of the MD&A. Specifically; it should address the two-year period covered in the insurer’s Annual Financial Statement and discuss any material changes.

Procedure #2 assists the analyst in determining if the insurer was required to prepare the MD&A on a non-consolidated basis, unless the following conditions were met: (1) the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or a 100-percent 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 percent of the company’s capital and surplus), or (2) the insurer’s state of domicile permits audited consolidated financial statements.

Results of Operations

Procedure #3 assists the analyst in determining if results of operations have been disclosed. Insurers should describe 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 and, in each case, indicate the extent to which net income or surplus was affected. In addition, the analyst should describe any other significant components of income in order to understand the insurer’s results of operations.
Insurers should 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 amount of existing products being sold, or the introduction of new products.

Prospective Information

**Procedure #4** assists the analyst in determining if results of prospective information have been disclosed. 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

**Procedure #5** assists the analyst in determining if material changes have been disclosed. 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, or where there are material increases or decreases in net premium.

Liquidity, Asset/Liability Matching and Capital Resources

**Procedure #6** assists the analyst in determining if liquidity, asset/liability matching, and capital resources have been disclosed. The discussion of liquidity shall include a discussion of the nature 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. Generally, short-term liquidity and short-term capital resources cover cash needs up to 12 months into the future. These cash needs and the sources of funds to meet such needs relate to the day-to-day operating expenses of the reporting entity and material commitments coming due during that 12-month period.

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. Insurers should identify any 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 increasing or decreasing in any material way. If a material decline in liquidity is identified, indicate the course of action that the insurer has taken or proposes to take to remedy the decline. 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 its capital resources, and indicate any expected material changes in the mix and relative cost of such resources. The discussion shall consider changes between equity, debt, and any off-balance sheet financing arrangements. Insurers should present a balanced discussion dealing with cash flows from operations, investing, and financing activities.

Loss Reserves (Property/Casualty Only)

Procedure #7 assists the analyst in determining if loss reserves have been disclosed. 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

Procedure #8 assists the analyst in determining if off-balance sheet arrangements have been disclosed. 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 in High Yield Financings, Highly Leveraged Transactions or Non-Investment Grade Loans and Investments

Procedure #9 assists the analyst in determining if participation in high-yield financing, highly leveraged transactions, or non-investment grade loans and investments has been disclosed. In view of these potentially greater returns and potentially greater risks, disclosure of the nature and extent of an insurer’s involvement with high-yield or highly leveraged transactions and non-investment grade loans and investments may be required, 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 Negotiations

Procedure #10 assists the analyst in determining if preliminary merger/acquisition negotiations have been disclosed.

Assessment of Management’s Discussion and Analysis

Procedure #11 assists the analyst in determining if any previously unknown and undocumented risks, concerns or unusual items were reported in the insurer’s MD&A.
The following procedures are intended to be performed by non-lead domestic states. Such procedures are intended to be used in order to develop and document an analysis of the impact of the holding company system on the domestic insurer.

Name of Holding Company System ____________________
Name of Lead State (if not your state) ____________

Identify and Understand Affiliated Risks within the Holding Company System

1. 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? Please document any material deficiencies or risks as well as mitigating factors. Notify the Lead State (if not your state) as to the existence of these items for discussion in available channels.
   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

2. Describe 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).

3. Determine and describe the level of reputational risk that the holding company (as a group) poses to the domestic insurer(s).

4. Determine if income of the domestic insurer(s) is being used to service holding company debt or other corporate initiatives (e.g., acquisitions).

5. Document in this checklist and notify the Lead State (if not your 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.

6. Obtain a copy of the Lead State’s (if not your state) Holding Company Analysis. If not available, obtain a summary (written or verbal) from the Lead State of the information that is necessary to evaluate the impact that the holding company system could have on the domestic insurer.

7. Were there any material risks or events identified during your holding company analysis that were not discussed in the Lead State’s (if not your state) holding company analysis? Please document any items briefly here and communicate those findings to the Lead State.
Supplemental Forms

8. If any of the following forms have been filed with the domestic regulator, indicate if concerns were noted in any of the following respective forms and/or Handbook checklists not previously noted above. Document and communicate any material concerns to the Lead State (if not your state).

- Form A (Acquisition of Control or Merger)
- Form B (Insurance Holding Company System – Annual Registration Statement)
- Form D (Prior Notice of a Transaction)
- Form E (Pre-Acquisition Notification) or Other Required Information
- Extraordinary Dividend/Distribution

Summary and Conclusion

Develop and document a summary and conclusion of the domestic regulator’s evaluation of the impact of the holding company system on the domestic insurer. Consider in that evaluation information obtained from the Lead State (if not your state) including identification of significant events, overall financial condition, key strengths and weaknesses and material concerns. In developing a summary and conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the impact of the holding company system on the domestic insurer. Update the Insurer Profile Summary for the impact of the holding company on the insurer based on the above analysis performed.

Recommendations for further action:

- Communicate any concerns to the Lead State (if not your state) and other domestic states to determine a plan of action (through available channels) to address concerns
- Other (explain)

Analyst ________________ Date________

Comments as a result of supervisory review.

Reviewer _______________ Date________
IV. Supplemental Procedures – E.2. Form A

Special Notes:
The following procedures do not supersede state regulation, but are merely additional guidance an analyst may consider useful.
The following procedures may be completed in part, or in total, at the discretion of the analyst 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. The review of these transactions may vary, as some states might have regulations that differ for Form A.

1. Enter data and other information into the NAIC Form A database within 10 days of receipt of the Form A. A filing may not be considered complete and active until all relevant information has been received. Data and information should be entered by the state’s designated person. Any changes to the status of the filing or other data elements should be entered into the Form A Database within 10 days.

2. 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.

3. Perform a query of the NAIC Form A database on the name of the applicant and its directors, executive officers, or owners of 10 percent or more of the voting securities of the applicant to identify the nature of other filings made in other states by similar individuals. Document any risks or concerns.

4. Establish contacts with other states 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). Document any risks or concerns.

Compliance and Review

5. Does the Form A provide a brief description of how control is to be acquired? Document any risks or concerns.

6. Does the Form A contain the following information:
   - Name and address (legal residence for an individual or street address if not an individual) of the applicant.
   - State the nature of the applicant’s business operations for the past five years, if the applicant is not an individual.
   - Describe the business to be performed by the applicant and its subsidiaries.
   - Determine whether the organizational chart identifies and states the relationship of every member of the insurance holding company system.

   Document any risk or concerns.
7. 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 percent or more of the voting securities of the applicant (if the applicant is not an individual)? Document any risks or concerns regarding competence, experience, and integrity of the applicant, as well as the results of any background investigation.

8. 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? 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.

9. If amounts will be borrowed, 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? Although not specifically required, if amounts will be borrowed, are the sources of funds to be used to service the debt stated? Document any risks or concerns.

10. Does the Form A explain the criteria used in determining the nature and amount of such consideration? Document any risks or concerns.

11. 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? Document any risks or concerns.

12. Does the Form A state: 1) the number of each class of shares of the insurer’s voting securities that the applicant, its affiliates, and any person plan 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? Document any risks or concerns.

13. Does the Form A state 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?

14. Does the Form A give 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. Document any risks or concerns.

15. Does the Form A 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? Document any risks or concerns.
IV. Supplemental Procedures – E.2. Form A

16. Does the Form A 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? Document any risks or concerns.

17. Does the Form A 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? Document any risks or concerns.

18. 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?

- Audited Financial Statements of ultimate controlling party(ies)/person(s) identified in the Form A.

- If fully audited financial information is not available, unaudited financial statements regarding the earnings and financial condition or tax returns of the ultimate controlling party(ies)/person(s), as deemed acceptable to the commissioner, may be reviewed.

- 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.

- Management’s assessment of internal controls accompanied by an independent public accountant’s report to the effect that the applicant maintained effective internal controls.

Based on the review of all financial statement information received, document any risks or concerns.

19. Does the Form A 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, 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?

20. Does the Form A contain the required signature and certification? Document any risks or concerns.

21. Does the Form A contain an agreement to provide the information required by Form F – Enterprise Risk Management within the required timeframe?

Assessment of the Change in Control

22. After the change of control, will the insurer be able to satisfy the requirements for the issuance of a license to write the classes of insurance for which it is presently licensed?

23. 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?
IV. Supplemental Procedures – E.2. Form A

24. Is the financial condition of any acquiring person such that it might jeopardize the financial stability of the insurer, or prejudice the interest of the insurer’s policyholders?

25. Will dividends from the insurer be required to support debt payments of the applicant or the applicant’s subsidiaries?

26. Are the competence, experience, and integrity of those persons who would control the operation of the insurer such that it would not be in the interest of the insurer’s policyholders and of the public to permit the acquisition of control?

27. After the change in control, will the insurer’s surplus be reasonable in relation to its outstanding liabilities and adequate for its financial needs?

28. 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 they are based on reasonable expectations.

29. 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.

30. 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.

31. 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.)?

32. 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?

33. Has the applicant included information on the assignment of specialized personnel (such as an attorney, actuary, or CPA) to the transaction?

34. Has the insurance department identified any reasons or circumstances surrounding the transaction to warrant the hiring of outside experts or consultants?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form A. In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the holding company Form A under the specific circumstances involved. Add any material items from the Form A review to the Insurer Profile Summary.

Recommendations for further action, if any, based on the overall conclusion above:

 Contact the insurer seeking explanations or additional information.
IV. Supplemental Procedures – E.2. Form A

- Obtain the insurer’s business plan.
- Require additional interim reporting from the insurer.
- Refer concerns to the examination section for target examination.
- Meet with the insurer’s management.
- Obtain a corrective plan from the insurer.
- Other (explain).

Analyst ________________ Date________

Comments as a result of supervisory review.

Reviewer ________________ Date________
IV. Supplemental Procedures – E.3. Form B

Special Notes:

The following procedures do not supersede state regulation, but are merely additional guidance an analyst may consider useful.

Form B – Insurance Holding Company System Annual Registration Statement

1. Did the registration statement, filed in accordance with the NAIC Insurance Holding Company System Regulatory Act (#440), include the following current information?
   a. 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.
   b. The identity and relationship of every member of the insurance holding company system. Document any risks or concerns regarding corporate structure.
   c. The following agreements in force and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:
      i. Loans, other investments, purchases, sales, or exchanges of securities of the affiliates by the insurer or vice versa, involving 0.5 percent or more of the registrant’s admitted assets as of Dec. 31 of the most recent prior year ended
      ii. Purchases, sales, or exchange of assets involving 0.5 percent or more of registrant’s admitted assets as of Dec. 31 of the most recent prior year ended
      iii. Transactions not in the ordinary course of business
      iv. 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 percent or more of registrant’s admitted assets as of Dec. 31 of the most recent prior year ended, other than insurance contracts entered into in the ordinary course of the insurer's business
      v. All reinsurance or management agreements, service contracts, consolidated tax allocation agreements, and cost-sharing arrangements
      vi. Dividends and other distributions to shareholders
   d. 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.
   e. 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.
   f. A summary outlining all items in the current registration statement representing changes from the prior registration statement (Form C).

Document any risks or concerns regarding agreements and transactions.

2. If the response is “yes” to any of the questions in 1.c. – 1.e. above, did the insurer provide a description of the transaction or agreement, which would permit a proper evaluation by the Commissioner, 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
IV. Supplemental Procedures – E.3. Form B

the transaction, and the relationship of the affiliated parties to the registrant. Document any risks or concerns.

3. Did each registered insurer properly report dividends and other distributions to shareholders in accordance with the following Model #440 requirements?
   a. Were all dividends and other distributions to shareholders reported within 15 business days following the declaration thereof?
   b. Were any dividends and other distributions to shareholders considered extraordinary?
   c. If the answer to 3.b. above is “yes,” did the transaction receive proper regulatory approval? Document any risks or concerns.

4. Did any transaction, which occurred during the last calendar year involving the insurer and others in its holding company system, require prior regulatory approval?
   a. Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments where the transactions equal or exceed:
      i. With respect to non-life insurers, the lesser of 3 percent of the insurer’s admitted assets or 25 percent of surplus as of Dec. 31 of the most recent prior year ended
      ii. With respect to life insurers, 3 percent of the insurer’s admitted assets as of Dec. 31 of the most recent prior year ended
   b. Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions are equal to or exceed:
      i. With respect to non-life insurers, the lesser of 3 percent of the insurer’s admitted assets or 25 percent of surplus as of Dec. 31 of the most recent prior year ended
      ii. With respect to life insurers, 3 percent of the insurer’s admitted assets as of Dec. 31 of the most recent prior year ended
   c. Reinsurance agreements or modifications thereto, in which the reinsurance premium or a change in the insurer’s liabilities equals or exceeds 5 percent 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 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.
   d. All management agreements, service contracts, and cost-sharing arrangements.
   e. Any material transactions, specified by regulation, which the Commissioner determines may adversely affect the interest of the insurer’s policyholders.
   f. If the answer to any of the questions in 4.a. – 4.e. above is “yes,” did the insurer receive proper prior regulatory approval? Document any risks or concerns.
Assessment of Form B – Insurance Holding Company System Annual Registration Statement

**Analyst should also utilize Chapter IV. – E.1. Holding Company System Analysis (Non-Lead State) Procedures in completing analysis of the holding company system registration statement.**

5. Based upon a review of the registration statement, were any significant and/or unusual items noted, such as the following?
   a. Person(s) holding 10 percent 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.
   b. Biographical information about directors or officers, which may elevate concerns such as convictions of crimes.
   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.
   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.

6. Were there any inconsistencies between responses indicated in the Level 2 Affiliated Transactions Procedures and the response in this Form B analysis?

**Summary and Conclusion**

Develop and document an overall summary and conclusion regarding the holding company Form B. In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the holding company Form B under the specific circumstances involved.

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
- Refer concerns to the examination section for target examination
- Meet with the insurer’s management
- Obtain a corrective plan from the insurer
- Other (explain)

Analyst ________________ Date________

Comments as a result of supervisory review.

Reviewer _______________ Date_______
IV. Supplemental Procedures – E.4. Form D Procedures

Special Notes:

The following procedures do not supersede state regulation, but are merely additional guidance an analyst may consider useful.

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.

1. If a material transaction has occurred, did the insurer file a Form D with their domestic state? (Section 5 of the NAIC Insurance Holding Company System Regulatory Act 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:
   - 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 Section 5A(1)(a) of the Act; 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
   - A description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like
IV. Supplemental Procedures – E.4. Form D Procedures

5. If the transaction involves consideration other than cash, does the 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 which 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 the 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.
IV. Supplemental Procedures – E.4. Form D Procedures

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 market.’ If market based, include rationale for using market instead of 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
   - A description of when amounts are settled and a provision for interest in the event that settlements are not made timely

Assessment of Form D – Prior Notice of a Transaction

14. Review Form D for any significant and/or unusual items or inconsistencies. Determine if the transaction appears fair and reasonable in relation to the following:
   a. For reinsurance agreements, are the general terms, settlement provision and pricing consistent with those of non-affiliated agreements?
   b. For management, service or cost-sharing agreement are the 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?
   f. Do unusual circumstances, risks or concerns exist?

15. Determine whether the transaction was accounted for properly, based on statutory accounting principles, with the NAIC AP&P Manual.
IV. Supplemental Procedures – E.4. Form D Procedures

Assessment of Form D – Captive Reinsurance Transactions

16. 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 being presented 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 48 (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 (a) Primary Security (as that term is defined in AG 48) and/or (b) held by or on behalf of the insurer on a funds withheld, trust, or modified coinsurance basis.

d. If no exemption under Actuarial Guideline 48 applies, require the insurer to submit current and five year projected calculations, and support therefor, of (a) the statutory reserves with respect to the XXX/AXXX business being ceded; and (b) 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: (i) 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 (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 (i) 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 a) 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 b) the insurer otherwise has a contingency plan to manage its capital at transaction maturity.
IV. Supplemental Procedures – E.4. Form D Procedures

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” 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. In determining the ability to absorb material unexpected losses, consider either reviewing the group’s ORSA Summary Report or obtaining similar information which 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 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.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form D. In developing a conclusion, consider the above procedures as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the holding company Form D under the specific circumstances involved.

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
- Refer concerns to the examination section for targeted examination
- Engage an independent actuary or other reinsurance expert to review specific reinsurance contracts
- Meet with the insurer’s management
- Obtain a corrective plan from the insurer
- Other (explain)

Analyst _______ Date______
Comments as a result of supervisory review.

Reviewer _______________ Date________
IV. Supplemental Procedures – E.5. Form E (or Other Required Information)

Special Notes:
The following procedures do not supersede state regulation, but are merely additional guidance an analyst 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.
IV. Supplemental Procedures – E.5. Form E (or Other Required Information)

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.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form E or other required information. In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the holding company Form E or other required information under the specific circumstances involved.

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________

Comments as a result of supervisory review.

Reviewer _______________ Date________

Special Note: The following procedures do not supersede state regulation, but are merely additional guidance an analyst 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 Extraordinary Dividend/Distribution form. In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the holding company Extraordinary Dividend/Distribution form under the specific circumstances involved.

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________

Comments as a result of supervisory review.

Reviewer _______________ Date________
Holding Company System Analysis (Non-Lead State) Procedures

Refer to Chapter V. Group-wide Supervisions - C. Insurance Holding Company System Analysis Guidance for guidance on holding company analytical 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 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 with the power to vote, or holds proxies, representing 10 percent or more of the voting securities. The review of Form B should be completed by the analyst within 60 days for priority companies and 120 days for non-priority companies.

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 percent of the insurer’s admitted assets or 25 percent of surplus, and for life insurers, 3 percent 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.
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:

1. Ten percent of the insurer’s surplus as regards to policyholders as of Dec. 31 of the prior year; or
2. 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.

Discussion of Supplemental Procedures for Forms A, B, D, E (or Other Required Information), and Extraordinary Dividend/Distribution

The analysis of Forms A, B, D, E (or Other Required Information) and Extraordinary Dividend/Distribution are documented in the separate Holding Company Supplemental Procedures due to the significance of the filings and the timing of these filings.
Form A – Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer

Procedures #1-4 provide instructions to enter and review information in the NAIC Form A database.

Procedures #5-21 assist the analyst in reviewing the Form A filing for completeness. They guide the analyst through each of the major items of information required by Form A and ask the analyst to document any risks or concerns noted during his/her review of the required information.

Procedures #22-34 assist the analyst in assessing the impact of the acquisition or merger on the domestic insurer and policyholders.

In addition to the supplemental procedures 1-34 as previously described, the analyst may also want to consider certain other qualitative factors when reviewing a Form A application. Most of these factors are intended to suggest the analyst contemplate the broader risks associated with the proposed transaction. Although the concept of identifying the broad risks of the transaction are embedded in many of the previously referenced procedures, in some cases it may be reasonable to approve the transaction, but only if certain conditions are met or agreed to by the applicant.

When considering the following guidance, it is appropriate to first consider the general statutory standards that regulators must apply in consideration of a Form A, namely that:

1) The financial stability of the insurer would not be jeopardized.
2) Policyholders will not be prejudiced.
3) The acquiring party’s future plans are not unfair and unreasonable to policyholders.
4) The transaction is not likely to be hazardous or prejudicial to the insurance-buying public.

Although these are the general statutory standards that apply, the analyst 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 the analyst in reaching a recommendation related to the proposed transaction.

The analyst is 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 includes considering the financial condition of the entire holding company structure as defined within state law and discussed separately within this Section E. Therefore, as the analyst considers the application for change in control, it may be appropriate to consider the following risks of the acquiring entity and the entire group of affiliated insurers and non-insurance affiliates under its control:

- **Credit**—Amounts actually collected or collectable are less than those contractually due.
- **Market**—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.
- **Pricing/Underwriting**—Pricing and underwriting practices are inadequate to provide for risks assumed.
Reserving—Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

Liquidity—Inability to meet contractual obligations as they become due because of an inability to liquidate assets or obtain adequate funding without incurring unacceptable losses.

Operational—Operational problems such as inadequate information systems, breaches in internal controls, fraud or unforeseen catastrophes resulting in unexpected losses.

Legal—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.

Strategic—Inability to implement appropriate business plans, to make decisions, to allocate resources and/or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

Reputational—Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.

In considering the above, 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/underwriting/reserving) tend to be most concentrated in the area of the insurers and therefore in these cases, it is reasonable that the analyst 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 the analyst to evaluate the ability of the group to execute its business plan.

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, 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 pertains 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,
the analyst 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, the analyst 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, the analyst 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 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.

The analyst 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.

After considering all of the risks of the proposed transaction, the analyst and the state 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 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 additionally 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.

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, the analyst 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.
- 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.

**Form B – Insurance Holding Company System Annual Registration Statement**

*Procedures #1- 2* assist the analyst in reviewing Form B for completeness. It guides the analyst through each of the major items of information required by Form B.

*Procedure #3* assists the analyst in determining whether dividends to shareholders were proper and in accordance with regulatory guidelines. The analyst should be particularly alert to extraordinary dividends, which require prior regulatory notification.

*Procedures #4 - 6* assist the analyst in reviewing other types of transactions involving the insurer and other entities in its holding company system. It guides the analyst through each type of transaction that requires prior regulatory notification/approval. The analyst should identify disclosures about the holding company that may potentially affect the insurer. The analyst 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. The analyst 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. The analyst 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.

Form D – Prior Notice of a Transaction

Procedures #1 - 15 assist the analyst in reviewing the Form D filing for completeness and help guide the analyst through major items of information required by Form D.

Form D – Captive Reinsurance Transactions

Procedure #16 assists the analyst 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 Insurance Policies Model Regulation (AG48). The analyst is 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. 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:

1. The ceding insurer establishes gross reserves, in full, using applicable reserving guidance (currently, the “formulaic” approach).
2. 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.
3. 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 the analyst 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 the analyst with names and addresses of all of the parties involved with the proposed merger or acquisition.

*Procedures #3 - 7* assist the analyst in gaining a clear understanding of the rationale and goals of the proposed merger or acquisition.

**Extraordinary Dividend/Distribution**

*Procedures #1- 6* assist the analyst in ensuring that any extraordinary dividend or distribution was approved by all of the appropriate channels, was fair and reasonable, and did not result in inadequate surplus for the insurer.
IV. Supplemental Procedures – F. Captives and/or Insurers Filing on a U.S. GAAP Basis

Special Note: These Supplemental Procedures are designed for Property/Casualty and Title captives and/or insurers filing to the NAIC on a U.S. GAAP basis, after the analyst has completed the traditional Level 1 Procedures.

Management Assessment
1. Refer to the Level 1 Procedures for the review of the insurer’s most recent business plan.

2. Summarize the insurer’s level of reliance on captive managers, TPAs or MGAs to run its business operations (e.g., underwriting, claims, record and reporting).
   a. If significant reliance exists, describe the services provided, any affiliated relationships, whether the expense ratio is in line with industry standards, and whether those parties service other insurers.

Balance Sheet Assessment
3. Review the Annual Financial Statement, Assets and Liabilities, Surplus and Other Funds.
   a. If risk-based capital is required, consider reassessing the impact to total adjusted capital if the insurer recorded assets typically non-admitted according to the NAIC Accounting Practices and Procedures Manual. If risk-based capital is not required, consider various methods to assess the capital sufficiency of the insurer.
      i. Consider the potential impact letters of credit, differences between GAAP and SAP investments, and/or deferred acquisition costs could have on the total adjusted capital component of the RBC calculation?
   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.
   c. Review any new letters of credit, principal or interest paid and whether any necessary approvals were obtained, if required.
   d. Review the Annual Financial Statement, Notes to Financial Statements, Note 1 – Summary of Significant Accounting Policies and document any individual asset category that is greater than 5 percent of total admitted assets that would typically be non-admitted according to the NAIC Accounting Practices and Procedures 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.
   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.
   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.
IV. Supplemental Procedures – F. Captives and/or Insurers Filing on a U.S. GAAP Basis

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.

h. Under U.S. GAAP, insurers are not 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.

Operations Assessment

4. Under U.S. GAAP, FAS 115 provides that debt and equity securities that are “being traded” (i.e. trading securities) 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.

Investment Practices

5. 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.

Review of Disclosures

6. Review the Annual Financial Statement, Notes to Financial Statements to assess the adequacy of disclosures regarding the reconciliation from the NAIC Accounting Practices and Procedures 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.


Assessment of Results from Prioritization and Analytical Tools

8. An analyst should be aware that the Financial Analysis Solvency Tools were designed to assess potential risks within statutorily filed financial statement in conformity with the NAIC Accounting and Practices and Procedures Manual and not in conformity with GAAP. Based on the reconciliation found in the Annual Financial Statement, Notes to Financial Statement, Note #1 – Summary of Significant Accounting Policies 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.)
Summary and Conclusion

After completion of the supplemental procedures, return to the Level One Procedures, and develop and document an overall summary and conclusion based on the findings.
Overview

The purpose of a captive insurer is to provide insurance for a specific sector or group of individuals that may be experiencing a need for insurance from a potentially more cost effective captive organization rather than to the traditional market. A captive insurance company is owned and operated by its members similar to a mutual insurer. Although there are five types of captives, the most notable are the single parent captive, or pure captive, and the group captive. The pure captive is typically owned and operated by a single company which is usually its parent and provides insurance to that parent and affiliated entities. The group captive is typically owned and operated by two or more entities to which the group captive provides insurance. The other three types of captives include the rent-a-captive, where a sponsor owns the company and manages it; protected cell companies, which provide complete separation of each cell’s assets; and an agency captive, which is owned by groups of intermediaries or brokers.

Most captive insurers file financial statements on a United States Generally Accepted Accounting Principles (GAAP) basis. The NAIC Annual Statement Blank and Instructions and corresponding Financial Solvency Tools have not been adjusted for insurers that prepare financial statements on a basis other than NAIC Statutory Accounting Principles (SAP). There are several differences between SAP and GAAP, including differences in presentation. Although GAAP requires items to be presented in a certain manner on the face of the financial statements, the exhibits and schedules are designed to present specific data elements from the reporting entity. For example, Schedule P, Part 1 as well as different parts of the Underwriting and Investment Exhibit require information regarding direct, assumed and ceded reserves. All of this information should be completed in the exhibits in order to maximize the information available to the analyst to assist in understanding the reporting entity’s business. Consequently, identification of information to the regulator should take precedence over any crosschecks that may fail as a result of the completion of such information. Similarly, when the schedule allows the reporting entity to disclose the most applicable information to the regulator (e.g., reporting “trading” and “available for sale” bonds at fair value in Schedule D), it should be so reported.

Similar variances may also be noted for other GAAP filing insurers that are not captives, such as risk retention groups organized as traditional insurers, as well as mutual, reciprocal, Lloyds, and stock insurers as identified in General Interrogatories, Part 1, #19.

Discussion of the Supplemental Procedures

Management Assessment

Procedure #1 refers to the Level 1 Annual Procedures regarding the business plan review.

Procedure #2 addresses two facets that relate to the need to assess the degree to which the insurer relies on a management company, TPA, or MGA, and the amount of expense incurred by the insurer to maintain those agreements. The first consideration is to determine whether the agreement is affiliated and whether it was established in an arms-length transaction. Through this review, the analyst should determine that the fees related to the services provided are reasonable and consistent with the overall industry. Assess the impact of the costs by closely reviewing and tracking changes in the insurer’s expense ratio. Excessive cost will be reflected in a high expense ratio. Increased contracted expenses from year to year should be justified by an increase in workload related to the services provided in the contracts, such as a significant rise in writings. In addition, to effectively assess the services, it’s critical...
to evaluate the history of the contracted companies. For example, it is important to know the number of years the contractors have been in business, the level of expertise of the employees, and the amount of staff turnover. It is critical to evaluate any contracted companies and their expertise. It’s also important to assess the level of communication between the insurer and the contractor.

**Balance Sheet Assessment**

*Procedure #3* directs the analyst to focus on key considerations during the review of the balance sheet. For example, during the review of the RBC ratio, the analyst might consider whether RBC is required by the state and the degree to which the insurer is capitalized via a letter of credit (LOC) allowed under a permitted and prescribed practice. Although the LOC is allowed, the analyst should continue to monitor changes in the value, language, or issuing bank. The issuing bank should be part of the Federal Reserve System and the LOC should be approved by the Commissioner.

Some additional considerations when reviewing an LOC:

- The terms “irrevocable” (cannot be canceled) and “evergreen” (automatically extended) are used within the LOC.
- If the bank elects not to renew, will the commissioner/director be notified in writing prior to the expiration date?
- Determine that the captive has no obligation to reimburse the bank, and the bank has no right of set off against any funds held by the bank for the captive in the event the LOC is drawn down, in whole or in part.
- Determine that the bank waives any common law, statutory or contractual right of reimbursement or set off against the captive that may arise in the event the LOC is drawn down, in whole or in part.
- Determine that the LOC terms are set forth and shall not in any way be modified, amended or amplified by reference to any note, document, instrument, statute, regulation or agreement.

Regarding the assessment of capital sufficiency, see NAIC staff for possible resources or techniques to assist in this evaluation.

For review of the liquidity calculation it’s important to note that GAAP, FAS 113 allows the insurer to report reinsurance recoverables for unpaid claims as an asset rather than a contra liability. Therefore the liquidity calculation may not provide a meaningful result because a typical SAP filer would include these balances as a liability. The analyst should examine the reinsurance recoverables balance to determine those amounts that relate to paid claims in order to appropriately understand the aging and any overdue amounts.

GAAP allows the insurer to discount its loss reserves under certain circumstances. The analyst should determine if unpaid losses and/or LAE have been discounted as disclosed in the Annual Financial Statement, Notes to Financial Statements, Note #1 - Summary of Significant Accounting Policies. The analyst should research the method and its reasonableness used to determine the discount.

GAAP allows the insurer to consolidate subsidiaries versus using the equity method to value the investment in subsidiary as SAP requires. The analyst needs to consider this impact to the financial results. One consideration may be to request the insurer to provide a footnote reconciliation in the audited financial report in order to isolate the results of the insurer to the NAIC blank.
GAAP allows the insurer to defer acquisition costs (DAC) when writing new policies through the establishment of DAC on the balance sheet. This allows the insurer to spread the cost over time by reclassifying the asset as an expense when premiums are earned, enabling the matching of expenses associated with acquiring policies to premiums earned. The analyst should be aware of impacts on financial results, as statutory accounting requires the insurer to recognize all acquisition costs at the onset of the policy.

The analyst should consider a sensitivity test to supplement the total adjusted capital component of the RBC calculation. The purpose of this test is to highlight the impact that LOCs, GAAP/SAP investment differences, and/or DACs could have on total adjusted capital, which, as the preceding paragraphs indicate, could be significant.

**Operations Assessment**

*Procedure #4* assists the analyst in understanding the impact of fair value reporting for trading securities (securities that are bought and held principally for the purpose of selling them in the near term) and their respective change, typically reported as either an aggregate write-in or investment income/realized gain or losses. Also, the analyst should consider the impact of loss reserve discounting on net income and ultimately on surplus. This discount is typically reported through losses incurred, however, it may be reported as an aggregate write-in. The analyst might consider reviewing a five-year trend of discounting to determine the significance and any upward trending.

**Investment Practices**

*Procedure #5* guides the analyst to review the impact of fair value reporting of securities available for sale and any resulting impact to surplus for changes in fair value. Close attention to fair value reporting is particularly necessary during volatile market conditions as the shift in fair value may have a material impact on surplus.

**Review of Disclosures**

*Procedure #6* directs the analyst to review the Annual Financial Statement, Notes to Financial Statements, Note #1 - Summary of Significant Accounting Policies. This note should be reviewed carefully to grasp a firm understanding of how the insurer’s financial filing deviates from SAP. The disclosure should include a detailed description of the practice along with any necessary supporting tables that illustrate the deviation from SAP. Also, the disclosure should illustrate any monetary reconciliation between prescribed and permitted practice regarding net income or surplus.

*Procedure #7* refers to the Level 1 Analyst Reference Guide regarding the Annual Financial Statement, General Interrogatories. Specific attention should be given to the Annual Financial Statement, General Interrogatories, Part 2, #13, the largest net aggregate risk written. This exposure should be measured as a percent of surplus to ensure that it is in compliance with state guidelines. If all or a portion of the risk is reinsured, the analyst should review all reinsurance contracts. Specifically, the analyst should ensure that limits of recovery would not increase the net risk reported in the General Interrogatories.

**Assessment of Results from Prioritization and Analytical Tools**

*Procedure #8* alerts the analyst that the insurer is reporting on a GAAP basis and that many of the ratios may not be applicable or may report results that are outside of the normal range. Careful attention should be given to the ratios individual components and the variation of the accounting used from SAP. For example, on a GAAP basis the insurer may be allowed to report its loss reserves on a gross basis which would alter the leverage ratio for loss and LAE reserves to surplus and the typical range for assessing the
result. It is necessary to review the ratios in conjunction with the disclosure provided in the Annual Financial Statement, Notes to Financial Statements, Note #1 - Summary of Significant Accounting Policies. Some additional examples of ratios that may not provide meaningful results, as typically seen with SAP reporting, include, but are not limited to, the liquidity ratio, the combined ratio and its respective components, and other ratios that utilize surplus as an element. It may be necessary for the analyst to recalculate some ratios.
V. Group-wide Supervision Procedures and Analyst Reference Guide

A. Framework

B. Roles and Responsibilities of Group-wide Supervisor/Lead State
   1. Group Profile Summary Example

C. Insurance Holding Company System Analysis Guidance (Lead State)

D. Corporate Governance Disclosure Procedures

E. Enterprise Risk Management Process Risks Guidance

F. Own Risk and Solvency Assessment (ORSA) Procedures

G. Form F – Enterprise Risk Report Procedures

H. Periodic Meeting with the Company Procedures

I. Targeted Examination Procedures

J. Supervisory Colleges
   1. Crisis Management Plan Sample

K. Group Code Assignment

L. Holding Company Best Practices
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 regulation 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. This distinction is also made because in other countries, it is not uncommon for the “regulations” to be established by policymakers that are not “day-to-day” supervisors that monitor the financial condition of the insurer and insurance group. In the U.S., the state insurance departments draft proposed legislation and are responsible for “day-to-day” 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.

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**

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.
V. Group-Wide Supervision – A. Framework

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].

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 in the states 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, which is in turn subject to group-wide supervision. 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 V.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 functional regulator 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 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.

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. All domestic states are expected to communicate any findings or concerns they have up to the lead state for consideration in the comprehensive holding company analysis.

The NAIC has developed procedures for carrying out the risk-focused surveillance process, and such procedures are documented in this Handbook and in the Financial Condition Examiners Handbook. The following summarizes some of these requirements. For more specific information, see Section V.B – Roles and Responsibilities of the Group-Wide Supervisor/Lead State of this Handbook.

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 supplemental procedures are intended to be used at the discretion of the analyst 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, the analyst should have a firm understanding of the following branded risk categories for each group:

- **Credit** – Amounts actually collected or collectible are less than those contractually due.
- **Market** – 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.
- **Pricing/Underwriting** – Pricing and underwriting practices are inadequate to provide for risks assumed.
V. Group-Wide Supervision – A. Framework

- **Reserving** – Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
- **Liquidity** – Inability to meet contractual obligations as they become due because of an inability to liquidate assets or obtain adequate funding without incurring unacceptable losses.
- **Operational** – Operational problems such as inadequate information systems, breaches in internal controls, fraud or unforeseen catastrophes resulting in unexpected losses.
- **Legal** – 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.
- **Strategic** – 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.
- **Reputational** – Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.
- **Other** – Any other risk(s) unique to the group.

The analyst 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 arise due to assessments of company management and/or operations or risks associated with future business plans. Common types of such risks for insurers may include, underwriting, investments, claims, and reinsurance 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. All groups have prospective risks. The *Financial Condition Examiners Handbook* provides guidance on prospective risks within Section 3—Examination Repositories.

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 current and prospective risks and communicate those risks to the respective examiners.

Communication is also discussed 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. See the V.B. – Roles and Responsibilities of Group-wide Supervisor/Lead State for discussion of the Group Profile Summary.

**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 the analyst, 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 respect to the group. In considering such a targeted review, it is important to consider both the flexibility envisioned within the 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 is not expected to result in a report of examination, but rather is intended to communicate any concerns noted with respect to the limited area of focus within the limited scope examination. In most cases, the work completed will merely inform the analyst 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: 1) a concise statement of the problem found; 2) the factors that caused or created the problem; 3) the materiality of the problem and its effect or potential effect on the financial statements; 4) the financial condition of the group; and 5) 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.
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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 nature and extent of detail 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 and management letter the results and observations noted during the examination.

The goals of the risk-focused examinations 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 purposes of completing a full-scope examination on an insurance legal entity. However, procedures related to governance and risk management are performed at the group level (See Section V.B. – Roles and Responsibilities of Group-Wide Supervisor/Lead State 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 the analyst and the examiner 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 could 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 the analysts that in turn may help the analysts focus on their next review.

**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 I-SITE, 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.

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 the “Holding Company Analysis” section.

The following diagram illustrates the risk assessment cycle:
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 supervision 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 V.J. – Supervisory Colleges, regarding international supervisory colleges). Ideally, when a foreign 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 monitoring the financial condition of the group which implicitly includes determining, through a coordinated process with other functional regulators, the extent to which additional information is appropriate and then determining the extent to which additional action is appropriate.

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, or put differently, 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 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 to the lead state, 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.
V. Group-Wide Supervision – B. Roles and Responsibilities of Lead State/Group-Wide Supervisor

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. 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.
- The assignment of specific regulatory tasks to respective state insurance departments in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise.
- The establishment of a task force consisting of personnel from various state insurance departments to carry out coordinated activities.
- Coordination and communication of insurance holding company system analysis.

The concept of lead state/group-wide supervision is not intended to relinquish the authority of any state, nor is it intended to increase any state’s statutory authority or to put any state at a disadvantage. It is intended to facilitate efficiencies when one state coordinates the regulatory processes of all states involved. Nevertheless, the lead state should coordinate with non-lead states 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
The ultimate decision of 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.

The Lead State Report is located in I-SITE, 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.

The following identifies the roles and responsibilities, or procedures that should be performed by the lead state 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.

**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 lead state will have many procedures assigned to it, which includes determining and documenting: 1) the depth of 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. However, what is most important is that the lead state acts as communicator of such 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 lead state. 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.

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.

**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.
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: credit (CR); legal (LG); liquidity (LQ); market (MK); operational (OP); pricing/underwriting (PR/UW); reputation (RP); reserving (RV); and strategic (ST). 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) 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 V.H. – Periodic Meeting with the Group Procedures for further guidance.

Completing the holding company analysis as detailed in Section V.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.

All results of holding company analysis are to be documented in the Group Profile Summary 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 Group Profile Summary also is to serve as the primary communication tool between the lead state and other regulators that provides consistency between the states. The Group Profile Summary is intended to serve as a “living document” to “house” summaries of information from legal entity Insurer Profile Summaries 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 Group Profile Summary 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. The analyst should work with the examination staff to update the Group Profile Summary.

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
Assessing the corporate governance of the group is one of the roles of the lead state.

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. The analyst, 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 so as 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.

Assessing the ERM process risks of the group as detailed in Section V.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 within 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 Level 1 procedures 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 Dec. 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 V.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.

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 in making such a determination. Non-lead states should defer to the lead state with regard to whether a targeted group examination is necessary.

**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 in its jurisdiction 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 (E) 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 issues for years, and just as state insurance regulators are aware that these situations demand mutual cooperation in order to build the relationship and trust needed, so too does the International Association of Insurance Supervisors (IAIS) recognize the same.

Considering if a supervisory college should be held and all of the related guidance included in Section V.J. – Supervisory Colleges is one of the roles of the lead state.
V. Group-Wide Supervision – C. Insurance Holding Company System Analysis Guidance (Lead State)

The following information is intended to provide a narrative description of the issues/considerations for the analyst when performing insurance holding company analysis as well as procedures and processes for developing a Group Profile Summary. As discussed in Section V.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 the analyst 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:

<table>
<thead>
<tr>
<th>When your state is the lead state and another state has a domestic in the group:</th>
<th>When your state is sharing duties with a lead state:</th>
<th>When your state is the lead state and all insurers within the group are domestics of your state:</th>
<th>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):</th>
<th>*When your state domestic has a group code, but your state is NOT the lead state:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complete an insurance holding company analysis that considers procedures similar to those contained within the Financial Analysis Handbook Insurance Holding Company Analysis checklist and document results in the Group Profile Summary.</td>
<td>• Coordinate the completion of holding company analysis and preparing a Group Profile Summary.</td>
<td>• Complete an insurance holding company analysis that considers procedures similar to those contained within the Financial Analysis Handbook Insurance Holding Company Analysis checklist and document the analysis results in Group Profile Summary.</td>
<td>• Offer a copy of the “legal entity insurer profile” or other applicable information to the lead state to assist in the completion of the insurance holding company analysis.</td>
<td>• Offer 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.</td>
</tr>
<tr>
<td>• The insurance holding company checklist represents guidance that the accreditation team will use to evaluate the sufficiency of depth and documentation considerations.</td>
<td>• The Financial Analysis Handbook Insurance Holding Company checklist represents guidance that the accreditation team will use to evaluate the sufficiency of depth and documentation considerations.</td>
<td>• Notify the other domestic regulators in the group by the end of August regarding when the insurance holding company analysis is anticipated to be completed.</td>
<td>• Complete before Dec. 31st.</td>
<td>• Complete an insurance holding company analysis that considers procedures similar to those contained within the Financial Analysis Handbook Insurance Holding Company Analysis checklist and document the analysis results in the Group Profile Summary.</td>
</tr>
<tr>
<td>• Notify the other domestic regulators in the group by the end of August regarding when the insurance holding company analysis is anticipated to be completed.</td>
<td>• Notify the other domestic regulators in the group by the end of August regarding when the insurance holding company analysis is anticipated to be completed.</td>
<td>• Complete before Oct. 31st.</td>
<td></td>
<td>• Complete before Dec. 31st.</td>
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<td>• Complete before Oct. 31st.</td>
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*Each state should still review Form B for its domestic companies.*
V. Group-Wide Supervision – C. Insurance Holding Company System Analysis Guidance (Lead State)

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. The analyst is required to document the results of the insurance holding company system analysis once annually, but will update it periodically as needed.

Documentation and Communication of Insurance Holding Company System Analysis

Documentation in the Group Profile Summary 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 Group Profile Summary should be updated and shared with other domestic states within the group prior to Oct. 31 each year. If the Group Profile Summary includes information from the analyst’s summary of the ORSA analysis, the analyst is reminded of the sensitivity of the information in the ORSA Summary Report and that it includes proprietary and trade secret information. Before sharing the Group Profile Summary 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. The analyst 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 Analysis

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 obtained from several sources, including the supplemental filings (i.e., Form A, Form B, Form D, Form E, and Form F). The Form B, Form C and any other holding company filings should be analyzed, to at least some extent, by the domestic state within 60 days for priority companies and 120 days for non-priority companies. Additionally, the domestic state should obtain a Group Profile Summary 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 of the respective domestic insurer on a yearly basis.
Communication of Holding Company System Analysis

The 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 Group Profile Summary. If a state relies on the insurance holding company analysis of another regulator, communication of such by the lead state should be completed by Oct. 31.

Holding Company System Analysis Consideration and Guidance

Overview of Insurance Holding Company System Structures

It is important for the analyst 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
- 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.

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. The analyst 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.—Information Concerning Activities of Insurer Members of a Holding Company Group, Part 1—Organizational Chart, Part 1A—Detail of Insurance Holding Company System, and Part 2—Summary of Insurer’s Transactions With Any Affiliates. 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 affiliated relationships within the insurance holding company system. To understand the different levels of interconnectivity and impact within the insurance holding company system, the analyst should review Form D which includes the management service agreements, tax sharing agreements and affiliated reinsurance. The analyst 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.

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 - Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties*, insurers are also required to provide detailed information on related party transactions and relationships in Note #10—Information Concerning Parent, Subsidiaries, and Affiliates. Refer to Section VI. – Guidance for Notes to Financial Statements 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 the analyst 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, the analyst 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 the analyst to assess the organization by its major operating business segments.

- **Directors and Executive Officers**
  - This section helps the analyst 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.

- **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 P/C 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 I-SITE Reports:** These I-SITE 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 I-SITE 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.
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
The analyst 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. The analyst 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; the analyst should monitor the price and volume. The analyst 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. The analyst may find that the
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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, no regulation regarding public financial reporting exists.

The analyst 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. The analyst 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.

The analyst 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 supplemental procedures for holding company considerations for domestic and non-lead states.

Lead State Holding Company Analysis – Process and Procedures

In completing the process of holding company analysis and developing a Group Profile Summary, 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 Group Profile Summary and/or eliminate certain sections of the
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Group Profile Summary 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 Group Profile Summary and/or in supporting analysis workpapers. Keep in mind, the Group Profile Summary 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.

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.

If the ultimate controlling person of the holding company is an insurance company, the analyst may consider preparing one document that includes elements of the Insurer Profile Summary and the Group Profile Summary, in order to promote efficiency in the overall analysis. For example, in addition to the standard elements of the Insurer Profile Summary, such a hybrid document may also include sections such as corporate governance, ERM/ORSA, non-insurance affiliates/subsidiaries, etc.

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 Group Profile Summary 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.

Specific Procedures for Completing the Insurance Holding Company Analysis

The following procedures are intended to assist the analyst completing a holding company analysis documented in the Group Profile Summary. 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, ORSA Summary Report, and financial filings of the insurance holding company system and/or person. Summarize the understanding of the holding company in the Group Profile Summary. If necessary, the analyst 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.).
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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).

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 (For example, 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. The analyst 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 the analyst 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 the analyst through inquiries to the group.

As part of this review, the analyst 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). The analyst should 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 Holding Company Analysis Liaison listing on StateNet, identify the primary contact of other involved domestic states. Based on the analysis of the overall holding company structure and the state’s preference, the analyst may consider whether there is a need to request the confidential insurer profile summary 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. (For example: A state may consider using the NAIC Prioritization Summary Report to assess the need to request such reports.) If the Insurer Profile Summaries 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 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 the 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 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, the analyst 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 the analyst may instead choose to request the insurer supply information via the non-insurance company grid provided. The analyst 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 the analyst in putting together the Holding Company System Summary section of the Group Profile Summary 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 Group Profile Summary 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 the analyst with regulator/supervisor communication and coordination and supervisory college considerations. See Section V.J. – Supervisory Colleges 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 Insurer Profile Summaries; 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 the analyst 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 Group Profile Summary. If necessary, the analyst 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; TPA/MGA relationships; 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; 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.
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- **Market Risk**—e.g., stress test results, concentrations in certain market segments, changes in asset valuation due to market shifts, etc.
- **Operational Risk**—e.g., impact of overall financial results on the capital position; have sufficient profits been generated to meet business model needs and to generate capital, etc.
- **Strategic Risk**—e.g., 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.
    - **Operational Risk**—e.g., 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.

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; stress testing.

12. 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
13. 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.

14. 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 Insurer Profile Summary of the state’s domestic insurer(s) in the group for the impact of the Holding Company on that insurer(s).

Procedures #8 - 13 assists the analyst 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 Group Profile Summary. The following summarizes some approaches/issues for the analyst to consider when completing these procedures. In most cases, the analyst 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.

Procedure #8 assists the analyst 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, the analyst 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. The analyst 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, the analyst 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, the analyst 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 including: e.g., pricing and underwriting risk, reserving risk, market risk, strategic risk and/or operational risk. Therefore, the analyst 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 the analyst 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 the analyst 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 entity, the analyst 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 Own Risk and Solvency Assessment (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 V.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 the analyst better make an appropriate assessment in this area.

In addition to evaluating the group’s and individual entity’s equity/surplus position, the analyst 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, the analyst 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 the analyst 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, the analyst 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.

<table>
<thead>
<tr>
<th>Interest Coverage</th>
<th>Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely strong</td>
<td>10 to 1 and higher</td>
</tr>
<tr>
<td>Strong</td>
<td>5 to 1</td>
</tr>
<tr>
<td>Adequate</td>
<td>4 to 1</td>
</tr>
<tr>
<td>Marginal</td>
<td>3 to 1</td>
</tr>
<tr>
<td>Weak</td>
<td>2 to 1</td>
</tr>
<tr>
<td>Extremely weak</td>
<td>1 to 1</td>
</tr>
</tbody>
</table>
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, the analyst 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 the analyst 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 the analyst. Updated information may be best obtained in the periodic meeting with the group as discussed within Section V.F. – Own Risk and Solvency Assessment (ORSA) Procedures, unless the group is more susceptible to immediate withdrawals, in which case the analyst may want to 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 Risk classification of branded risk assessments.

Procedure #12 assists the analyst with identifying if there are any concerns regarding the insurance holding company system’s independent public audit report and other related reports.

Procedure #13 assists the analyst in identifying any significant risks identified through a review of the Insurer Profile Summary obtained for its domestic insurer(s) in the group. As the Insurer Profile Summary 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 Insurer Profile Summary to assist in conducting holding company analysis and preparing a Group Profile Summary.

Procedure #14 is intended for the analyst 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 Insurer Profile Summary 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 the analyst, depending on the level of concern, the area in which the risk was identified, and the degree of interdependence within the holding company entities.

The analyst 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 Group Profile Summary. 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 Group Profile Summary.

[Legend of the branded risk classifications that may be identified through the following procedures: credit (CR); legal (LG); liquidity (LQ); market (MK); operational (OP); pricing/underwriting (PR/UW); reputation (RP); reserving (RV); strategic (ST).]

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. (e.g., 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? (e.g., 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. (e.g., CR, MK, LQ, ST)
4. Review the distribution of the non-invested assets, and assess the overall collectability risk. (e.g., 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. (e.g., LQ, OP) If significant, summarize the following:
   a. Nature of intangible assets.
   b. Change or trend in goodwill.
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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 (e.g., 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. (e.g., ST)

8. Determine the level of insurance holding company debt and its relative value-to-equity. (e.g., 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. (e.g., 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. (e.g., RV, LG)

10. Gain an understanding of and document the use of collateral across the holding company system. (e.g., ST, LQ).

Financial Position

11. Review the insurance holding company’s statement of shareholders’ equity. (e.g., 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?
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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. (e.g., ST)

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. (e.g., LO, ST)
   b. Compare current year extraordinary dividends to prior year dividends to identify any excessive trends in payments. (e.g., 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? (e.g., 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? (e.g., ST, OP)
   c. Has the volume of business increased or decreased significantly over the prior year? If “yes,” explain the reason for the change. (e.g., 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 (e.g., CR)
   b. Collateralization to unauthorized reinsurance (e.g., CR)
   c. Recent reinsurance transactions (e.g., CR, ST)
   d. Credit quality of the reinsurer (e.g., CR)
   e. Collectability of recoverables (e.g., CR)
   f. Level of surplus aid (e.g., ST)

Profitability

16. 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. (e.g., ST, MK)
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b. Document the amount of investment income by sector that is attributed to dividends received from insurance subsidiaries. (e.g., ST)

c. Document the annual investment yield. Has the yield decreased materially over the prior year? If “yes,” explain the reason(s) for the change. (e.g., 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. (e.g., ST, CR, MK)

e. Did the insurance holding company report material realized capital gains/losses? If “yes,” identify the cause of the loss. (e.g., ST, CR, MK)

17. Review all other sources of revenue, and note any material changes or weaknesses. (e.g., PR/UW, ST)

18. Review expenses.

a. Have losses increased or decreased substantially over the prior year? If “yes,” explain the reason for the change. (e.g., RV)

b. Have administrative and other expenses increased significantly over the prior year? If “yes,” explain the reason for the change. (e.g., OP)

c. Summarize the loss and expense ratios by line of business for material insurance lines and review the trend. (e.g., OP, RV, PR/UW)

19. 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. (e.g., ST, OP)

20. 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. (e.g., ST, OP)

21. 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. (e.g., LQ)

22. Evaluate any downstream payments and explain the reason(s) for the downstream contributions. (e.g., LQ)

Procedures #1 - 3 assist the analyst 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 the analyst 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 the analyst 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 the analyst 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. The analyst should take note of the trend over past reporting periods and the
factors that have significantly influenced an increase or decline.

Procedures #14 -15 assist the analyst 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 the
analyst 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, the analyst should refer to Part III. Analyst Reference Guide—Section B8 and Section
C11.—MGAs and TPAs of this Handbook.

The analyst 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, the analyst 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.

*Procedures #16 - 20* assist the analyst 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 #21 - 22* assist the analyst 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.

The analyst should assess the level of liquid assets to current liabilities to determine the proper matching of assets to claims obligations. The analyst should also assess the material risk associated with low-quality assets and understated reserves.

**Contents of the Group Profile Summary (GPS)**

The following analysis work should be documented in the Group Profile Summary:

- **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
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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.

- **Corporate Governance Summary** – Present a summary of the group’s overall corporate governance structure 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 financial position, liquidity, leverage, and profitability. Such documentation should include summarizing key risks noted within the Insurer Profile Summaries 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 the analyst 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.

The following provides an example template for use in developing a Group Profile Summary.

The following provides an example template for use in developing a Group Profile Summary.
GROUP PROFILE SUMMARY

GROUP NAME
As of 12/31/20XX
Updated as of XX/XX/20XX

HOLDING COMPANY SYSTEM SUMMARY

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 personal 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 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.

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 supervision by the FOREIGN SUPERVISOR. COMPANY 9 reported $547 million in retained profit in 2011, so its operations are not overly significant to the Group.

Captive: 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
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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.

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 to outline the group’s financial position, which may be more detailed than the insurer profile summary as 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.

EXmple:

<table>
<thead>
<tr>
<th>Consolidated Balance Sheet (U.S. GAAP)</th>
<th>20XX</th>
<th>20XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year Ended December 31 (Dollars in millions)</td>
<td>20XX</td>
<td>20XX</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>13,447</td>
<td>8,786</td>
</tr>
<tr>
<td>Investments</td>
<td>38,944</td>
<td>35,033</td>
</tr>
<tr>
<td>Real estate investments, net</td>
<td>2,370</td>
<td>1,956</td>
</tr>
<tr>
<td>Loans receivable</td>
<td>38,103</td>
<td>37,548</td>
</tr>
<tr>
<td>Premiums due from policyholders</td>
<td>2,309</td>
<td>2,124</td>
</tr>
<tr>
<td>Property and equipment, net</td>
<td>1,309</td>
<td>1,343</td>
</tr>
<tr>
<td>Other Assets</td>
<td>7,870</td>
<td>7,472</td>
</tr>
<tr>
<td>TOTAL ASSETS</td>
<td>$104,352</td>
<td>94,262</td>
</tr>
<tr>
<td>Insurance reserves</td>
<td>$15,588</td>
<td>14,062</td>
</tr>
<tr>
<td>Life insurance-funds on deposit</td>
<td>15,368</td>
<td>13,626</td>
</tr>
<tr>
<td>Bank deposits</td>
<td>46,432</td>
<td>39,775</td>
</tr>
<tr>
<td>Borrowings</td>
<td>1,974</td>
<td>3,441</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>5,050</td>
<td>4,647</td>
</tr>
<tr>
<td>TOTAL LIABILITIES</td>
<td>$84,312</td>
<td>75,551</td>
</tr>
<tr>
<td>Equity</td>
<td>20,040</td>
<td>18,711</td>
</tr>
<tr>
<td>TOTAL LIABILITIES AND EQUITY</td>
<td>$104,352</td>
<td>$94,262</td>
</tr>
</tbody>
</table>

EXmple:

<table>
<thead>
<tr>
<th>Consolidated Income Statement</th>
<th>20XX</th>
<th>20XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance premiums</td>
<td>$11,960</td>
<td>$11,205</td>
</tr>
<tr>
<td>Total investment return</td>
<td>2,940</td>
<td>2,723</td>
</tr>
<tr>
<td>Fees, sales and loan income, net</td>
<td>3,489</td>
<td>3,422</td>
</tr>
<tr>
<td>Real estate investment income</td>
<td>253</td>
<td>190</td>
</tr>
<tr>
<td>Other income</td>
<td>424</td>
<td>406</td>
</tr>
<tr>
<td>Total revenues</td>
<td>19,036</td>
<td>17,946</td>
</tr>
</tbody>
</table>

LOSSES, BENEFITS AND EXPENSES

| Policyholder Benefits                 | 177      | 157      |
| Net losses, benefits and settlement expenses | 10,998   | 9,160    |
| Deferred policy acquisition costs     | 574      | 556      |
V. Group-Wide Supervision – C. Insurance Holding Company System Analysis Guidance (Lead State)

<table>
<thead>
<tr>
<th>Description</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real estate investment expenses</td>
<td>189</td>
<td>153</td>
</tr>
<tr>
<td>Interest expense</td>
<td>475</td>
<td>604</td>
</tr>
<tr>
<td>Dividends to policyholders</td>
<td>112</td>
<td>223</td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>3,899</td>
<td>3,669</td>
</tr>
<tr>
<td>Total losses, benefits and expenses</td>
<td>16,247</td>
<td>14,365</td>
</tr>
<tr>
<td>Pre-tax income</td>
<td>2,789</td>
<td>3,581</td>
</tr>
<tr>
<td>Income tax expense</td>
<td>661</td>
<td>944</td>
</tr>
<tr>
<td>NET INCOME</td>
<td>$2,148</td>
<td>$2,637</td>
</tr>
<tr>
<td>CASH FLOW From Operations</td>
<td>$4,737</td>
<td>$2,828</td>
</tr>
</tbody>
</table>

**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.

**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 reports to the Risk Management Committee at least quarterly, providing updates on the organizations 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 results of the most recent regulatory assessment of the organization’s ORSA Summary Report (filed 10/25/XX) indicate that the ERM function is generally performing at “Level 4”, which is at or above the majority of its peers in this area. Similar conclusions were reached during the last supervisory college conducted for the Group.

BRANDED RISK ASSESSMENTS

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 “no/minimal concern,” “moderate concern” or “significant concern” as well as the direction in which the risk is trending. If no significant 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 for each branded risk classification. Update the Branded Risk Classification Heat Map to illustrate your conclusions.

EXAMPLE:

<table>
<thead>
<tr>
<th>Trend</th>
<th>Branded Risk Classification Heat Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: ↑ Increasing</td>
<td>Pricing/UW Other</td>
</tr>
<tr>
<td>B: ↔ Static</td>
<td>Operational Reputation Liquiditiy Market Credit Strategic</td>
</tr>
<tr>
<td>C: ↓ Decreasing</td>
<td>Legal Reserving</td>
</tr>
</tbody>
</table>

1: No/Minimal Concern 2: Moderate Concern 3: Significant Concern

Assessment

Credit: Based upon a review of consolidating financial statements, 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. 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 material concentrations in non-investment grade bonds, equities, private securities or other types of invested assets. In addition, the group’s ORSA Summary Report does not list credit as an area of material risk. 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.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loan Portfolio</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Reinsurance/Insurer investments</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
</tbody>
</table>

Overall Credit Assessment: Moderate Concern  
Overall Trend: ↔
V. Group-Wide Supervision – C. Insurance Holding Company System Analysis Guidance (Lead State)

Legal: No specific concerns identified through either review of the legal entity insurer profile summaries, results of recent coordinated exam, the ORSA Summary Report, discussions with the Federal Reserve, or any other sources. The group is periodically involved in individual claim lawsuits, but frequency has trended downward and results are not historically significant.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim lawsuits</td>
<td></td>
<td></td>
<td>↓</td>
</tr>
</tbody>
</table>

Overall Legal Assessment: No/Minimal Concern

Liquidity: As previously discussed, although the insurance assets are fairly conservative, and despite finding no Insurer Profile Summaries of legal entities that identified liquidity as an issue, this may be an area requiring greater focus at the group level moving forward. The Federal Reserve indicated that the banking operations were subject to liquidity strain under certain conditions, but did not provide specifics regarding those conditions or the results. In addition, although the ORSA Summary Report provides some information on the insurance operations liquidity management program, a greater understanding is needed given in part the group’s exposure to certain types of catastrophic risks as well as certain risks with its banking operations. We suggest this as an area of focus during the next coordinated on-site examination to better understand the entire group’s liquidity management.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banking operations</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Liquidity in a cat scenario</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
</tbody>
</table>

Overall Liquidity Assessment: Moderate Concern

Market: 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. Despite the relatively conservative investment portfolio, the Company identified in its ORSA 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.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loan Portfolio</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Insurance Portfolio</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
</tbody>
</table>

Overall Market Assessment: Moderate Concern

Operational: 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 per the ORSA Summary Report appears to be well above target even under adverse conditions. The group is not structured like most companies and its overall approach is geared towards its policyholders. 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 holding company debt. However, 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.

<table>
<thead>
<tr>
<th>Interest Coverage</th>
<th>CY</th>
<th>PY</th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.5X</td>
<td>4.4X</td>
<td>4.4X</td>
<td>2.2X</td>
<td>5.2X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings &amp; Group Capital</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Holding Company Debt</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
</tbody>
</table>

Overall Operational Assessment: No/Minimal Concern
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. Per review of the legal entity Insurer Profile Summaries, Company 6 was identified as having a concentration of catastrophe risk in one state, which was identified as a significant concern by State Y. However, after review of the ORSA Summary Report, and after significant discussions with management, we determined that CAT risk for the entire group as a whole was moderate. Additionally, 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, as discussed in the Group’s Form F filing. We suggest that although this is a risk mitigator, the details of the structure should be examined more closely during a targeted exam as soon as possible and that regulators monitor this activity closely as it could represent a significant concern if not structured effectively. Also the group’s workers compensation 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).

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto/home underwriting &amp; pricing</td>
<td>CAT risk</td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td></td>
<td>WC underwriting and pricing</td>
<td>Insurance linked securities</td>
<td>↑</td>
</tr>
<tr>
<td>Overall Pricing/Underwriting Assessment: Moderate Concern</td>
<td>Overall Trend: ↑</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reputation: No significant issues were identified. The Group appears to monitor its reputation on a regular basis as described in its ORSA Summary Report.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall reputation</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Overall Reputation Assessment: No/Minimal Concern</td>
<td>Overall Trend: ↔</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reserving: The group continues to maintain a relatively conservative ratio of reserves to equity of 78% although it has been trending slightly negative. This is offset by a slight shift in the insurer’s exposure from less casualty business to more property business and is the primary driver for the change. However, as shown in the insurer’s ORSA Summary Report, the insurance group sets aside economic capital to cover a one-in-500-year event in addition to other amounts set aside for other risks.

<table>
<thead>
<tr>
<th>Metric</th>
<th>CY</th>
<th>PY</th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss &amp; LAE/C&amp;S</td>
<td>77.8%</td>
<td>76.2%</td>
<td>76.8%</td>
<td>73.7%</td>
<td>71.9%</td>
</tr>
<tr>
<td>Two Year Develop</td>
<td>8.0%</td>
<td>-10.0%</td>
<td>-10.4%</td>
<td>-5.6%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leverage</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Loss development</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Overall Reserving Assessment: No/Minimal Concern</td>
<td>Overall Trend: ↑</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strategic: The primary risks for the Group are divided into insurance and banking segments. 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. In addition, as discussed above, the one area of risk that is not easy to get a handle on at the group level is its liquidity risk. The ORSA Summary report discusses some aspects (insurance focused) of ERM but it is not sufficiently detailed to assess. See above suggestion regarding liquidity.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall strategic planning</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Competition</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
<tr>
<td>Liquidity strategy</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Overall Strategic Assessment: Moderate Concern</td>
<td>Overall Trend: ↔</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other: The most recent Form F report provided by COMPANY 1 indicated that 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.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geopolitical risk (COMPANY 9)</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
</tbody>
</table>

**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 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.).

**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. 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.

**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, supervisory college 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.

*Examination Follow-Up*

- 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.
- Increase the focus on national underwriting procedures and current pricing on workers’ compensation during the next coordinated examination.
- Increase the focus on the entire group’s (including banking) liquidity management program during the next coordinated examination.
<table>
<thead>
<tr>
<th>NAIC #</th>
<th>FEIN</th>
<th>Name of Securities Exchange if Publicly Traded (U.S. or International)</th>
<th>Name of Parent, Subsidiaries or Affiliates Domicile</th>
<th>Primary Regulator and Contact</th>
<th>Primary Regulator Email</th>
<th>Description &amp; Purpose of Entity</th>
<th>Business Segment</th>
<th>Inter-Company Guarantee (Yes/No)</th>
<th>Revenue</th>
<th>Net Income</th>
<th>A.M. Best Rating</th>
<th>Moodys Rating</th>
<th>S &amp; P Rating</th>
</tr>
</thead>
</table>

Non-Insurance Company Grid

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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 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. As of the date of this publication, most states had not adopted such legislation. The following procedures are applicable to only those states that have adopted such legislation. All other states should instead consider completion of applicable questions within the Management Consideration chapter of this Handbook based upon the level of concern an analyst may have with management performance and the driving forces behind operations. The Management Consideration chapter may also be used by an analyst of a state that has obtained the disclosure for an insurer or insurance group subject to the aforementioned corporate governance disclosure. However, the analyst should not request information related to the Management Considerations procedures that has already been provided by the insurer or insurance group from the corporate governance disclosure.

Introduction

The Corporate Governance Annual Disclosure Model Act (#305) and Corporate Governance Annual Disclosure Model Regulation (#306) requires 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. Although by inclusion in this section, reviewing the corporate governance disclosure of a group is a responsibility of the lead state, the approach on this is different from that taken with the ORSA. This is because it’s common for most groups to have different layers of governance that is important in achieving the objectives of the group. More specifically, most groups have some level of governance at the individual legal entity level. However, because it is common for legal entity governance to be a less significant aspect of the governance objectives, even those companies that incorporate governance at the individual legal entity level are likely to include materially less documentation on such, may instead summarize such processes and list those entities for which they exist.

Because Model #305 allows the filing to be made with the lead state, it may be necessary for the lead state to share the filing with another state that has adopted a substantially similar law including similar confidentiality requirements. Alternatively, or in addition, it may be necessary or acceptable for the lead state to share its work papers with another state, related to such filing, provided such information is shared in accordance with the confidentiality provisions of Model #305. This is because similar to other solvency regulation models, Model #305 contemplates both off-site and on-site examination of such information.

Procedures #1 - 2 assist the analyst in reviewing the Corporate Governance disclosure for completeness and help guide the analyst through each of the major items of information required by Model #306.

1 Taken directly from the “Overview of the Financial Analysis Process” section contained within the “Financial Analysis Framework” chapter of this Handbook
Compliance with Corporate Governance Disclosure Requirements

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.
      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:
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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.

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.
   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;
V. Group-Wide Supervision – D. Corporate Governance Disclosure Procedures

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);
2. Actuarial function.
3. Investment decision-making processes.
4. Reinsurance 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, consider completing some of the procedures with the Management Consideration chapter of this handbook.

4. Based on the analyst’s review of Corporate Governance disclosure and any additional information related to the corporate governance of the insurer or insurance group, document any material concerns regarding corporate governance of the insurer or insurance group.

5. Do any of the concerns pose an immediate risk to the insurer’s or insurance group’s operations, policyholder surplus or capital position?

For the U.S. lead state:

☒ The analyst should update the Group Profile Summary and Supervisory Plan with any material information.

☒ The analyst should communicate to the examiner-in-charge (EIC) any prospective risks identified in the review of corporate governance disclosure that affects the domestic insurer.

Recommendations for further action, if any, based on the overall conclusion above:
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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.
☐ 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).

Analyst ________________ Date________

Comments as a result of supervision review.

Reviewer ________________ Date________

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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 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). 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 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 group and/or any targeted examination work.

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. The model gives the insurer and insurance group discretion as to whether the report is submitted by each individual insurer within the group or by the insurer group as a whole (See the NAIC Own Risk Solvency Assessment Guidance Manual for further discussion).

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. 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 an ORSA 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.

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, 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.

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 including in its initial review of the ORSA Summary Report the lead state examiner or any other individual acting under the authority of the commissioner or designated by the commissioner with special skills and subject to confidentiality. Additionally, the lead state examiner may want to include them in possible dialogue 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. A joint review such as this prior to the lead state analyst documenting its summary of the ORSA Summary Report may be appropriate.

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 organizations 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.

Collectively, the goals above are the basis upon which the guidance is established. However, the ORSA Summary Report will not serve this function or have this direct impact until the lead state becomes fairly familiar and comfortable with evaluating each insurer’s report and its processes. This could take more than a couple of years to occur in practice, since the lead state would likely need to review at least one or two ORSA Summary Reports to fully understand certain aspects of the processes used to develop the report.

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 it was at Level 5 (defined below), but in practice by review of Section II, it appears to meet the level. Likewise, the lead state analyst may assess Section II as Level 5 but may be unable to see through Section III how the totality of the insurer’s system is Level 5 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 page (or paragraphs), the other two sections have very distinct objectives, whereas the assessment of Section I is broader.

Section I procedures are focused on assessing the insurer’s maturity level with respect to its overall risk management framework. The maturity level may be assessed through a number of ways, one of which is through the incorporation of concepts developed within the Risk and Insurance Management Society’s (RIMS) Risk Maturity Model (RMM). While insurers or insurance groups may utilize various frameworks in developing, implementing and reporting on their ORSA processes (e.g., COSO Integrated Framework, ISO 31000, IAIS ICP 16, other regulatory frameworks, etc.), elements of the RMM have been incorporated into this guidance to provide a framework for use in reviewing and assessing ERM/ORSA practices. However, as various frameworks may be utilized to support effective ERM/ORSA practices, lead state regulators should be mindful of differences in frameworks and allow flexibility in assessing maturity levels. The RMM, which is only one of a number of processes that may be used to determine maturity levels, provides a scale of six maturity levels upon which an insurer can be assessed. The six maturity levels can generally be defined as follows:

- **Level 5**: Risk management is embedded in strategic planning, capital allocation and other business processes and is used in daily decision-making. Risk limits and early warning systems are in place to identify breaches and require corrective action from the board of directors or the appropriate committee thereof (hereafter referred to as the “board” for this chapter) and management.

- **Level 4**: Risk management activities are coordinated across business areas and tools and processes are actively utilized. Enterprise-wide risk identification, monitoring, measurement and reporting are in place.

- **Level 3**: The insurer has risk management processes in place designed and operated in a timely, consistent and sustained way. The insurer takes action to address issues related to high-priority risks.

- **Level 2**: The insurer has implemented risk management processes, but the processes may not be operating consistently and effectively. Certain risks are defined and managed in silos, rather than consistently throughout the organization.

- **Level 1**: The insurer has not developed or documented standardized risk management processes and is relying on the individual efforts of staff to identify, monitor and manage risks.

- **Level 0**: The insurer has not recognized a need for risk management, and risks are not directly identified, monitored or managed.

The guidance developed for use in this Handbook integrates the concepts of RIMS maturity level scale of the RMM with the general principles and elements outlined in Section I of the ORSA Guidance Manual.
assist lead state regulators in reaching an overall assessment of the maturity of an insurer’s risk management framework. The design of ERM/ORSA practices should appropriately reflect the nature, scale and complexity of the insurer. Lead state regulators should understand the level of maturity that is appropriate for the company based on its unique characteristics. Attainment of “Level 5” level maturity for ERM/ORSA practices is not appropriate, nor should be expected, for all insurers or for all components of the framework.

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. 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 the nine branded risk classifications contained elsewhere in this Handbook, which are used as a common language in the risk-focused surveillance process. The primary reason for utilizing this approach is that it is not uncommon for insurer’s to identify within their ORSA Summary Reports, many of the same types of risks, therefore the lead state analyst can leverage this information in their analysis of the insurer. However, lead state regulators should not restrict their focus to only the nine branded risk classifications; as such an approach may not encourage independent judgment in understanding the risk profile of the insurer. Therefore, the reference to the nine branded risk classifications provides a framework to organize the lead state’s summary, but it should not discourage regulators from documenting other risks or excluding branded risk categories that are not relevant. From this standpoint, Section II will also provide regulators with information to better understand current insurance market risks and changes in those risks as well as macroeconomic changes and the impact they have on insurers risk identification and risk management processes.

Finally, 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. Section III of the ORSA Summary Report is intended to be more informative regarding capital than other traditional methods of capital assessment since its sets forth the amount of capital the group determines is reasonable to sustain its current business model.

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 when considering such principles as well as examples of attributes that may indicate the insurer is more or less mature in its handling of key risk management principles. These attributes are meant to assist the lead state analyst in reaching an initial high-level assessment of the insurer’s maturity level for each key principle as “Level 5” through “Level 0”.

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
Consideration When Reviewing for Key Principles:

When reviewing the ORSA Summary Report, the lead state analyst should consider the extent to which of the above principles are present within the organization. In reviewing these principles, examples of various attributes/traits associated with various maturity levels (e.g., “Level 5” practices) are provided for each principle in the following sections. The intent in providing these attributes or traits is to assist the lead state analyst in assessing the risk management framework. However, these attributes only demonstrate common practices associated with each of the various maturity levels and practices of individual insurers may vary significantly from the examples provided.

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.

• **Level 5**
  Risk culture is analyzed and reported as a systematic view of evaluating risk. Executive sponsorship is strong, and the tone from the top has sewn an ERM framework into the corporate culture. Management establishes the framework, and the risk culture and the board reviews the risk appetite statement in collaboration with the chief executive officer (CEO), chief risk officer (CRO) where applicable, and chief financial officer (CFO). Those officers translate the expectations into targets through various practices embedded throughout the insurer. Risk management is embedded in each material business function. Internal audit, information technology, compliance, controls and risk management processes are integrated and coordinate and report risk issues. Material business functions use risk-based best practices. The risk management lifecycle for business process areas are routinely evaluated and improved (when necessary).

• **Level 4**
  The insurer’s ERM processes are self-governed with shared ethics and trust. Management is held accountable. Risk management issues are understood and risk plans are conducted in material business process areas. The board, CEO, CRO (if applicable) and CFO expect a risk management plan to include a qualitative risk assessment for reasonably foreseeable and relevant material risks with reporting to management or the board on priorities, as appropriate. Relevant areas use the ERM framework to enhance their functions, communicating on risk issues as appropriate. Process owners incorporate managing their risks and opportunities within regular planning cycles. The insurer creates and evaluates scenarios consistent with its planning horizon and product timelines, and follow-up activities occur accordingly.

• **Level 3**
  ERM risk plans are understood by management. Senior management expects that a risk management plan captures reasonably foreseeable and relevant material risks in a qualitative manner. Most areas use the ERM framework and report on risk issues. Process owners take responsibility for managing their risks and opportunities. Risk management creates and evaluates scenarios consistent with the business planning horizon.

• **Level 2**
  Risk culture is enforced by policies interpreted primarily as compliance in nature. An executive
champions ERM management to develop an ERM framework. One area has used the ERM framework, as shown by the department head and documented team activities. Business processes are identified, and ownership is defined. Risk management is used to consider risks in line with the insurer’s business planning horizon.

- **Level 1**
  Corporate culture has little risk management accountability. Risk management is not interpreted consistently. Policies and activities are improvised. Programs for compliance, internal audit, process improvement and IT operate independently and have no common framework, causing overlapping risk assessment activities and inconsistencies. Controls are based on departments and finances. Business processes and process owners are not well-defined or communicated. Risk management focuses on past events. Qualitative risk assessments are unused or informal. Risk management is considered a quantitative analysis exercise.

- **Level 0**
  There is no recognized need for an ERM process and no formal responsibility for ERM. Internal audit, risk management, compliance and financial activities might exist but are not integrated. Business processes and risk ownership are not well-defined.

**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.

- **Level 5**
  Information from internal and external sources on reasonably foreseeable and relevant material risks, including relevant business units and functions, is systematically gathered and maintained. A routine, timely reporting structure directs risks and opportunities to senior management. The ERM framework promotes frontline employees’ participation and documents risk issues or opportunities’ significance. Process owners periodically review and recommend risk indicators that best measure their areas’ risks. The results of internal adverse event planning are considered a strategic opportunity.

- **Level 4**
  Process owners manage an evolving list of reasonably foreseeable and relevant material risks locally to create context for risk assessment activities as a foundation of the ERM framework. Risk indicators deemed critical to their areas are regularly reviewed in collaboration with the ERM team. Measures ensure downside and upside outcomes of risks and opportunities are managed. Standardized evaluation criteria of impact, likelihood and controls’ effectiveness are used to prioritize risk for follow-up activity. Risk mitigation is integrated with assessments to monitor effective use.

- **Level 3**
  An ERM team manages an evolving list of reasonably foreseeable and relevant material risks, creating context for risk assessment as a foundation of the ERM framework. Risk indicator lists are collected by most process owners. Upside and downside outcomes of risk are understood and managed. Standardized evaluation criteria of impact, likelihood and controls’ effectiveness are used, prioritizing risk for follow-ups. Enterprise level information on risks and opportunities are
shared. Risk mitigation is integrated with assessments to monitor effective use.

- **Level 2**
  Formal lists of reasonably foreseeable and relevant material risks exist for each relevant business unit or function, and discussions of risk are part of the ERM process. Corporate risk indicators are collected centrally, based on past events. Relevant business units or functions might maintain their own informal risk checklists that affect their areas, leading to potential inconsistency, inapplicability and lack of sharing or under-reporting.

- **Level 1**
  Risk is owned by specialists, centrally or within a business unit or function. Risk information provided to risk managers is probably incomplete, dated or circumstantial, so there is a high risk of misinformed decisions, with potentially severe consequences. Further mitigation, supposedly completed, is probably inadequate or invalid.

- **Level 0**
  There might be a belief that reasonably foreseeable and relevant material risks are known, although there is probably little documentation.

### 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. Understanding of the risk appetite statement ensures alignment with the risk strategy set by senior management and reviewed and evaluated by the board. Not included in the 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 risk areas as deemed appropriate by the company. The company 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. 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.

- **Level 5**
  A risk appetite statement has been developed to establish clear boundaries and expectations for the insurer to follow. A process for delegating authority to accept risk levels in accordance with the risk appetite statements is communicated throughout the insurer. The management team and risk management committee, if applicable, may define tolerance levels and limits on a quantitative and/or qualitative basis for relevant business units and functions in accordance with the defined risk appetite. As part of its risk management framework, the insurer may compare and report actual assessed risk versus risk tolerances/limits. Management prioritizes resource allocation based on the gap between risk appetite and assessed risk and opportunity. The established risk appetite is examined periodically.
Level 4
Risk appetite is considered throughout the ERM framework. Resource allocation decisions consider the evaluation criteria of business areas. The insurer forecasts planned mitigation’s potential effects versus risk tolerance as part of the ERM framework. The insurer’s risk appetite is updated as appropriate, and risk tolerances are evaluated from various perspectives as appropriate. Risk is managed by process owners. Risk tolerance is evaluated as a decision to increase performance and measure results. Risk-reward tradeoffs within the business are understood and guide actions.

Level 3
Risk assumptions within management decisions are clearly communicated. There is a structure for evaluating risk and gauging risk tolerance on an enterprise-wide basis. Risks and opportunities are routinely identified, evaluated and executed in alignment with risk tolerances. The ERM framework quantifies gaps between actual and target tolerances. The insurer’s risk appetite is periodically reviewed and updated as deemed appropriate by the insurer, and risk tolerances are evaluated from various perspectives as appropriate.

Level 2
Risk assumptions are only implied within management decisions and are not understood outside senior leadership with direct responsibility. There is no ERM framework for resource allocation. Defining different views of business units or functions from a risk perspective cannot be easily created and compared.

Level 1
Risk management might lack a portfolio view of risk. Risk management might be viewed as risk avoidance and meeting compliance requirements or transferring risk through insurance. Risk management might be a quantitative approach focused on the analysis of high-volume and mission-critical areas.

Level 0
The need for formalizing risk tolerance and appetite is not understood.

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 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 and risk limits put in place. In addition, controls are also put in place on the backend, by either the internal audit team, or some independent consultant, 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.

Level 5
ERM, as a management tool, is embedded in material business processes and strategies. Roles and responsibilities are process driven with teams collaborating across material central and field positions. Risk and performance assumptions within qualitative assessments are routinely revisited and updated. The insurer uses an ERM process of sequential steps that strive to improve
decision-making and performance. A collaborative, enterprise-wide approach is in place to establish a risk management committee staffed by qualified management. Accountability for risk management is woven into material processes, support functions, business lines and geographies as a way to achieve goals. To evaluate and review the effectiveness of ERM efforts and related controls, the insurer has implemented a “Three Lines of Defense” model or similar system of checks and balances that is effective and integrated into the insurer’s material business processes. The first line of defense may consist of business unit owners and other front line employees applying internal controls and risk responses in their areas of responsibility. The second line of defense may consist of risk management, compliance and legal staff providing oversight to the first line of defense and establishing framework requirements to ensure reasonably foreseeable and relevant material risks are actively and appropriately managed. The third line of defense may consist of auditors performing independent reviews of the efforts of the first two lines of defense to report back independently to senior management or the board.

- **Level 4**
  Risk management is clearly defined and enforced at relevant levels. A risk management framework articulates management’s responsibility for risk management, according to established risk management processes. Management develops and reviews risk plans through involvement of relevant stakeholders. The ERM framework is coordinated with managers’ active participation. Opportunities associated with reasonably foreseeable and relevant material risks are part of the risk plans’ expected outcome. Authentication, audit trail, integrity and accessibility promote roll-up information and information sharing. Periodic reports measure ERM progress on reasonably foreseeable and relevant material risks for stakeholders, including senior management or the board. The insurer has implemented a “Three Lines of Defense” model to review and assess its control effectiveness, but those processes may not yet be fully integrated or optimized.

- **Level 3**
  The ERM framework supports material business units’ and functions’ needs. ERM is a process of steps to identify, assess, evaluate, mitigate and monitor reasonably foreseeable and relevant material risks. ERM frameworks include the management of opportunities. Senior management actively reviews risk plans. The ERM process is collaborative and directs important issues to senior management. The “Three Lines of Defense” are generally in place, but are not yet performing at an effective level.

- **Level 2**
  Management recognizes a need for an ERM framework. Agreement exists on a framework, which describes roles and responsibilities. Evaluation criteria are accepted. Risk mitigation activities are sometimes identified but not often executed. Qualitative assessment methods are used first in material risk areas and inform what needs deeper quantitative methods, analysis, tools and models. The “Three Lines of Defense” are not yet fully established, although some efforts have been made to put these processes in place.

- **Level 1**
  Management is reactive and ERM might not yet be seen as a process and management tool. Few processes and controls are standardized and are instead improvised. There are no standard risk assessment criteria. Risk management is involved in business initiatives only in later stages or centrally. Risk roles and responsibilities are informal. Risk assessment is improvised. Standard collection and assessment processes are not identified.

- **Level 0**
  There is little recognition of the ERM framework’s importance or controls in place to ensure its effectiveness.

**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. The transparency is generally available because of reporting that can be made available to management, the board, or compliance departments, as appropriate. However, 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.

- **Level 5**
  The ERM framework is an important element in strategy and planning. Evaluation and measurement of performance improvement is part of the risk culture. Measures for risk management include process and efficiency improvement. The insurer measures the effectiveness of managing uncertainties and seizing risky opportunities. Deviations from plans or expectations are also measured against goals. A clear, concise and effective approach to monitor progress toward strategic goals is communicated regularly with relevant business units or functional areas. Individual, management, departmental, divisional and corporate strategic goals are linked with standard measurements. The results of key measurements and indicators are reviewed and discussed by senior management or the board, on a regular basis and as frequently as necessary to address breaches in risk tolerances or limits in a timely manner.

- **Level 4**
  The ERM framework is an integrated part of strategy and planning. Risks are considered as part of strategic planning. Risk management is a formal part of strategic goal setting and achievement. Investment decisions for resource allocation examine the criteria for evaluating opportunity impact, timing and assurance. The insurer forecasts planned mitigation’s potential effect on performance impact, timing and assurance prior to use. Employees at relevant levels use a risk-based approach to achieve strategic goals. The results of key measurements and indicators are shared with senior management or the board on a regular basis.

- **Level 3**
  The ERM framework contributes to strategy and planning. Strategic goals have performance measures. While compliance might trigger reviews, other factors are integrated, including process improvement and efficiency. The insurer indexes opportunities qualitatively and quantitatively, with consistent criteria. Employees understand how a risk-based approach helps them achieve goals. Accountability toward goals and risk’s implications are understood and are articulated in ways frontline personnel understand. The results of key measurements and indicators are shared with senior management or the board.

- **Level 2**
  The ERM framework is separate from strategy and planning. A need for an effective process to collect information on opportunities and provide strategic direction is recognized. Motivation for management to adopt a risk-based approach is lacking.

- **Level 1**
  Not all strategic goals have measures. Strategic goals are not articulated in terms the frontline management understands. Compliance focuses on policy and is geared toward satisfying external oversight bodies. Process improvements are separate from compliance activities. Decisions to act on risks might not be systematically tracked and monitored. Monitoring is done, and metrics are chosen individually. Monitoring is reactive.

- **Level 0**
  No formal framework of indicators and measures for reporting on achievement of strategic goals exists.

**Documentation for Section I**

The lead state analyst should prepare a summary of Section I by developing an assessment of each of the five principles set forth in the *ORSA Guidance Manual* using the template at the end of these procedures. The lead state analyst should understand that ORSA summary reports may not 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 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 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, the assessment from the lead state examiner should be used as a starting point for the lead state analyst to update. Consequently, the lead state analyst update may focus as much on changes to the ORSA Summary Report (positive or negative) since the insurer was previously examined; and, similar to an initial assessment by the lead state analyst, they may want to direct targeted onsite verification and testing for changes that have occurred since the last examination.

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 Group Profile Summary (if the ORSA Summary Report is prepared on a group basis) or the Insurer Profile Summary (IPS) (if the ORSA Summary Report is prepared on a legal entity basis).

**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* does not require the insurer to include specific risks, but does give possible examples of reasonably foreseeable and relevant material risk categories (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.

Documentation for Section II

Prepare a summary of Section II by identifying the significant reasonably foreseeable and material relevant risks of the insurer per the ORSA Summary Report, including those that correspond to the nine branded risk-classifications, if applicable. Following the documentation on each of the significant reasonably foreseeable and material relevant risks 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.

After completing a summary of Section II, the lead state analyst should use the information to update either the Group Profile Summary (if the ORSA is prepared on a group basis) or the IPS (if the ORSA is prepared on a legal entity basis).

Overall Risk Assessment Summary

After considering the various risks identified by the insurer through Section II, develop an overall risk assessment summary of possible concerns that may exist.

Review of Section III - Group Assessment of Risk Capital

Section III of the ORSA is unique in that it is required to be completed at the insurance group level as opposed to the other sections which may be completed at a legal entity level. However, in many cases, insurers will choose to also complete Section I and Section II at the group level. This requirement is important because it provides the means for lead state regulators to assess the reasonableness of capital of the entire insurance group based upon its existing business plan.

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, the report may not provide sufficient detail to fully evaluate the group capital position.

Section III will be directly used as part of the lead state’s insurance holding company analysis evaluation of group capital.

Documentation for Section III

Insurance groups will use different means to measure risk (i.e., required) capital and they will use different accounting and valuation frameworks. The lead state analyst may need to request management to discuss their overall approach to both of these items and the reasons and details for each so that they can be considered in the evaluation of estimated risk capital.

The ORSA Summary Report should summarize the insurer’s process for model validation, including factors considered and model calibration. 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 (e.g., stochastic vs. deterministic) and be prepared to dialogue about and understand the material assumptions that affected the model output, such as prospective views on risks. The aforementioned dialogue may occur during either the financial analysis process and/or the financial examination process.

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 Group Profile Summary or IPS.

Support the assessment of the reasonableness of capital by developing a narrative that considers the following:

- **Actual Capital Amount**
  Discuss the extent to which the group available capital amount exceeds the group risk capital amount per the ORSA Summary Report. In the rare situation where the calculation revealed group capital was not sufficient compared to internal/rating agency/regulatory capital, immediately contact the group to determine what steps it is taking to address the issue. Consider in that discussion, the section below, which requires the lead state analyst to consider the controls the group has in place relative to this issue. For all other groups, when considering if group capital is either well in excess of internal/rating capital or currently sufficient, consider all of the following considerations, but paying particular attention to the cushion based upon the use of economic capital scenarios and/or stress testing.

- **Cushion Based Upon Use of Economic Capital Scenarios and/or Stress Testing**
  Perhaps the most subjective determination when considering group capital is determining the sufficiency of such amount compared to a predefined minimum. That minimum, be it regulatory, rating agency, or economic, uses certain assumptions, including assumptions that may already provide a cushion. The lead state analyst shall bear in mind the “Own” in ORSA, noting that each insurer’s methodology and stress testing will vary. However, the lead state analyst should be able to develop and document the general methodology applied and how outputs from the prospective solvency calculations compare with recent trends for the group and, in general, be able to determine the sufficiency of capital.

- **Method of Capital Measurement**
  Discuss the method used (e.g., internal, rating agency) by the insurer in assessing group capital and their basis for such decision. If no information on this issue exists within the ORSA Summary Report, consider asking the insurer the question. 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.

- **Quality of Capital**
  If the insurer uses an internal capital model, evaluate the quality of available capital included in the report from the standpoint of whether that capital is freely available to meet policyholder obligations. In addition, determine if there is any double counting of capital through the stacking of legal entities. If the insurer used rating agency capital, verify if capital used internally in the ORSA Summary Report meets such firm’s requirements. If no information on this issue exists
within the ORSA Summary Report, the lead state analyst should consider asking the insurer the question.

**Prior Year Considerations**

Some insurers will provide qualitative information in the ORSA Summary Report that describes their movement of required capital from one period to the next, the drivers of such change, and any decisions made as a result of such movement. If no information on this issue exists within the ORSA Summary Report, consider asking the insurer questions, particularly if there have been material changes in the group capital position year over year or material changes to business plans, operations or market conditions, without a corresponding change in group capital position. This information, as well as the lead state analyst’s existing knowledge of the group, and its financial results, should be used to determine the overall reasonableness of the change in group capital and should be an input into evaluating the group capital calculation.

**Quantification of Reasonably Foreseeable and Relevant Material Risks**

Discuss and document if the group capital fails to recognize any reasonably foreseeable and relevant material risks the lead state analyst is aware of.

**Controls over Capital**

Discuss the extent to which the ORSA Summary Report demonstrates the group has a strategy, including senior management or the board oversight, for ensuring adequate group capital is maintained over time. This includes plans for obtaining additional capital or for reducing risk where required. If no information on this issue exists within the ORSA Summary Report, consider asking the insurer the question.

**Controls over Model Validation and or Independent Reviews**

If the insurer uses an internal capital model, discuss the extent to which the group uses model validation and independent review to provide additional controls over the estimation of group capital. If no information on this issue exists within the ORSA Summary Report, consider asking the insurer the question. Lead state analysts and lead state examiners are encouraged to: 1) look to the insurer’s own process by which they assess the accuracy and robustness of its models; look how the insurer governs model changes and parameter or assumption setting; and 3) limit lead state examiner-lead validation of model output to more targeted instances where conditions warrant additional analysis.

**Review of Section III – Prospective Solvency Assessment**

The ORSA Guidance Manual requires the insurer to estimate its prospective solvency. Insurers may include in the ORSA Summary Report information developed as part of their strategic planning and may include pro forma financial information that displays possible outcomes as well as projected capital adequacy in those future periods based on the insurer’s defined capital adequacy standard. The lead state analyst should understand the impact such an exercise has on the ongoing business plans of the insurer. For example, to the extent such an exercise suggests that at the insurer’s particular capital adequacy under expected outcomes the group capital position will weaken, or recent trends may result in certain internal limits being breached, the lead state analyst should understand what actions the insurer expects to take as a result of such an assessment (e.g., reduce certain risk exposure, raise additional capital, etc.). It should be kept in mind, however, that a mere “weakening” of a group capital position, or even trends, are less relevant than whether group available capital exceeds the group’s risk capital over the forecast period. The lead state analyst should document its findings/review of this section.
Suggested Follow-up by the Examination Team

As noted at the end of each section 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. If there are specific reports, information and/or control processes addressed in the ORSA Summary Report that the 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. The lead state will direct the examination team to take steps to verify information included in the report and test the operating effectiveness of various risk management processes on a sample basis (e.g., reviewing certain supporting documentation from Section I; testing the reasonableness of certain inputs into stress testing from Section II; and reviewing certain inputs, assumptions and outputs from internal models).

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 - Enterprise Risk Report. 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 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. Lead states and other domestic states receiving and sharing the Form F must have in place confidentiality agreements as prescribed in Model 440.

Although by inclusion in this section, reviewing the group Form F report is a responsibility of the lead state, the approach on this is different from that taken with the ORSA. Generally speaking, a non-lead state should not review the ORSA with the same level of depth as the lead state. However, that same approach is not encouraged with respect to the Form F. The entire purpose of the Form F is to identify if there is any contagion risk within the group, and domestic states should not be discouraged from reviewing such information because ultimately they are required to relate the financial condition of the group to their domestic state. Most believe that the ORSA is much more detailed and less related to contagion as it is the group’s actual risk management processes used to mitigate risk. The Form F must be reviewed by the lead state but other domestic states are also expected to review it. 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.

Procedures #1 - 2 assist the analyst in reviewing the Form F filing for completeness and help guide the analyst through each of the major items of information required by Form F. The analyst should review Form F in conjunction with a review of Form B and should document any nondisclosure of information.
Procedures #3 - 7 assist the analyst in evaluating the risks described within Form F. The analyst should consider whether any enterprise risks not reported in Form F exist, and for all risks identified both within Form F and by the analyst, the analyst should review information available and document any concerns. The analyst should also evaluate whether the risks identified result in an impact to surplus, RBC, insurance operations, or balance sheet and liquidity.
V. Group-Wide Supervision – F. Own Risk and Solvency Assessment (ORSA) Procedures

Lead State Analyst Template for Summary of Review

Lead State Regulator’s Analysis of ORSA Summary Report
Insurer XYZ
Using ORSA Summary Reported Dated XX/XX/XXXX

Section I

Prepare a summary of Section I by developing an assessment of each of the five principles set forth in the Own Risk and Solvency Assessment Guidance Manual followed by a narrative that supports the assessment.

A. **Risk Culture and Governance** - Governance structure clearly defines and articulates roles, responsibilities and accountabilities, and a risk culture supports accountability in risk-based decision making.
   
   ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

   **Supporting Narrative**

B. **Risk Identification and Prioritization** - Risk identification and prioritization process is key to the organization, responsibility for this activity is clear, and the risk management function is responsible for ensuring the process is appropriate and functioning properly.

   ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

   **Supporting Narrative**

C. **Risk Appetite, Tolerances and Limits** - A formal risk appetite statement, and associated risk tolerances and limits are foundational elements of risk management for an insurer. Understanding of the risk appetite statement ensures alignment with risk strategy set by senior management and is reviewed and evaluated by the board of directors (e.g., relationship between risk tolerances and the amount and quality of risk capital).

   ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

   **Supporting Narrative**

D. **Risk Management and Controls** - Managing risk is an ongoing enterprise risk management (ERM) activity, operating at many levels within the insurer (e.g., monitoring processes and methods)

   ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

   **Supporting Narrative**

E. **Risk Reporting and Communication** - Provides key constituents with transparency into the risk-management processes and facilitates active, informal decisions on risk-taking and management (e.g., risk assessment tools, feedback loops, used to monitor and respond to changes in risks, operations, economic environment and strategies, and includes new risk information)

   ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

   **Supporting Narrative**
V. Group-Wide Supervision – F. Own Risk and Solvency Assessment (ORSA) Procedures

Overall Assessment

After considering the assessment of each of the five previously identified principles, develop an overall assessment of the insurer’s risk management framework followed by any factors outside of those already identified by the lead state analyst in each of the above sections.

☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

Supporting Narrative

Section II

Prepare a summary of Section II by identifying the significant reasonably foreseeable and material relevant risks of the insurer per the ORSA Summary Report, including those that may correspond to the nine branded risk classifications, if applicable. Following the evaluation or assessment of the reasonably foreseeable and material and relevant significant risks per the report, include an assessment of the insurer’s analysis of such risks.

(Note: The ORSA Summary Report is based on the insurer’s own risks and is not required to include or be in a format that aligns with branded risk classifications.)

1. Based on your knowledge of the group, did the insurer include in its ORSA a discussion of risks and related stresses that you consider appropriate for the group? Note whether the following are applicable or not.

a. **Credit** - Amounts actually collected or collectible are less than those contractually due.  
   Lead State Analyst Summary of Risks

b. **Legal** - 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.  
   Lead State Analyst Summary of Risks

c. **Liquidity** - Inability to meet contractual obligations as they become due because of an inability to liquidate assets or obtain adequate funding without incurring unacceptable losses.  
   Lead State Analyst Summary of Risks

d. **Market** - 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.  
   Lead State Analyst Summary of Risks

e. **Operational** - Operational problems such as inadequate information systems, breaches in internal controls, fraud or unforeseen catastrophes resulting in unexpected losses.  
   Lead State Analyst Summary of Risks
V. Group-Wide Supervision – F. Own Risk and Solvency Assessment (ORSA) Procedures

Lead State Analyst Summary of Risks

f. **Pricing/Underwriting** - Pricing and underwriting practices are inadequate to provide for risks assumed.

Lead State Analyst Summary of Risks

g. **Reputational** - Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.

Lead State Analyst Summary of Risks

h. **Reserving** - Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

Lead State Analyst Summary of Risks

i. **Strategic** - 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.

Lead State Analyst Summary of Risks

j. **Other** - Discuss any other reasonably foreseeable and relevant material risks facing the insurer that do not fit into one of the nine branded risk classifications identified above.

**Overall Risk Assessment Summary**

After considering the various risks identified by the insurer, as well as an analysis of such risks, develop an overall risk assessment summary of possible concerns that may exist.

**Section III**

**Capital Assessment**

The lead state analyst should summarize the overall assessment of capital followed by a narrative that supports that assessment.

The lead state examiner should supplement the assessment by incorporating his or her own assessment of controls, culture, and internal detailed calculations of an insurer if the lead state analyst was not able to obtain such information by interacting and analyzing supporting information.

**Prospective Solvency Assessment**

Document any findings from review of this section.

**Analyst Suggested Follow-Up by the Lead State Examiner**

Please include a list of suggested verification/areas of focus for the financial examination as well as the purpose of such suggestions at the end of this summary (such as the following-example only):
## V. Group-Wide Supervision – F. Own Risk and Solvency Assessment (ORSA) Procedures

Suggested Additional Verification/Areas of Focus for the Financial

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Purpose</th>
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<tbody>
<tr>
<td>1</td>
<td>Walk through risk tracking process and documentation in use</td>
<td>Verification</td>
</tr>
<tr>
<td>2</td>
<td>Interview select management for corroboration on risk committee responsibilities</td>
<td>Verification</td>
</tr>
<tr>
<td>3</td>
<td>Discuss assumptions, inputs, and outputs of internal capital model as well as use and walkthrough change in any of the above</td>
<td>Understanding and documentation</td>
</tr>
</tbody>
</table>
Special Note: The following procedures do not supersede state regulation, but are merely additional guidance an analyst may consider useful.

Compliance with Reporting Requirements

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 percent 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 the insurer’s policyholder surplus or risk-based capital position?

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)?

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:
- The analyst should update the Holding Company System Analysis, Branded Risk Assessments and Supervisory Plan in the Group Profile Summary with the risks identified and results from the Form F review.
- The analyst 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).

Analyst ________________ Date________

Comments as a result of supervision review.

Reviewer ________________ Date________

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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.

Name of Insurance Holding Company System ____________________
Name of Lead State ____________
Date of Meeting____________
Meeting Held with CFO or Other Identified Group Officer____________

Financial Performance and Related Indicators

1. Discuss the 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. To the extent there are any weaknesses within the profitability results, discuss the drivers of such issues 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. To the extent there are strengths in the profitability results and trends, describe any actions being taken by the group to capitalize on 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. Discuss the 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. Consider 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. Discuss any 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. To 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.
V. Group-Wide Supervision – H. Periodic Meeting with Group

8. Discuss any changes in the group’s liquidity program and the internal measures used by the group to measure such adequacy.

9. Discuss any changes in the group’s investment strategy or any market changes that are shifting the group’s general approach.

Other Group Risks

10. Discuss the 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.

11. Discuss the group’s non-insurance entities, as well as any risks they originate and could pose to the group.

12. Discuss the 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. Discuss the group’s most recent results/position compared to any corresponding covenants the group is required to meet.

14. Discuss the 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. Discuss the 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. Discuss the 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. Discuss any 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. Discuss whether there are 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. Discuss the 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. Discuss any other events that are affecting the group’s strategy or ability to execute its strategy.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the periodic meeting. In developing a conclusion, the analyst should consider the most important aspects from the meeting, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the holding company under the specific circumstances involved. The analyst may want to consider documenting any questions that were asked during the meeting, and provide a copy of such questions and answers to the examiner to help
V. Group-Wide Supervision – H. Periodic Meeting with Group

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.

- The analyst 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.

- The analyst should communicate to the examiner-in-charge (EIC) any prospective risks identified.

  Analyst ________________ Date________

Comments as a result of supervision review.

  Reviewer ________________ Date_______
V. Group-Wide Supervision – I. Targeted Examination Procedures

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 may want to perform certain limited examination procedures as part of the continual risk assessment process. However, the analyst 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.

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 – 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 V.D. – Corporate Governance Disclosures Procedures for a detail of such procedures) or risk management process (see Section V.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 agencies, banks or other lenders.

8. Copy of the most recent liquidity strategy and walkthrough of daily monitoring process.
V. Group-Wide Supervision – I. Targeted Examination Procedures

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.

Summary and Conclusion
Develop and document an overall summary and conclusion regarding the targeted examination. In developing a conclusion:

- The analyst should update the Insurance Holding Company System Analysis and Supervisory Plan in the Group Profile Summary.

  Analyst ________________ Date________

Comments as a result of supervision review.

  Reviewer ________________ Date_______
V. Group-Wide Supervision – J. Supervisory Colleges

**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 when leading a Supervisory College.

As a lead state reviews this section, it should be well understood that in those holding company structures where the lead state is not the group-wide supervisor (e.g., with groups based outside of the U.S. or where the Federal Reserve is the group-wide supervisor), and in accordance with accreditation standards, lead states may choose to rely on the analysis work performed by international insurance supervisors or another functional regulator (e.g., the Federal Reserve). However, 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, they are responsible for notifying all other domestic states. This specific note relates more specific to holding company analysis, but to the extent that the lead-state utilizes any work documented from the Supervisory College, that this same principle should be applied to such work.

**Overview**

**Background Information**

In 2009 the Group Solvency Issues (E) Working Group (the working group) of the Solvency Modernization Initiative (E) Task Force endorsed as guidance the IAIS *Guidance Paper on the Use of Supervisory Colleges in Group-Wide Supervision* [October 2009] (the IAIS guidance paper). The working group supported the IAIS guidance paper in part because it recognizes the need for flexibility in the design, membership and establishment of Supervisory Colleges in accommodating the organizational structure, nature, scale and complexity of the group risks, and the level of international activity and interconnectivity within the group. The IAIS guidance paper discusses factors to consider in the implementation of a Supervisory College framework, including its form and membership, the role and possible functions of a Supervisory College, and the interrelationship between a designated group-wide supervisor and the Supervisory College.

Additionally, IAIS document literature indicates that 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. The IAIS has also documented that 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

**International Expectations**

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 April 2008, the Financial Stability Forum (now known as the Financial Stability Board FSB) issued a report to the G7 Finance Ministers and Central Bank Governors setting out a comprehensive set of recommendations for strengthening the global financial system. One key recommendation therein was the operationalization and expanded use of Supervisory Colleges for certain global financial institutions.\(^ii\)

The International Monetary Fund (IMF) through its Financial Sector Assessment Program (FSAP) is assessing whether jurisdictions have enhanced regulatory cooperation and coordination through the development of Supervisory Colleges. The IMF 2010 FSAP of the U.S. financial sector made several recommendations for the insurance sector relating to this issue, stating that, “the U.S. should ensure that colleges of supervisors for the U.S. groups with major international operations are established and functioning effectively—and led by U.S. regulators with appropriate insurance expertise.” The FSAP, relating to the insurance sector, assesses U.S. compliance with the Insurance Core Principles (ICPs) of the IAIS. The NAIC’s Solvency Modernization Initiative (SMI) was put in place in 2008 and represents a critical self-examination of the U.S.’ insurance solvency regulation framework and includes a review of international developments regarding insurance supervision, banking supervision, and international accounting standards and their potential use in U.S. insurance regulation. In this regard, state regulators have considered what international approaches are appropriate for the U.S. system by including aspects of ICP 23-Group-wide Supervision, and ICP 25-Supervisory Cooperation and Coordination.

Regarding the role and duties of the group-wide supervisor, the primary role of the group-wide supervisor is to facilitate coordination and communication between regulators. State insurance regulators recognize that the legal framework with regard to the role of the group-wide supervisor differs sometimes significantly from one jurisdiction to another and, therefore, the role of a group-wide supervisor within a Supervisory College will depend on the jurisdictions involved and should be specifically outlined at the outset to meet the expectations of the members of the Supervisory College. The working group’s support for the IAIS guidance paper can also be attributed to the fact that Supervisory Colleges by definition are consistent with state insurance regulators view regarding group supervision. In the U.S., the Insurance Holding Company System Regulatory Act (#440) provides a more specified approach to be used when determining a group-wide supervisor, which is also consistent with the approach discussed in this Handbook.

The various ICPs include standards and guidance with respect to Group-Wide Supervision. The following summarizes one of those key concepts:

- At a minimum, the group-wide supervision framework includes, as a supplement to legal entity supervision, extension of legal entity requirements, as applicable according to the relevant ICPs, on:

\(^i\) 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."

V. Group-Wide Supervision – J. Supervisory Colleges

- Solvency assessment (group-wide solvency)
- Governance, risk management and internal controls (group-wide governance)
- Market conduct (group-wide market conduct)

As it relates to the above and any following references to the ICPs and their standards and guidance, this should not be read as a requirement for states, but rather should be used by the state to understand the expectation that other jurisdictions may have on a lead state serving as a group-wide supervisor.

ICP 25-Supervisory Cooperation and Communication provides among other things, the following:

- “At present, it is not generally possible to consider or establish international legislation which grants legal power and authority to a group-wide supervisor across jurisdictional borders. It is important, therefore, that there are clear agreements (formal or otherwise) between all involved supervisors in order to allow the group-wide supervisor to fulfill its tasks and to ensure support from involved supervisors.”

- “Involved supervisors determine the need for a group-wide supervisor and agree on which supervisor will take on that role (including a situation where a Supervisory College is established).”

- “The designated group-wide supervisor takes responsibility for initiating discussions on suitable coordination arrangements, including establishing a Supervisory College, and acts as the key coordinator or chairman of the Supervisory College, where it is established.”

- “The designated group-wide supervisor establishes the key functions of the Supervisory College and other coordination mechanisms.”

- “The supervisor takes steps to put in place adequate coordination arrangements with involved supervisors on cross-border issues on a legal entity and a group-wide basis in order to facilitate the comprehensive oversight of these legal entities and groups. Insurance supervisors cooperate and coordinate with relevant supervisors from other sectors, as well as with central banks and government ministries.”

- “Coordination agreements include establishing effective procedures for: information flows between involved supervisors; communication with the head of the group; convening periodic meetings of involved supervisors; and conduct of a comprehensive assessment of the group.”

- “The designated group-wide supervisor understands the structure and operations of the group. Other involved supervisors understand the structure and operations of parts of the group at least to the extent of how operations in their jurisdictions could be affected and how operations in their jurisdictions may affect the group.”

- “The designated group-wide supervisor takes the appropriate lead in carrying out the responsibilities for group-wide supervision. A group-wide supervisor takes into account the assessment made by the legal entity supervisors as far as relevant.”
Structure

Determination of the Group-Wide Supervisor

The IAIS ICPs also contain the following guidance regarding determination of the group-wide supervisor. This is not meant to be read as a requirement for states, but rather should be used by the state to understand the expectation that other jurisdictions may have on a lead state serving as a group-wide supervisor.

- “In principle the supervisor in the jurisdiction where the group is based and where that supervisor has the statutory responsibility to supervise the head of the group should be first considered to take the role of the group-wide supervisor.”

- “The location of the group's head office, given that this is where the group's Board and Senior Management is most likely to meet, and ready access of the group-wide supervisor to the group’s Board and Senior Management is an important factor.”

- “Where the registered head office is not the operational head of the group, the location where the main business activities of the group are undertaken; and/or main business decisions are taken; and/or main risks are underwritten; and/or group has its largest balance sheet total.”

In addition to the above, other criteria to consider include where the group has the most substantial insurance operations, the origin of the insurance business and regulatory resources available for serving as the group-wide supervisor. Once there is some clear distinction, to the extent the criterion suggests it’s a state insurance regulator, discussion with the insurance group should take place and the state insurance regulator should consider establishing the first Supervisory College. In general, once the group-wide supervisor is determined, it generally should not be changed, unless there is a material change in the group’s business or operations that were considered in originally determining the group-wide supervisor.

As previously noted, in the U.S., Model #440 provides a more specified approach to be used when determining a group-wide supervisor for an internationally active insurance group as defined within that model, but the approach in that model is consistent with the approach discussed in this Handbook to be used in determining the lead state for a group. Note however that few jurisdictions have adopted the specific section being referred to as of date of this publication. The following excerpt from Model #440 provides the specifics for those that have an interest (the analyst should refer to the entire Model #440 to better understand the entire context for the following):

The commissioner shall consider the following factors when making a determination or acknowledgment under this subsection:

1. The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group’s written premiums, assets or liabilities;

2. The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;

3. The location of the executive offices or largest operational offices of the internationally active insurance group;

4. Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:
   (a) Substantially similar to the system of regulation provided under the laws of this state, or

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(b) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(5) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

Organizational Procedures Performed Before Conducting a Supervisory College

The information included in ICP 25 show some of the key considerations of organizing a Supervisory College before the college meets for the first time. 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 group-wide supervisor that is responsible for coordination and communication among supervisors within the group strengthens the global insurance regulatory system. The international criterion for determining a group-wide supervisor and similar expectations internationally does not materially differ from the criteria contained within Model #440 and this Handbook for determining the Lead State. Various information from the IAIS guidance paper is discussed throughout this document.

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.

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 that 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 the 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
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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 are 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.

Information-Sharing Agreements

One of the most critical, and often one of the most time consuming and lengthy tasks undertaken by the
group-wide supervisor is drafting, distributing and obtaining executed information sharing agreements
from the participating supervisory college membership. 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.

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 agreement between the involved supervisors must be agreed upon and
entered into by all parties wishing to participate in the Supervisory College. This agreement can be
achieved in various ways, such as: 1) through bilateral memorandums of understanding (MoUs) 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 objective of the MMoU is for a signatory authority\(^\text{iii}\) 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

\(^\text{iii}\)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.
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 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.

In addition to the legal requirements for information sharing, there are also practical requirements or expectations to consider. It should be understood that some jurisdictions and some insurance groups may have different views on communication. For example, some jurisdictions exclude people such as the holding company analyst, or the examiner in charge of the group. Therefore, it may be appropriate to describe to other regulators why department financial regulation staff may be involved in the college. In some jurisdictions, regulators seek permission from the insurance group before releasing certain group information that may be sensitive. These are simply examples of the items to consider since they can have an impact on trust, which is key to any successful long-standing relationship.

Chairing the Supervisory College/other Supervisory Duties

As previously noted, an immediate expectation of the group-wide supervisor is serving 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 (See below for further discussion).
- Set the agenda for the meeting and distributing at least one week in advance (See below for further ideas). 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); consider documenting in the form of minutes. It will be the responsibility of the Supervisory 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 (see below for further discussion)
- 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 (See below for further discussion)
In addition to these items identified in ICP 25, 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
- Circulate presentations and other materials for the meeting once information sharing-agreements are obtained from all college participants

Understanding the Regulatory Roles of Supervisory College Members

It is important for all participants in a Supervisory College to have a clear understanding of the regulatory mission of each of the regulatory bodies which are being considered for any Supervisory College. There can be important and significant differences amongst regulatory bodies which may be encountered by a diverse group of regulators if comprised of federal agencies and members from other countries. The regulated group’s organizational structure and the personalities of the regulators involved will also have a large tendency to direct how the group organizes and conducts itself. This information could be accumulated and summarized into a Terms of Reference document, or some other related document.

Key Functions of the Supervisory College Including 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 “Terms of Reference”. A Terms of Reference document 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
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and responsibilities of the group-wide supervisor. As it relates to frequency and location of meetings members should strive to physically attend the meetings however members should be given the ability to participate by conference call. A sample “Terms of Reference” document is included in the appendix to this section. The supervisory work plan sets out timelines and deliverables and any tasks to be completed by college members based on key areas related to risks that are to be monitored within a certain time frame. Regular review and updating should be made to the supervisory work plan on a periodic basis.

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.

Minimum College Expectations (For U.S. States Determined To Be The Group-Wide Supervisor)

College Requirements for U.S. States Determined to be the Group-Wide Supervisor

The following sets forth a minimum set of regulatory procedures to be used by U.S. lead states when leading a Supervisory College. Many of these items are further discussed in prior parts of this document but some are not, and require additional judgment.

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 I-SITE.
- 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
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- 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.

- At the college, present an initial 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 jurisdictions 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 regulators 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.

  - 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
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- 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 lead state should consider utilizing a Group Profile Summary, or a similar document in a form similar to such document or the Insurer Profile Summary, to meet this objective. 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 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 complete. The updated Supervisory Work Plan should be updated and distributed to all members of the college within approximately three weeks of the college meeting, or something more flexible if that is agreeable to college members.

- Record a summary of each meeting, documenting decisions that were reached. Distribute the summary to the participants within approximately two weeks following each college meeting, or something more flexible if that is agreeable to college members.

- Distribute an updated contact list of members within approximately one week 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.

- Using the information from the survey, prepare a summary of the self-assessment of the effectiveness of the college and distribute to all members of the college within approximately four weeks following the college meeting, or something more flexible if that is agreeable to college members.
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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.

General College Guidance for U.S. State Determined to be the Group-Wide Supervisor

As colleges evolve, providing consistency for what is appropriate in order that colleges are functioning effectively is important. Therefore, it is appropriate that the NAIC enhancements for Supervisory Colleges be updated to reflect the most current views. This Handbook encourages all states that have participated in international Supervisory Colleges to consider on an ongoing basis, the changes that should be made to this section of this Handbook, and to submit them to NAIC staff for discussion and possible adoption.

Group Risks Perspective from Each Supervisory College Member

As discussed previously, the 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 state insurance regulator consider having some time set aside at the very first college where each college member is afforded the time to share their perspective with the group. The following is a list of the things the college may want to ask each member to provide, perhaps in a five-to-0-minute presentation.

Presentation of the Entities

- Simplified holding company chart of the local entities.
- Premium written by local regulated insurer by line of business and/or by product.
- Affiliated relationships and any major transactions, including pooling arrangements and other reinsurance relationships.

Market Share

- Major lines of business.
- Gross written if not identified above.
- Share of the local market (at the branch or state level if possible) and rank in the country.

Key Financial Information

- Size of the balance sheet for most recent two years (or more current if available).
- Profit and loss statement for most recent two years (or more current if available).

Risks

- Reserves - gross and net of reinsurance for most recent two years.
- Primary risks to which the entity is exposed.
- Exposure to other entities within the group.
- Any other material risks.
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Specific Issues of the Insurer

- Status of any current or recent financial or market conduction examinations.
- Any recent or pending material transactions including mergers, acquisitions and/or reorganizations.
- Any regulatory action.

Crisis Management Plan – (Note: Sample Plan is available within I-SITE – 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 are constantly trying to avoid situations of distress on the company, 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. In fact, in most Supervisory Colleges, it’s difficult to define a crisis plan because it is impossible to know how the college will react. In most cases, the college will agree that a physical meeting would be desirable as soon as practical, but that it may be necessary to meet by conference call as soon as possible.

Regular Assessment of Effectiveness

At the outset of establishing a Supervisory College, the group-wide supervisor should discuss the need to regularly assess the effectiveness of the Supervisory College. Such an evaluation may consider the original “Terms of Reference” document as this outlines the participating member expectations. In addition, the college should determine the extent to which it believes there could be some regulatory gaps in the supervisory process, or areas of the group that have not been considered. Once the group-wide supervisor completes this assessment, it should share with all members of the college allowing the involved regulators to provide input into the assessment. The group-wide supervisor should also consider any prior college experience, and consider improvements for that “baseline” meeting (e.g., what worked, what did not, etc.)

College Meetings - As The Group-Wide Supervisor

Planning And Logistics

Setting the Date for the Meeting

Setting the date for the Supervisory College is critical and requires extensive planning. It is suggested by state regulators that have planned Supervisory Colleges that plenty of advance notice is given to participants of each meeting to attendees with 90 days representing the optimal minimum amount of notice. However, many of these same regulators have suggested that it is better to establish the date of the college, or approximate date, six months in advance. As a result, it is suggested that state insurance regulators start planning the Supervisory College nine months before its expected date. The below section on other logistical aspects for the meeting demonstrate the significance of the various items that must be considered in planning the meeting, and therefore the need for extensive planning to occur far in advance of the actual meeting. Planning should also include the insurer. It is important to discuss the general time frame with the insurer, as set time tables are often in place for board meetings, and it may be productive
to have the flexibility of using the most current board presentations in the college materials, as applicable, provided those same materials are expected to also meet the expectations of the collective supervisors.

Experienced regulators have also noted that the length of the meeting should be specific, with consideration given to allowing each member to fully explain its viewpoints, methods and processes. Supervisory college meetings should always have a clear purpose (See note regarding the chairs responsibility to record outcomes/assignments for each meeting). In many cases, the portion of the meeting with the insurer can be addressed in one full day college meeting. However, specific circumstances may differ.

Planning Other Logistical Aspects for the Meeting

Tentative research should be completed by the lead state to determine the availability of hotel facilities prior to ascertaining how many regulators may be attending. Once a decision has been made that the content for a college is sufficient to substantiate the costs, state insurance regulators may want to consider the timing of such college, and some states suggest that a Supervisory College only be scheduled during the spring or the fall to avoid potential weather-related concerns. The primary reason it is important to schedule a college during the spring or the fall is to increase the chances of regulators from other countries to attend the college and therefore have a successful one. Clearly, the amount of work and costs that must be undertaken to administer a college is significant therefore, it is unreasonable to think that another Supervisory College could be administered on short notice due to a lack of participation from a couple of other countries.

Another reason to schedule a college well in advance of its expected date is to ensure that senior management of the insurance group is available while the college is taking place. Most state insurance regulators believe that it is critical that the CEO, CFO, CRO and Chief Legal Counsel are all available during the college when appropriate senior regulators are also in attendance. The scheduling of the college should begin with establishing a range of dates to ensure attendance of these officers. If the management/officers are not in attendance at certain times of the college, it should be communicated and made clear that they need to be available to supervisors if questions arise that requires their immediate explanation.

Once the general dates and the potential number of college attendees are identified, the insurer’s designated college coordinator can then locate appropriate meeting accommodations. The best site would allow meals and refreshments to be brought into the meeting, which would reduce the need for participants to travel away from the site for meals. Further, consideration should include facilities that allow participants to communicate with their home office and include breakout rooms with phone, computer, and printer capabilities that can also be used for subgroup meetings as needed. It has also been suggested that the meeting space be set up in a “U” shape to maximize the ability to engage each of the participants. A “U” shape room also works well with the need for projectors and screens (for presentations) and use of whiteboards and markers for discussion points. These details are usually worked out between the lead state and the insurer’s designated college coordinator.

Once the location of the meeting is identified, the state insurance regulator should immediately proceed to obtain hotel accommodations that can support all of the attendees and is in close proximity to the meeting location, seeking assistance from the group designated college coordinator as deemed appropriate between the lead state and the group. Hotels which provide for a portal website that gives each participant the ability to make their reservations online is ideal. The dates selected should allow attendees adequate travel time to and from the meeting site.
An evening group dinner is an excellent way for Supervisory College participants to better acquaint themselves and enhance the flow of communication both during and after the Supervisory College. Another important point is to determine the communication that will be provided. Specifically, it will be important to establish that most of the college communication will occur in English. However, it may be appropriate to arrange for translators to be engaged for some other languages, and then for booths to be established where such communication will occur within the room set-up. Again, this may be necessary to consider before establishing the location, and as evidenced with the various important details above, may require the type of lead time suggested previously for establishing such logistics.

As part of its preliminary duties, the group-wide supervisor should determine if the other Supervisory College participants will seek to recoup expenses for attending the Supervisory College, and if so, how the group-wide supervisor be involved with this activity. Many jurisdictions do not seek direct reimbursement for expenses associated with attending a Supervisory College. The group-wide supervisor should identify the process it will use early in the planning stages of a Supervisory College, and communicate this to the other states that will be participating in the college.

One final logistical consideration for colleges is the costs associated with them. Some within the industry have suggested budgets be used by regulators related to Supervisory Colleges. This position may be driven from the standpoint that in the U.S., Model #440 provides that the state’s costs associated with college may be charged to the company. The inclusion of this provision within that NAIC model was intended to prevent limited state resources as a reason that may otherwise preclude key state regulators from attending such meetings regarding the risks of the group with other key national and international regulators. Given its desirable that all major jurisdictions coordinate their understanding and work related to the group or the insurers within the group, this generally has not been disputed. However, the costs themselves can be significant; therefore it is reasonable that the states’ attending the college do what they can to limit such costs to what is reasonable. It may also be helpful if the group-wide supervisor can provide information to the group that allows the members to make estimates of the costs and manage the costs to the extent that is feasible. For this reason, some state regulators have suggested a group designated college coordinator can be used by an insurance group as a means to handle different logistical aspects of the meeting in a manner that helps to keep costs to a reasonable level.

Setting Agendas

In the initial college, the focus will be on establishing the college, the group-wide supervisor, the membership, the “Terms of Reference” document, and related details. Some state insurance regulators may wish to complete these activities of the college via conference calls, or e-mail in order to minimize costs and maximize effectiveness by fitting the college into busy schedules. However, some believe that face-to-face communication cannot be replaced in order to make sure every member of the college is completely engaged in the discussion and issues. Some even suggest that a phone-in number should not be an option for attending a college, because it is likely that a phone attendee would not be as engaged and would be easily distracted. One downfall to full engagement by all members is the difficulty in setting an agenda that can be adhered to within the allotted time. In some cases, this may result in the need to establish approximate time allotments per topic. Most state insurance regulators agree with the practicality of setting such limits, provided the discussion on a particular important topic is not artificially ceased and the group-wide supervisor attempts to find an appropriate place to end the discussion on a topic.

There are a number of other considerations for what should be discussed and considered within the first initial Supervisory Colleges. The following enumerates some potential agenda items for the group-wide supervisor to consider:
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Initial Supervisory College Agenda Topics

- Introductions.
- Discuss individual college members’ views regarding role and responsibilities of the group-wide supervisor.
- Discuss plans for documenting agreements into a Terms of Reference document.
- Hear initial high level presentation from the insurance group regarding its business structure, significant operations, interconnectivity (including non-insurance affiliates), including ownership and management structure and overall operating results.
- Discuss material risks of the group and format for future discussion.
- Discuss a preliminary Supervisory Work Plan.
- Discuss/establish a crisis management plan.
- Set the date and time for the next meeting.

Next Meeting of Supervisory College Agenda Topics

- Introductions.
- Review and reach consensus on the “Terms of Reference” document.
- Recap discussions regarding material risks of the group.
- Secondary presentation/deeper dive from the insurance group regarding its business plan, financing strategy and perceived risks and risk mitigation strategies. Consider requesting specific presentations regarding:
  - Underwriting strategies.
  - Investment strategy.
  - Reinsurance strategy and program.
  - Capital adequacy at the group level including a discussion of internal model development and assumptions (group’s Own Risk and Solvency Assessment).
  - Corporate governance and internal fit and proper requirements.
  - Interconnectivity (including reinsurance, guarantees, securities lending and non-insurance affiliates).
  - Updated operating results.
- Discuss the possibility of a regulator-to-regulator session with external auditors to discuss their audit approach, and material risks (obtain clearance from the insurance group before proceeding).
- Discuss the group-wide supervisor’s initial assessment of the group.
- Share views and assessments on the group as a whole on those risks deemed significant to the members.
- Develop common understanding amongst supervisors on the overall group-wide risk profile relative to the major insurance aspects of the group.
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- Identify a consensus regarding any changes in the assessments of the company’s group-wide risks (strengths and weaknesses).
- Identify any group-wide efforts that the members need to focus on.
- Update the Supervisory Work Plan.
- Identify any correspondence deemed necessary to be distributed to all members of the group.
- Set the date and time for the next meeting.

Ongoing Meetings of the Supervisory College Agenda Items

- Introductions.
- Recap discussions and follow up from past meeting.
- Invite the group-wide supervisor to share an assessment of the group.
  - Continue to share views and assessments of both specific insurers and of the group as a whole on those risks deemed significant.
    - Discuss modifications to the preliminary group-wide assessment by the group-wide supervisor, including changes to the format of the assessment regarding business structure and overview, assessment of profitability, leverage, liquidity and overall financing position/capital adequacy.
    - Consider added documentation for discussion of reinsurance and other forms of risk transfer where material to the perceived risks of the group.
    - Consider added documentation for other intragroup transactions and exposures, including intragroup guarantees, possible legal liabilities, and any other capital or risk transfer instruments.
    - Consider added documentation for internal control mechanisms and risk management processes, including reporting lines and fit-and-proper assessment of the board, senior management and the propriety of significant owners.
- Selected ongoing presentations from the insurance group regarding its risks and changes. This may include but should not be limited to, having each of the business unit heads present on each of their areas.
- Continue to refine the assessments of the company’s group-wide risks (strengths and weaknesses).
- Identify any group-wide efforts that the members need to focus on.
  - Consider coordinated efforts (examinations) of a particular area (e.g., internal audit, actuarial function or risk management processes).
  - Consider break out groups to hear presentations on specific topics (e.g., specific product or economic trends in the industry and company plans for addressing).
  - Breakout groups can also be used as a mechanism for focused discussions. These can be organized by region, type of business, risks, and can present brainstorming sessions where the group lists various issues or concerns, prioritizes them, and then the breakout groups separately present their views to all of the supervisors attending the college meeting.
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- Update the Supervisory Work Plan.
- Identify any correspondence deemed necessary to be distributed to all members of the group.
- Discuss the effectiveness of the Supervisory College.
- Set the date for the next meeting.

Output

Most state insurance regulators agree that it is important for each participant of a Supervisory College to leave with clear outputs and takeaways. Specifically, the college members should agree on the primary risks of the group and how the supervisors are going to monitor such risks. Additionally, most state insurance regulators believe that each insurance group should set up a secure website where the insurance group can post information that may have been requested by the college, or that the insurance group believes is important to provide an update to the various college participants. As part of the Supervisory College, the group-wide supervisor should obtain contact information for each participant and share the information with all the participants during or immediately after the college. State insurance regulators may want to consider providing such information to the insurance group, so it can tabulate such information to minimize the resource impact of this effort. This information can be useful and valuable in facilitating subsequent communication with members regarding follow-up issues.

College Meetings - 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 through the voluntary submission of information via the Web-based NAIC International Supervisory Colleges Request Form.
- 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.
Summary and Conclusion

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.)
- The analyst should update the Holding Company System Analysis if there are observations from the college that have a material impact on the view of the group.
- Group Profile Summary and Supervisory Plan if there are observations from the college that have a material impact on the view of the group.

Analyst ________________ Date________

Comments as a result of supervisory review.

Reviewer ________________ Date________
TERMS OF REFERENCE

for the COMPANY Supervisory College

General Statement: The purpose of this Supervisory College is the development and implementation of an ongoing flexible mechanism to coordinate the exchange of valuable information pertaining to [COMPANY NAME] and its subsidiaries, amongst and for the benefit of those regulatory supervisory authorities responsible for the financial regulation of [COMPANY NAME] and its subsidiaries. The Supervisory College serves as a permanent platform for facilitating the exchange of information, views, and assessments enabling its members to gain a common understanding of the risk profile of the group to enhance risk based supervision and thereby enhance solo supervision efforts.

Terms of Operation: Supervisory College members shall ensure the safe handling of confidential supervisory information by signing the Confidentiality Agreement specific to the College of Supervisors of [COMPANY NAME] (the “Confidentiality Agreement”) thereby facilitating the efficient exchange of information among its members. The Supervisory College has the flexibility in its operation to identify and address immediate, developing, actual and prospective risks. The Supervisory College will discuss efforts to involve Supervisory College members in possible future coordinated supervisory actions and/or arrangements when deemed suitable.

Membership: Supervisory College membership will change over time due to Changes in [COMPANY NAME’s] operations, size and complexity. A current listing of the Tier I, Tier II, and Tier III members are identified in Schedule A attached hereto. The Tier I members will continually evaluate whether any changes in membership are required based on changes related to the nature, size and complexity of [COMPANY NAME].

Chair of the College: Tier I members will appoint a supervisor (group-wide chair) as the chair of the Supervisory College, and may appoint sub-group chairs when deemed appropriate. The chair is responsible for organizing and scheduling meetings as well as ensuring that appropriate information is disseminated to members. The chair should propose the agenda for the meetings and incorporate the views and opinions of other Supervisory College members. A chair need not be a specific person as the chair could be a particular supervisory authority or title of a person at such supervisory authority.

Scope of Activities: The Supervisory College will strive to have a central focus on the following issues at a group level:

- Solvency and financial stability of the insurance group
- Assessment of intragroup transactions and exposures
- Internal control and risk management within the insurance group
- Appropriate actions to mitigate risks identified
- Crisis management

To assist in these central activities, the Supervisory College members will discuss possible arrangements for managing crisis situations based on the risk profile of the group. In addition, where applicable, Supervisory College members will discuss possible procedures for dealing with issues such as breaches of solvency positions and/or the crystallizing of risk exposures.
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Information from the Supervisory College will attempt to incorporate references towards the applicability of [COMPANY NAME] and the stated overall strategic plans of its insurance subsidiary(ies).

Supervisory College members are encouraged to continuously notify their fellow Supervisory College members through the Supervisory College mechanism on any matters deemed relevant to enhance risk-based supervision.

**Frequency and Locations of Meetings:** The Tier I members will attempt to agree to meeting dates and locations that are likely to ensure the participation of as many of the members as possible. When it is unknotted feasible for supervisors to be present at a meeting, best endeavors will be made to allow participation by other means such as by conference call or other electronic means. Tier I members will attempt to meet quarterly, and will attempt to conduct at least one meeting annually in person. The Tier I members may call a meeting together on short notice in the event of an emergency situation. Participation and/or involvement of Tier II and Tier III members will be addressed at least annually.

**Meetings:** At each meeting, each Tier I member should attempt to provide an update on any relevant material event(s) and/or any new information which could have a significant impact on the group-wide risk profile.
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 |
Crisis Management Plan

For the [Group Name] Supervisory College

Introduction

The Insurance Department, as lead regulator (“Group Supervisor” or “Group Lead Regulator”) of the [group name] (“Group”) insurance holding company system, and other regulators of the group and its regulated affiliates (collectively “regulators” each a “regulator” or “college members” each a “member”) may refer to this Crisis Management Plan (“plan”) for managing communication, responsibilities and coordinating regulatory actions relating to the groups regulated and non-regulated affiliates within the framework of the group holding company system.

This plan for this group will support the management of an arising crisis situation by the Department standing as the group lead regulator, and the college participants as defined by the memorandum of confidentiality pertaining to this specific college.

This document is designed to provide a framework for managing communication, responsibilities and coordinating regulatory actions by:

- Defining the responsibilities and channels for sharing information between college members
- Providing a current contact list of supervisory college members (Appendix 1)

College Members shall cooperate closely in a crisis situation, in order to coordinate the actions of the supervisory authorities responsible for the management and resolution of the crisis. This cooperation will be according to their national law and may include other relevant supervisors involved in the crisis management process as necessary.

The Department will coordinate crisis management activities, encouraging the cooperation of actions as well as the exchange of information.

Definition of a Crisis Situation

A crisis situation is defined as any situation or event, regardless of its origin, that happens unexpectedly, demands immediate attention, and could materially affect or impair the financial condition of either the overall group or an insurance entity in a country or jurisdiction with a potential cross-border impact on one or more entities of the Group.

Whenever a potential emergency situation is identified by a member of the Supervisory College regarding an entity that it supervises, the regulator should inform the Department as soon as possible. In any case, if
any of the circumstances listed below occur at an entity level, the member regulator should alert the Department.

- Significant deterioration in a legal entity’s risk-based capital ratio.
- Significant deterioration in a legal entity’s solvency position (below locally accepted criteria).
- Major violation of legal requirements, e.g. coverage of technical reserves,
- Danger of failure of a utilized reinsurer (external or internal),
- Public investigation against managing body of an undertaking (e.g. fraud).
- Macro-economic and financial developments as well as insurance sector specific developments which may affect the financial soundness of the group (contagion risk, etc.).

The Department will share the above information with the other college members within a reasonable time frame.

The Department should also provide information to the college members pertaining to:

- Significant deterioration in the group’s solvency position.
- Unbalanced distribution of available statutory capital and surplus within the group, which is an indicator of problems at a specific legal entity.
- Major violation of legal requirements.
- Liquidity problems caused by the corporate structure or member entities.
- Imminent danger of insolvency of an undertaking of the group.
- Major downgrading of a significant subsidiary’s financial strength rating or group debt rating
- Macro-economic and financial developments as well as insurance sector specific developments that may affect the financial soundness of the group (contagion risk, etc.).

**Crisis Contact List Procedures**

All college members involved in the supervision of the group will have specific personnel and contact information as listed in the crisis contact list in Appendix 1. This contact list should be updated as each annual supervisory college is held, or as requests are made to the Department by members of the college.

**Communication Tools**

The participating regulators will provide the Department with the necessary information to allow for an accurate understanding of the nature of the situation. The Department will then distribute its understanding of the situation to the college members.

In order to manage the exchange of information smoothly and efficiently during a crisis situation, the college may use the most efficient means depending on the situation, such as:

- Conference calls /video conference.
- E-mails.

- Bilateral or multilateral meetings among College Members.

This communication will be coordinated by the Department or by other college members as may be deemed appropriate by the Department for a particular crisis.

Crisis Assessment

Based on the information received, the Department will assess the nature of an emergency situation and its implications for the group in conjunction with the college members. Regulators should perform their own assessment of the crisis and implications to both their legal entity and the group as a whole. Discussions between the Department and college members should include discussion for the crisis at hand and what actions should be undertaken. The decision may be made to monitor the situation or specific factors, contacting other regulators who may have involvement or jurisdiction over portions of the group. Or the determination may be made to intervene, and the discussion should include the intervention mechanisms available to regulators.

Crisis Management

The Department is responsible for planning and coordinating the management of the emergency situation. This will be performed in close cooperation with the college members so that a consistent and coordinated plan of action can be drafted and implemented.

After having assessed and reached a common understanding of the nature of the crisis and its implications, the Department may wish to establish within the college a smaller supervisory team for handling the crisis situation and designate, on the basis of the contact list in Appendix 1, a crisis management team. This might be especially useful if only part of the group is affected. The Department will inform the college members of the establishment of such a team.

Led by the Department, based on the common assessment, the crisis management team should analyze the need, scope and conditions for any supervisory actions to be taken. The analysis should define the following elements:

Which actions are needed?

- What cooperative measures with the company exist that may be helpful?
- What regulatory measures are available at either a holding company level or at a legal entity level (in various involved jurisdictions)?
- If multiple actions may be required, what would the ideal sequence and implementation schedule be?
- What would the ideal outcome be of such actions?
- Would these proposed actions generate unintended consequences and what would their impact be on:
  - The company
  - The regulator
  - The marketplace
  - The industry

- How would these actions be communicated to the company and college participants, as well as other potentially involved parties?

Supervisory actions and information sharing should be coordinated within the supervisory college in order to avoid inconsistencies.

**Other Communication Items**

The Department is in charge of coordinating the College internal communication at each stage of the crisis.

College members should coordinate the external communication of crisis-related information. The Department is normally responsible for co-coordinating the public communication, as required, at each stage of the crisis. Again, this should be done in conjunction with the college members and should consider the possibility of exercising discretion over the information to be to ensure that market confidence is not adversely affected.

In the case when one regulator is obliged to make a separate public statement, it should be ensured:

- Maximum possible coordination with the other regulator and college members, which should be prepared to respond promptly.
- All Regulators should be informed about the statement before its release.
- No use of information delivered by one regulator to another will be made without the consent of the authority delivering the information.
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 I-SITE.
  - 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 percent 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.
V. Group-Wide Supervision – K. Group Code Assignment

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 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).
- If a decision is made to exclude an insurer from a group code, regulators should consider whether any inter-connectedness between the insurer and the group will still be transparent in public disclosures.

The following examples provide unique organizational situations that may require the analyst 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 that 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.
A. INTRODUCTION - BACKGROUND/PURPOSE

The purpose of this document is to provide guidance and best practices for use by state insurance regulators in their regulatory oversight of insurance companies within insurance holding company systems. It is recommended these best practices be incorporated into existing NAIC Publications, such as the Financial Analysis Handbook, which already incorporates the 2005 Holding Company Framework concepts.

The information in this best practice document is meant to provide guidance to state insurance regulators and be an advisory resource.

B. COMMUNICATION/COORDINATION BETWEEN FUNCTIONAL REGULATORS

1. CROSS-BORDER AND OTHER FINANCIAL SECTOR COORDINATION

Insurance holding company systems can include numerous U.S. non-insurance entities that are regulated by other U.S. federal or state regulatory authorities (e.g., Securities and Exchange Commission, Office of Thrift Supervision, Federal Reserve Board, Centers for Medicare and Medicaid Services, etc.) as well as non-U.S. insurance or non-insurance entities regulated by international regulatory authorities. Efficient and effective financial regulatory oversight of the domestic insurer includes communicating and coordinating during the examination and through the quarterly analysis processes, when necessary, with other regulatory bodies which have authority over entities within the group that directly or indirectly impact the insurer. The direct or indirect impact can result from various relationships including ownership and control, reputation, board of director influence, reinsurance and other affiliated transactions and agreements.

Steps to achieving successful cross-border and other financial sector coordination include:

- Understand the holding company structure and intercompany relationships. Review Schedule Y, Form B and other information available to identify other entities within the holding company system. Identify intercompany relationships: reinsurance, management and cost-sharing agreements, common management, and boards of directors.

- Identify the functional regulators of entities within the holding company system. In addition to other state insurance regulators, identify U.S. Federal or state authorities, foreign insurance regulators with authority over foreign parents, subsidiaries or affiliates.

- Establish points of contact and communication channels with other functional regulators.

- Establish a plan for communication with other functional regulators. Establish the timing, frequency and scope of discussions. The communication plan may vary depending on the nature and materiality of intercompany relationships, the financial solvency of the insurer, the financial solvency of the other entities within the group, and whether Form A or Form D applications have been filed, or if regulatory actions are being considered or taken by either the insurance department or the other functional regulator(s) on entities within the group.
Establish confidentiality agreements or memorandums of understanding (MOUs) with other functional regulators. Regarding the confidentiality of sensitive company information that is provided to or received from other functional regulators, the insurance department should establish confidentiality agreements or a memorandum of understanding with that functional regulator to ensure that confidentiality can be maintained.

2. INFORMATION FROM FEDERAL AGENCIES

When state insurance regulators coordinate with other functional federal regulators, efforts should be made to attempt to share information on the respective regulated entities within the holding company system. The attached Federal Agency Holding Company Regulation table in Section V. L. Holding Company Best Practices – F. provides a list of federal agency reports that could be requested by state insurance regulators under the MOUs in place. In addition to the items listed in Section V. M. Holding Company Best Practices – F., state insurance regulators could request from functional regulators copies of any internally-generated reports, recommendations, oversight plans, regulatory orders, management comment letters or any type of agreement pertaining to the holding company and/or any subsidiary within that holding company system.

3. COMMUNICATION/COORDINATION OF HOLDING COMPANY INFORMATION

It is important for state insurance departments to communicate with other state insurance departments about analysis, examination and other regulatory findings and to coordinate regulatory activities on insurers within a holding company system. The following sections deserve special mention:

- Role of the Lead State
- Utilizing the Lead State Report
- Sharing the Insurer Profile Summary and Holding Company Analysis Work papers

ROLE OF THE LEAD STATE

As already outlined in this Financial Analysis Handbook, the lead state concept is intended to facilitate effectiveness and efficiencies when one or more state(s) coordinate and communicate the regulatory processes and perspectives of all states involved. Its importance was stressed in the passage of the Gramm-Leach-Bliley Act (GLBA). The concept is not intended to relinquish the authority of any state, increase any state’s statutory authority, nor is it intended to put any state at any disadvantage.

The role of the Lead State(s) encompasses many responsibilities, which vary depending upon the size and complexity of the group and situations creating the need for regulatory coordination. For example, the lead state(s) should coordinate the review of the holding company system, which includes an analysis of the group’s financial results and overall business strategy, or coordinate discussion on a Form A filing. The Lead State should serve as a liaison for other financial or international regulatory requests, when the holding company system includes non-insurance or non-U.S. domestic insurance entities that are regulated by other functional or international regulators. This communication will allow
for more effective and efficient regulation on key issues impacting the holding company system.

Other communication and coordination activities hosted by a lead state may include, but are not limited to, the following activities:

- Communicate supervisory activities regarding troubled insurers with other state insurance departments, functional regulators and/or international regulators.
- Coordinate analysis or examinations efforts, where feasible.
- Consensus assignment of specific regulatory tasks among different state insurance departments in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise.
- Coordinate information requests to management.
- Initiate Supervisory Colleges of groups (See Supervisory College section for guidance)

**USING THE LEAD STATE REPORT**

The Lead State Report is an important regulator only tool that state insurance regulators can utilize to establish direct lines of communication among insurance departments to coordinate holding company analysis efforts. The report provides the name and contact information for the analyst or supervisor assigned to each insurer within an insurance holding company group (i.e., an entity with a group code).

In order for the report to continue to be useful to regulators, it must be maintained by regulators. The information regarding the assigned analyst can be updated by the state in an effort to ensure it remains up to date. States are encouraged to notify NAIC Financial Analysis staff any time of any other changes to the report that are necessary. It is recommended states review the report prior to each annual statement filing to ensure the contact information is correct.

**SHARING THE INSURER PROFILE SUMMARY**

The Insurer Profile Summary is a “living document” maintained by the state of domicile to “house” high-level summaries of risk-focused financial analysis, examinations, internal and external changes, priority scores, supervisory plans, and other standard information. In order to prepare a complete and comprehensive holding company analysis, it is recommended each state provide the profile of their domestic insurer to the lead state(s) or designee (i.e., state within the group conducting the coordinated holding company analysis) upon request.

The documentation contained in the Insurer Profile Summary is generally considered proprietary, confidential information that is not intended to be distributed to individuals other than state insurance regulators, without the express written consent of the applicable state insurance department. This documentation, if needed, should be requested in writing and state that the requesting state has the ability under its laws and regulations to maintain the information as confidential, and specifying the requesting state’s law.
SUMMARY OF BEST PRACTICES ON HOW TO ACCOMPLISH INFORMATION SHARING

- Actively participate as a Lead State carrying out the responsibilities of a lead state and encouraging communication and coordination among regulators of the group.
- If your state is not the Lead State, contact the lead state(s) as necessary to discuss outstanding issues and seek information.
- Proactively request and share the Insurer Profile Summaries on insurance legal entities within the group.
- Update your state’s contact information on the Lead State Report at least quarterly.
- In potentially troubled insurance company situations, share information and/or host conference calls with other impacted states (domiciliary, licensed or business written) as soon as issues are identified at either the insurer or its holding company.
- Update and utilize the NAIC’s Form A Database. Contact the lead state or other states within the group to discuss Form A filings, Form D filings or other material transactions either at the insurer or holding company level. Depending on the magnitude and scope of the transaction, it is best to engage in discussions with other regulators during the review process, prior to approval or denial of the transaction, to understand and coordinate regulatory actions.
- Establish routine schedules for communication between states and other functional and international regulators, where relevant. This may be most applicable for large groups, groups with numerous or complicated affiliated transactions and interdependencies, or stacking of insurance company ownerships (i.e., insurer owns insurer). Consideration should be given to calling Supervisory Colleges for some groups. In doing so, it should be well understood that in those holding company structures where the lead state is not the group-wide supervisor (e.g. with groups based outside of the U.S. or where the Federal Reserve is the group-wide supervisor), and in accordance with accreditation standards, lead states may choose to rely on the analysis work performed by international insurance supervisors or another functional regulatory (e.g., the Federal Reserve). However, 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, they are responsible for notifying all other domestic states.

C. OWNERSHIP AND CONTROL

1. MERGERS & ACQUISITIONS OF CONTROL – UNIFORM PRACTICES

BEST PRACTICES
Notify lead state(s) of any merger or acquisition involving your domestic insurer(s) within the holding company.

Lead state(s) and domestic state(s) involved in transaction should decide if the transaction is material to the holding company.

If transaction is deemed to be material, the lead state(s) should notify all states with domestic companies in the holding company and all other functional international and federal regulators of the pending transaction along with the purpose of the transaction.

Depending on the nature of the transaction, the lead state(s) or domestic state(s) should regularly communicate with all states and other functional regulators, as warranted, to provide updates on the transaction and get feedback from the other states and regulators. If warranted, based on the nature or significance of the transaction, consider the formation of an NAIC “Subgroup” to facilitate timing, review and effective communication.

Merger(s)

Merger 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:

- 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

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 of the actual documents to be executed related to the acquisition.

2. **COORDINATION OF FORM A REVIEWS**

When an insurance department receives a Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer (Form A) filing involving an insurer in a group with multiple states or other functional regulators (i.e., state, federal, or international), the insurance department should: (1) inform the other regulators, (2) maintain communication throughout the filing review process, and (3) coordinate analysis efforts and regulatory actions with the other impacted regulators. Depending on the size and complexity of the acquisition/merger, the lead state(s) may need to take responsibility for the coordination and facilitation of communication. Regardless of whether a joint hearing is requested, 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.
BEST PRACTICES

- Lead state(s) or designee should assume the role of coordinator and communication facilitator. 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.

- 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 should encourage analysts to sign up for 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.

- 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 when deemed necessary by the lead state as set forth in the Insurance Holding Company Model Act ( #440). If the proposed acquisition of control will require the approval of more than one commissioner, Model #440 provides that a public hearing may be held on a consolidated basis upon request of the person filing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten (10) business days of the receipt of the statement by the commissioner. A hearing conducted on a consolidated basis shall be public and shall be held within the United...
States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner or designee may attend such hearing, in person or by telecommunication.

D. **STANDARDS OF MANAGEMENT OF AN INSURER WITHIN A HOLDING COMPANY SYSTEM**

1. **FORM A EXEMPTIONS**

The following are suggestions for additional oversight when considering an exemption under §440 Section 3E (2) of the Holding Company Act. Specifically the following should be considered when reviewing an exemption 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.

2. CORPORATE GOVERNANCE POLICIES

The following are suggestions when reviewing corporate governance policies within the holding company system.

OPERATIONAL AND LEGAL RISK - UNSUITABLE INFRASTRUCTURE DUE TO LACK OF POLICIES, PROCEDURES AND/OR RESOURCES

Regarding Model #440 Section 4 – Registration of Insurers and Section 5 – Standards and Management of an Insurer within a Holding Company System; holding company group members may inappropriately shift insurance company assets to other group members.

BEST PRACTICES

- Make management responsible to ensure assets remain as such unless otherwise approved by the domiciliary jurisdiction.
- The insurer’s management should be responsible for ensuring that an annual evaluation is made of corporate governance and internal control procedures and for communicating the results of the evaluation to the board of directors.
- The senior management corporate governance and internal control procedures should be reviewed and assessed when deemed necessary.

E. AFFILIATED MANAGEMENT AND SERVICE AGREEMENTS

1. CHARGES FOR FEES FOR SERVICES

SSAPs 25 and 70 and Appendix A-440 discuss the Transactions Involving Services, Allocation of Costs, and Other Management Requirements.

Transactions entered into at arm’s length by 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. 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.
Transactions at Market Rate – there are at least three ways to establish fairness and reasonability with substantiating documents:

- The entity providing the service performs a substantial portion of its business with non-affiliated entities and can establish a price for affiliates similar to charges 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. Since each transaction of service is unique, determining a fair and reasonable charge is very difficult and time consuming. This method is the least relevant and reliable, and not efficient in establishing the rate.

- Transactions at cost plus mark-up that is equal to market rate should be reviewed carefully and should be deemed fair and reasonable. Transactions at cost plus mark-up that is less than market rate should be reviewed carefully to determine if it is fair and reasonable.

Transactions at Cost – this is the simplest method to determine fair and reasonable. The costs borne by the entity providing the agreed upon services are simply allocated to the entity receiving those services. As stated in the SSAPs, cost allocation must be done in ways that yield the most accurate results. Theoretically the service provider should not make a profit or incur a loss if the transaction is at cost.

- 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.

- Transactions at cost less a discount should be reviewed carefully to determine if it is fair and reasonable.

If cost is the method used (or required) to establish “reasonability,” identifying a “rate per unit” estimated on the amount of costs and number of units, does not in and of itself make the charge reasonable. This rate per unit is a close approximation of the actual costs. Using a rate per unit is merely a method for easily calculating interim payments that are due to the provider of the service. If a rate per unit is used to allocate costs, an expense “true-up” needs to be prepared and settled at least annually to reconcile the estimated costs (payments) with the actual costs incurred. The expense “true up” essentially replaces the estimated amounts with the actual amounts and includes the subsequent settlement of any differences.

Note: alien transactions will need additional deliberation due to potential conflicts between international tax laws and provision of services at cost vs. market.

2. **REGULATOR CONSIDERATIONS**

Items for initial filing review—the actual document(s) should be filed, not merely a summary:

- Identify and document:
The specific services that will be provided.
  - The specific expenses and/or costs that are to be covered by each party.

The entity(ies) providing and receiving each of those services.
  - Separate affiliate entities from non-affiliates.

Allocation method (market or cost) of the agreement.
  - The charges or fees for the services indicated.

The accounting basis used to apportion expenses.

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.
- Determine the agreement does not divert funds that could be considered a dividend.
- 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.
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<td>Denver Regional Office Donald Hoerl, Regional Director 1801 California Street, Suite 1500 Denver, CO 80202-2656 (303) 844-1000 e-mail: <a href="mailto:denver@sec.gov">denver@sec.gov</a> State jurisdiction: Colorado, Kansas, Nebraska, New Mexico, North Dakota, South Dakota, Wyoming</td>
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<td>FFIEC 041</td>
<td>Required of each bank, saving association, BHC and SLHC that is subject to the Advanced Capital Adequacy Framework to determine their capital requirements. <a href="http://www.ffiec.gov/ffiec/report/forms.htm">http://www.ffiec.gov/ffiec/report/forms.htm</a></td>
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<td>Required of U.S. commercial banks and BHCs holding $30 million or more in claims on residents of foreign countries. See the report instructions for additional criteria. <a href="http://www.ffiec.gov/ffiec_report_forms.htm">http://www.ffiec.gov/ffiec_report_forms.htm</a></td>
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<td>FFIEC 009a</td>
<td>Respondents file the FFIEC 009a if exposures to a country exceed 1 percent of total assets or 20 percent of capital of the reporting institution. FFIEC 009a respondents also furnish a list of countries in which exposures were between 3/4 of 1 percent and 1 percent of total assets or between 15 and 20 percent of capital. <a href="http://www.ffiec.gov/ffiec_report_forms.htm">http://www.ffiec.gov/ffiec_report_forms.htm</a></td>
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<tr>
<td>FFIEC 009a</td>
<td>The Home Mortgage Disclosure Act (HMDA) was enacted by Congress in 1975 and was implemented by the Federal Reserve Board’s Regulation C. On July 21, 2011, the rule-writing authority of Regulation C was transferred to the Consumer Financial Protection Bureau (CFPB). Regulation C, requires lending institutions to report public loan data. <a href="http://www.ffiec.gov/hmda/forms.htm">http://www.ffiec.gov/hmda/forms.htm</a></td>
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<tr>
<td>FRB FR H- (b)11</td>
<td>Required of exempt SLHCs.¹ Report includes SEC filings, audited annual financial statements, quarterly financial statements, descriptions of material events, etc. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<tr>
<td>FR 2320</td>
<td>Required of exempt top-tier SLHCs. However, if a top-tier SLHC is not required to file the FR 2320, then a lower-tier SLHC must file FR 2320. Such determination as to which SLHC will be required to file the FR 2320 will be made by the district Federal Reserve Bank. In addition, lower-tier SLHCs may voluntarily file the FR 2320 or may be required to file (in addition to the top-tier SLHC) for safety and soundness purposes at the discretion of the district Federal Reserve Bank. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<tr>
<td>FR Y-8</td>
<td>All top-tier BHCs, including financial holding companies, must provide this report for each insured depository institution that they own. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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¹ An exempted SLHC includes (1) a grandfathered unitary SLHC whose assets are primarily commercial and whose thrifts make up less than 5 percent of its consolidated assets; and (2) a SLHC whose assets are primarily insurance-related and who does not otherwise submit financial reports with the Securities and Exchange Commission pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934. (76 FR 81933).
<table>
<thead>
<tr>
<th>Report Code</th>
<th>Description</th>
<th>Details</th>
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<tbody>
<tr>
<td>FR Y-9C</td>
<td>Consolidated Financial Statements for Holding Companies</td>
<td>All top-tier bank holding companies (BHCs), savings and loan holding companies (SLHCs), and a securities holding company (SHCs) with consolidated assets of $500 million or more, and holding companies meeting certain criteria regardless of size, must file this report. See the instructions for further detail. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<tr>
<td>FR Y-9LP</td>
<td>Parent Company Only Financial Statements for Large Holding Companies</td>
<td>All BHCs, SLHCs, and SHCs with a parent that files the FR Y-9C must file this parent company only report. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
</tr>
<tr>
<td>FR Y-9SP</td>
<td>Parent Company Only Financial Statements for Small Holding Companies</td>
<td>All BHCs, SLHCs, and SHCs with consolidated assets less than $500 million, except holding companies that meet certain criteria and file the FR Y-9C, must file this parent company only report. See the instructions for further detail. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
</tr>
<tr>
<td>FR Y-9ES</td>
<td>Financial Statements for Employee Stock Ownership Plan Holding Companies</td>
<td>All Employee Stock Ownership Plans (ESOPs) that are also BHCs or SLHCs as of the last calendar day of the year must file this report. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<tr>
<td>FR Y-11</td>
<td>Financial Statements of U.S. Nonbank Subsidiaries of U.S. Holding Companies</td>
<td>Required of any top-tier holding companies file the FR Y-11 report quarterly for each individual nonbank subsidiary that is owned or controlled by a holding company that files the FR Y-9C and if the nonbank subsidiary has (a) total assets of $1 billion or more, or (b) total off-balance sheet activity of $5 billion or more, or (c) equity capital of at least 5 percent of the consolidated equity capital of the top-tier holding company, or (d) operating revenue of at least 5 percent of consolidated operating revenue of the top-tier holding company. Top-tier holding companies file the FR Y-11 annually for each individual nonbank subsidiary (that does not meet the criteria for filing quarterly) with total assets of $500 million or more and less than $1 billion. Top-tier holding companies file the FR Y-11S report annually for each individual nonbank subsidiary (that does not meet the criteria for filing quarterly) with assets of at least $250 million and less than $500 million. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<tr>
<td>FR Y-12</td>
<td>Consolidated Holding Company Report of Equity Investments in Nonfinancial Companies</td>
<td>A holding company that files the FR Y-9C and holds, either directly or indirectly through a subsidiary or affiliate, any non-financial equity investments with a Small Business Investment Company (SBIC) structure, or under section 4(c)(6) or 4(c)(7) of the Bank Holding Company Act, or pursuant to the merchant banking authority of section 4(k)(4)(H) of the Bank Holding Company Act, or pursuant to the investment authority granted by Regulation K, and has aggregate nonfinancial equity investments equal or exceed the lesser of $100 million (on an acquisition cost basis) or 10 percent of the holding company’s consolidated Tier 1 capital as of the report date. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<tr>
<td>FR Y-12</td>
<td>Consolidated Holding Company Report of Equity Investments in Nonfinancial Companies</td>
<td>A holding company that files the FR Y-9SP and holds, either directly or indirectly through a subsidiary or affiliate, any non-financial equity investments with a Small Business Investment Company (SBIC) structure, or under section 4(c)(6) or 4(c)(7) of the Bank Holding Company Act, or pursuant to the merchant banking authority of section 4(k)(4)(H) of the Bank Holding Company Act, or pursuant to the investment authority granted by Regulation K, and has aggregate nonfinancial equity investments that equal or exceed 10 percent of the holding company’s total capital as of the report date. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<tr>
<td>FR Y-12A</td>
<td>Annual Report of Merchant Banking Investments Held for an Extended Period</td>
<td>Financial holding companies (FHCs) that have owned, controlled or held investments under the Merchant Banking Authority (section 4(k)(4)(H) of the Bank Holding Company Act and Subpart J of Regulation Y) for a period that exceeds the “applicable reporting period” for the investment, as of December 31 of the relevant calendar year. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<tr>
<td>FR Y-14A/M/Q</td>
<td>Capital Assessments and Stress Testing</td>
<td>Any top-tier BHC (other than a FBO), that has $50 billion or more in total consolidated assets, as determined based on: (i) the average of the BHC’s total consolidated assets in the four most recent quarters as reported quarterly on the BHC’s FR Y-9C; or (ii) the average of the BHC’s total consolidated assets in the most recent consecutive quarters as reported quarterly on the BHC’s FR Y-9Cs, if the BHC has not filed an FR Y-9C for each of the most recent four quarters. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<td>FRB</td>
<td>Report Type</td>
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<tr>
<td>FRB</td>
<td>FR Y-15</td>
<td>BHCs with total consolidated assets of $50 billion or more as of the June 30th prior to the December 31st as-of date, and any BHC organized under the laws of the U.S. or any of the states therein that is identified as a global systemically important bank and does not meet the consolidated assets threshold. Only the top tier BHC of a multi-tiered company that meets these criteria must file.</td>
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<tr>
<td>FRB</td>
<td>FR Y-16</td>
<td>Any BHC or SLHC with average total consolidated assets of greater than $10 billion but less than $50 billion, and any affiliated or unaffiliated state member bank (SMB) that has average total consolidated assets of greater than $10 billion but less than $50 billion excluding SMB subsidiaries of covered companies.</td>
</tr>
<tr>
<td>FRB</td>
<td>FR Y-20</td>
<td>Required of all BHCs that applied and received Federal Reserve Board approval under section 4(c)(8) of the Bank Holding Company Act and section 225.23 of Regulation Y for their designated Section 20 subsidiaries to engage in underwriting and dealing in bank-ineligible securities to a limited extent. The parent company includes a foreign bank that is treated as a BHC under the International Banking Act of 1978 and the Bank Holding Company Act of 1956.</td>
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<tr>
<td>FRB</td>
<td>FR 2314</td>
<td>A U.S. banking organization must file quarterly for its subsidiary if the foreign subsidiary is owned or controlled by a parent U.S. holding company that files the FR Y-9C, or a state member bank or an Edge Act or agreement corporation that has total combined assets of $500 million or more and if the nonbank subsidiary has (a) total assets of $1 billion or more, or (b) total off-balance sheet activity of $5 billion or more, or (c) equity capital of 5 percent or more of the consolidated equity capital of the top-tier organization, or (d) operating revenue of 5 percent or more of the consolidated operating revenue of the top-tier organization.</td>
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<td>FRB</td>
<td>FR 2314S</td>
<td>A U.S. holding company must file the FR 2314 report annually for its foreign subsidiary (that does not meet the criteria for filing quarterly) if the foreign subsidiary has total assets of $500 million or more and less than $1 billion. A holding company must file the FR 2314S report annually for its foreign subsidiary (that does not meet the criteria for filing quarterly) if the foreign subsidiary has assets of $250 million or more and less than $500 million.</td>
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<tr>
<td>FRB</td>
<td>FR Y-6</td>
<td>Annual Report of Holding Companies</td>
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<td>Required of all top-tier holding companies organized under U.S. law, any top-tier holding company that is organized under foreign law but is not a foreign banking organization, any foreign banking organization that does not meet the requirements of and is not treated as a qualifying foreign banking organization under Regulation K, any employee stock ownership plans that are also holding companies, and any securities holding companies. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<tr>
<th>FR Y-10</th>
<th>Report of Changes in Organizational Structure</th>
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<td>Required of all top-tier BHCs, (including employee stock ownership plans (ESOPs) or employee stock ownership trusts (ESOTs) that are BHCs, including FHCs; top-tier SLHCs, ESOPs, ESOTs, or trusts that are SLHCs pursuant to Regulation LL; state member banks that are not controlled by a BHC or an FBO; Edge and agreement corporations that are not controlled by a member bank, a domestic BHC, or an FBO; nationally chartered banks, with regard to their foreign investments only, that are not controlled by a BHC or an FBO; security holding companies; and FBOs. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
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<td><strong>Agency</strong></td>
<td><strong>SEC</strong></td>
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VI. Guidance for Notes to Financial Statements
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Note 1 – Summary of Significant Accounting Policies and Going Concern

This Note is split into four primary sections. Section (A) focuses on the insurer’s accounting policies compared to the NAIC Accounting Practices and Procedure Manual (AP&P Manual) and is required as a result of Statement of Statutory Accounting Principles (SSAP) No. 1, Disclosure of Accounting Policies, Risks and Uncertainties, and Other Disclosures (SSAP No. 1). Section (B) is also required by SSAP No. 1 and is focused on the insurer’s compliance with the Annual Statement Instructions, the AP&P Manual, and the insurer’s use of estimates. Section (C), also required by SSAP No. 1, focuses on disclosure of all accounting policies that materially affect the assets, liabilities, capital and surplus, or results of operations. Section (D), also required by SSAP No. 1 effective December 31, 2016, focuses on the insurer’s going concern disclosures. These sections provide information that an analyst should use in evaluating the accounting procedures of the insurer.

Section (A) of this Note is broken into two parts. The first part of section A addresses accounting policies that differ from the AP&P Manual. The second part of section A addresses accounting policies not discussed in the AP&P Manual.

The analyst should use the information provided in the first part of section (A) of this Note to determine if an insurer’s financial position would be different if all the accounting rules of the NAIC were followed. Not only does the disclosure require the insurer to indicate permitted practices that have been provided by the state of domicile (a disclosure that was previously required by the Model Audit Rule), but it also requires that prescribed differences be disclosed. 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. 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 5 percent or greater as a result of applying the NAIC methods. A difference of this magnitude indicates that the insurer’s financial position may vary significantly from what is reported using the accounting rules that have been established by the state of domicile.

The analyst should use the information provided in the second part of section (A) of this Note to determine if the insurer has any unusual transaction(s) for which the NAIC has not developed any standard accounting rules. 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 analyst should review the insurer’s disclosure to obtain an understanding of the transaction(s). 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 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.

Section (B) of this Note requires the insurer to disclose its compliance with the NAIC Annual Statement Instructions. 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.
VI. Guidance for Notes to Financial Statements

The analyst should use the information provided in section (C) of this Note to determine if the insurer has used any unusual accounting methods for its invested assets. 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 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.

Section (D) of this Note requires the insurer to provide going concern disclosures after management’s evaluation of the insurer’s ability to continue as a going concern and consideration of management’s plans to alleviate any substantial doubt about the insurer’s ability to continue as a going concern. The disclosures are required for annual and interim reporting periods effective December 31, 2016. Early application of the going concern guidance is permitted. 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; management’s 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.

Note 2 – Accounting Changes and Corrections of Errors

This Note focuses 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 (SSAP No.3). It includes four sections that require additional details regarding the accounting changes and corrections of errors. The information provided in this Note can be helpful in assessing the continuing operations of the insurer.

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 percent 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.

The analyst should also 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 percent or greater. 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 (SSAP No. 24), 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.

The analyst should also use the information provided in this Note to understand any change in 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.

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.

**Note 3 – Business Combinations and Goodwill**

This Note has four primary sections. Section (A) focuses on statutory purchases, section (B) focuses on statutory mergers, section (C) focuses on assumption reinsurance and Section (D) focuses on impairment losses.

For the first part of business combinations, the statutory purchase method is addressed in section (A) and is probably the most common. The accounting guidance for the statutory purchase method is discussed in SSAP No. 68, *Business Combinations and Goodwill* (SSAP No. 68) and SSAP No. 97, *Investments in Subsidiary, Controlled and Affiliated Entities, A Replacement of SSAP No. 88* (SSAP No. 97). One of the most significant aspects of SSAP No. 68 as superseded by SSAP No. 97 provides that 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.

The second type of business combination, the statutory merger, is addressed in section (B) of the Note. The accounting guidance for this type of business combination is also discussed in SSAP No. 68. The 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.

The third type, assumption reinsurance, is addressed in section (C) of the Note. This section of the note requires the insurer to disclose information regarding goodwill resulting from assumption reinsurance. This includes the name of the ceding entity, the type of business assumed, the cost of the acquired business and the amount of goodwill, and also the amount of amortization of goodwill recorded for the period.
VI. Guidance for Notes to Financial Statements

As described above, the analyst should use the information in the first three 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 (D) 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.

Note 4 – Discontinued Operations

This note is split into four different sections and each requires the insurer to report certain information on discontinued operations. 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. 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.

The first section requires an insurer to describe the facts and circumstances leading to the disposal or expected disposal and a description of the expected manner and timing of the disposal, loss recognized on the disposal as well as certain carrying amount, fair value and income received amounts.

The second section requires an insurer to disclose the rationale if the entity decides to change its plan of sale for the discontinued operation, disclose a description of the facts and circumstances leading to the decision to change the plan and the effect on the assets reported in the financial statements.

The third section requires the insurer to describe the nature of any significant continuing involvement with a discontinued operation after the disposal transaction, including a description of the activities that brings about the continuing involvement by the insurer and the period of time the involvement is expected to continue as well as the impact on the financial statement from the continued involvement.

The fourth section requires that in the event the entity decides to retain ownership or equity interest in the discontinued operations after the disposal date, the insurer provides information regarding the ownership or equity interest before and after the disposal transaction and the entity’s share of the income or loss of the investee as of the year-end reporting date after the disposal transaction.

All of this information should be used to obtain a greater understanding of the transaction. 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 use the information provided to gain a greater understanding of why the segment was discontinued. The analyst should consider if the disposal was approved by the domiciliary state and if a plan of run-off was also approved.

Note 5 – Investments

This Note is split into twelve primary sections. Section (A) focuses on the 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 (SSAP No. 37). Section (B) focuses on the recording of the investment in loans
VI. Guidance for Notes to Financial Statements

that have been recognized as impaired as required by SSAP No. 36, *Troubled Debt Restructuring* (SSAP No. 36). Section (C) focuses on 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* (SSAP No. 39). Section (D) focuses on determining sources of prepayment assumptions for yield calculations and the risk exposure in loan-backed securities as required by SSAP No. 43R, *Loan-backed and Structured Securities* (SSAP No. 43R). Section (E) focuses on the 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, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* (SSAP No. 103). Section (F) focuses on the 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* (SSAP No. 40). Section (G) focuses on information regarding the investment in low-income housing tax credit (LIHTC) properties and the accounting for the asset and income associated with it as required by SSAP No. 93, *Accounting for Low Income Housing Tax Credit Property Investments* (SSAP No. 93). Section (H) focuses on the recording of restricted assets, which are assets pledged to others as collateral or otherwise restricted by the insurer. Section (I) focuses on the recording of the book/adjusted carrying value of working capital finance investments in aggregate, as required by SSAP No. 105, *Working Capital finance Investments* (SSAP No. 105). Section (J) focuses on disclosures regarding the offsetting and netting of assets and liabilities as required by SSAP No. 64, *Offsetting and Netting of Assets and Liabilities* (SSAP No. 64). Section (K) focuses on disclosure regarding structured notes as defined per the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*. Section (L) focuses on disclosure regarding 5* securities as defined per the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*. All twelve sections of this Note include significant parts, but each part of each section simply requires additional details. 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.

The information provided in section (A) of this Note can be helpful in quantifying the insurer’s investment in mortgage loans, including mezzanine real estate loans, and assessing the impact of impaired loans. The analyst should use the information provided in this section to 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.

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, 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. 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.

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.

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
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operations, direct write-downs charged against the allowance, and recoveries of amounts previously charged off.

The analyst should use the information provided for mortgage loans derecognized as a result of foreclosure to evaluate the impact on assets as a result of the foreclosure. The information provided in this section also allows the analyst to evaluate the collateral recognized on the foreclosed mortgage loans.

The information provided in section (B) of this Note can be helpful in quantifying the insurer’s investment in loans determined to be impaired. The analyst should use the information provided in this section to determine whether the insurer has recorded the investment in loans recognized as impaired as prescribed by SSAP No. 36.

The analyst should consider the information disclosed in this section to evaluate the insurer’s investment in loans impaired and the terms agreed upon for debt restructuring. The analyst should note 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.

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 note 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.

The analyst should consider the information provided in section (D) to gain an understanding of the insurer’s assumptions in determining prepayment of loan-backed securities. The information should help the analyst determine how closely the insurer followed the principles of valuation and prepayment assumptions as prescribed by SSAP No. 43R. As described in SSAP No. 43R 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 with other-than-temporary impairments have not been recognized in earnings.

Prepayments are a significant and variable element in the cash flow of a loan-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
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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. Loan-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.

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 note 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. 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.

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 schedules should be disclosed by the insurer. 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. The insurer should provide details, including contract terms and the collateral’s current fair value, on accepted transactions of collateral that is not permitted by contract or custom to sell or repledge. For all securities lending transactions, the insurer should disclose collateral for transactions that extend beyond one year from the reporting date.

The information provided in section (F) of this Note can be helpful in quantifying the insurer’s investment in real estate determined to be impaired. The analyst should use the information provided in
VI. Guidance for Notes to Financial Statements

this section to determine whether the insurer has recorded the investment in real estate recognized as impaired as prescribed by SSAP No. 40. 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 real estate impaired. 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 and the planned expenditures and recorded obligations for improvements.

The analyst should use the information provided in section (G) of this Note to gain an understanding of an insurer’s investment in LIHTC properties. The insurer is required by SSAP No. 93 to provide the number of remaining years of unexpired tax credits and the required holding period for the LIHTC investments, as well as comment on whether any LIHTC properties are currently subject to any regulatory reviews and the status of such review. The insurer is also required to provide details regarding the ownership, accounting policies, and valuation of each partnership or limited liability company investment if the aggregate investment in LIHTC properties exceeds 10 percent of total admitted assets. In addition, the insurer is required to disclose any recognized impairments and the nature of any write-downs or reclassifications made during the year. 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 or reclassifications.

Section (H) 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 percent of total cash and invested assets. Restricted assets impact liquidity as they are not assets available to pay policyholder claims.

Section (I) requires the reporting entity to disclose certain working capital finance investments on an aggregate basis regarding the book/adjusted carrying value, by NAIC designation as required by SSAP No. 105. 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.

Section (J) for Life/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.

Section (K) requires the reporting entity to disclose the following per the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*: the CUSIP, actual cost, fair value, and book/adjusted carrying value of the structured note. The reporting entity is also required to disclose if the structured note is a Mortgage-Referenced Security. The analyst should review the structured note procedures in Section
III – Annual Procedures – Level 2 Investments to determine if there are concerns due to the level of investment in structured notes. The information provided in this note identifies structured notes and, if material, should be reviewed in conjunction with the Level 2 procedures on structured notes.

Section (L) requires the reporting entity for each annual reporting period, to provide a comparable disclosure to the prior annual reporting period of the number 5* securities, by investment type, and the book adjusted carrying value and fair value for those securities, per the Purposes and Procedures Manual of the NAIC Investment Analysis Office, Special Reporting Instructions.

**Note 6 – Joint Ventures, Partnerships and Limited Liability Companies**

This Note focuses on investments in joint ventures, partnerships, and limited liability companies and is split into two primary sections. Section (A) requires the insurer to disclose information about investments in joint ventures, partnerships, and limited liability companies that exceed 10 percent of the admitted assets of the insurer. Section (B) requires the insurer to disclose specific information on the above types of investments that have become impaired.

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). 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 of these investments that are held by the insurer, 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.

**Note 7 – Investment Income**

This Note is split into two primary sections. Section (A) 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.34), SSAP No. 26, Bonds, Excluding Loan-Backed and Structured Securities (SSAP No. 26), and SSAP No. 32, Investments in Preferred Stock (including investments in preferred stock of subsidiary, controlled, or affiliated entities) (SSAP No. 32). Section (B) discloses the amount the insurer non-admits upon determining collectability of due and accrued investment income. The information provided in both sections is helpful to the analyst in reviewing the financial statements and related exhibits and schedules for real estate, mortgage loans, and long-term bonds.
VI. Guidance for Notes to Financial Statements

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 (SSAP No. 4) 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. 5R, Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R) 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.

Note 8 – Derivative Instruments

This Note contains six sections. Section (A) focuses on 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, Accounting for Derivative Instruments and Hedging, Income Generation, and Replication (Synthetic Asset) Transactions (SSAP No. 86). The discussion provided in section (A) of this Note can be helpful in determining the insurer’s risk exposure associated with its derivative investments. Section (B) focuses on the insurer’s objectives for holding or issuing derivative financial instruments and is also required under SSAP No. 86. The information provided in section (B) of this Note is useful in understanding the insurer’s investment strategy in regards to its use of derivative instruments. Section (C) focuses on how each category of derivative instrument is reported in the financial statements and is also required by SSAP No. 86. The information provided in section (C) is helpful to the analyst in reviewing the financial statements and, more specifically, the related schedules, for derivatives and exhibits for investment income from derivatives and gains and losses on derivatives. The information provided in sections (D) and (E) assist the analyst in evaluating the portion of the unrealized gains or losses on derivatives that represents derivatives excluded from the assessment of hedge effectiveness or no longer qualifying for hedge accounting. The information in section (F) provides details about derivatives accounted for as cash flow hedges of a forecasted transaction.

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.
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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.

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. For additional discussion of derivative instruments, see Section III – Analyst Reference Guide – Level 2 Investments – Primer on Derivatives.

The analyst should consider the information disclosed in the Primer on Derivatives in conjunction with information provided 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 percent of net investment income or if the insurer is experiencing capital losses on derivative instruments of more than 10 percent of capital and surplus. In cases where the insurer’s total derivative instruments represent more than 10 percent of capital and surplus, special attention should also be given to this Note. For specific guidance in evaluating the materiality of an insurer’s risk to derivatives, see Section III – Annual Procedures – Level 2 Investments.

The analyst should consider the information disclosed in section (D) 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. 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.

The analyst should consider the information disclosed in section (E) 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.

The analyst should consider the information disclosed in section (F) 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.

**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 and liabilities 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. 10R and SSAP No. 10* (SSAP No. 101),
simply requires the recognition of the tax consequences of that transaction or event in the financial
statements. Note that SSAP No. 101 became effective January 1, 2012.

**Income Tax Assets**
Current income tax recoverables include all current income taxes, including interest (net of federal tax),
reasonable 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 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.

Deferred tax liabilities (DTLs) represent temporary differences that will result in future taxable amounts.
Deferred tax assets (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.” The easiest way to
understand the concept of a temporary difference is to review an example of one.

One of the most common types of temporary differences for life insurers is deferred acquisition expenses.
SSAP No. 71, *Policy Acquisition Costs and Commissions* (SSAP No. 71), 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 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 accident and health), 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
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revenue and expense streams. The following illustrates the temporary difference that exists for 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 percent—IRS percentage). The insurer will amortize this asset (for tax purposes) over the next 10 years, resulting in annual amortization of $710 thousand. However, in the current year, the insurer will only be allowed to amortize $355 thousand, 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:

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<th>Stat</th>
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<tr>
<td>Deferred Acquisition Costs</td>
<td>$0</td>
<td>$6,745,000</td>
<td>$6,745,000</td>
<td>$2,360,750</td>
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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 corporate tax rate (35 percent), 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 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 percent 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
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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 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 Statement of Financial Accounting Standards 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.
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Admission of Deferred Tax Assets
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, EDP equipment, and operating system software and any net positive goodwill; and (3) Amount of gross DTAs (after 1 and 2) that can be offset against existing DTLs. If an entity meets risk-based capital (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 risk-based capital requirements or is required to file a Risk-Based Capital Report with the domiciliary state, shall use the Realization Threshold Limitation Table – RBC Reporting Entities in this component of the admission calculation. For mortgage guaranty insurers or financial guaranty insurers that are not subject to risk-based capital requirements and not required to file a Risk-Based Capital 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 Limitation Table – Financial Guaranty or Mortgage Guaranty Non-RBC Reporting Entities in this component of the admission calculation. If the reporting entity 1) is not subject to risk-based capital requirements, 2) is not required to file a Risk-Based Capital 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.

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 are broken down into six parts. Section (A) of this Note requires that the insurer disclose the financial components (assets, liabilities, and surplus impact) of the deferred taxes. Section (B) of this Note requires that the insurer disclose any DTLs that are not required to be reported as a liability in connection with paragraph 31 of FASB 109. Section (C) of this Note requires the insurer to disclose the significant components of its current income taxes incurred. Section (D) of this Note requires an insurer to disclose the types and amount of temporary differences that affect the insurer’s effective tax rate. Section (E) of this Note requires the insurer to
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disclose certain information on operating loss and tax credit carry forwards. Section (F) of this Note requires the insurer to disclose certain information on consolidated tax returns, if applicable.

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 total adjusted capital 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. Despite these limitations, the number of insurers that may report an increase in capital and surplus as a result of this statement may outnumber the number of insurers that report a decrease. Because a 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 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 (See the Internal Revenue Code for further discussion) account.

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.

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 of the significant reconciling items between the two amounts. Again, this disclosure can be helpful in analyzing the significant temporary differences that an insurer maintains.

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. As noted above, 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.

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
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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.

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 percent 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 percent of capital and surplus. It should be noted that the 10 percent limitation requirement within SSAP No. 101 actually includes some additional calculations that make the limitations even more conservative.

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 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, Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties (SSAP No. 25), 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 affiliated transactions. It is broken up into fourteen different sections that provide specific information on an insurer’s affiliated relationships or transactions. 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.

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 impact 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 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 affiliated transactions. 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 important to evaluate the effect of any guarantees or affiliated undertakings 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 funding and its impact on the insurer.

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.

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.

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 affiliated transactions 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.
Note 11 – Debt

This note contains two sections. Section (A) requires disclosure of information related to all other debt, including capital notes. The accounting guidance is provided by SSAP No. 15, *Debt and Holding Company Obligations* (SSAP No. 15). SSAP No. 15 requires a full description of the type of borrowing, (e.g., amounts, interest rates, collateral, interest paid, and debt terms, covenants, and any violations). Section (B) requires disclosure of information related to agreements with the Federal Home Loan Bank (FHLB).

For section (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 percent of capital and surplus, special attention 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.

For section (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.

Note 12 – Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefits

This Note contains nine sections. Section (A) requires the insurer to disclose details of a reporting entity-sponsored defined benefit plans and is required by SSAP No. 102, *Accounting for Pensions, A Replacement of SSAP No. 89* (SSAP No. 102) and SSAP No. 92, *Accounting for Postretirement Benefits Other than Pensions, a Replacement of SSAP No. 14* (SSAP No. 92). Section (B) focuses on investment policies and strategies, and Section (C) concentrates on classes and fair value of assets. A narrative description of the basis used to determine expected long-term rate-of-return-on-assets should be provided in Section (D). Section (E) focuses on the details of defined contribution plans and other postretirement benefit plans and is required by SSAP No. 102 and SSAP No. 92. Section (F) focuses on multi-employer plans and is required by SSAP No. 102 and SSAP No. 92. Section (G) discusses parent or holding company sponsored plans and is required by SSAP No. 102 and SSAP No. 92. Section (H) discusses postemployment benefits and compensated absences that do not meet the conditions for accrual as a liability and is required by SSAP No. 11, *Postemployment Benefits and Compensated Absences* (SSAP No. 11). Section (I) focuses on the impact the Medicare Modernization Act has on postretirement benefits as discussed in SSAP No. 92 and INT 04-17.

Section (A) of this Note provides significant disclosure regarding the reporting entity-sponsored defined benefit plans. 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.

Section (B) of this Note provides a narrative 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. This information should give the analyst an indication of the reporting entities risk appetite.

The fair value of each class of plan assets as of each date for which a statement of financial position is presented in provided in Section (C) of this Note. This information enables the analyst to assess the inputs and valuation techniques used to develop fair value measurements of plan assets at the reporting date.

Section (D) of this Note provides a narrative description of 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.

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. Also, they must disclose a description of significant changes to the plan. The analyst should evaluate the plan disclosures to determine the impact to the financial statements.

Section (F) of this Note focuses on multi-employer plans. It is similar to section (E) in regard to the type of disclosure required. 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.

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 provided in section (G) of this Note 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.

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 for 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 in section (H) to determine if there is concern regarding a potential impact to the financial statements.

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
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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.

Note 13 – Capital and Surplus, Dividend Restrictions and Quasi-Reorganizations

This Note is split into 13 separate sections and covers several key areas of an insurer’s overall capitalization. The first area is capital and surplus and includes items #1-#10. The analyst should be familiar with the overall holding company structure of the insurer before reviewing and analyzing the information included in this Note. However, 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.

The second area of this Note requires the insurer to disclose certain information on surplus notes. The analyst should use the information required in item #11 of the Note to obtain a greater understanding of the insurer’s surplus note obligations. Using the information required, 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. Other areas the analyst should review and consider when there are any new surplus notes include verifying: the proper accounting for the notes and any associated interest, the payment schedule for repayment and if the insurer will be able to meet this schedule, the type and quality of assets received in the transaction, and if the notes were issued to a parent or affiliates. If the notes were issued to an affiliate, the analyst should consider reviewing the affiliate’s financial statements to verify the notes are appropriately reported by the other entity.

The third and final area covered in this Note is quasi-reorganization. The analyst should use the information required in items #12 and #13 of the Note to obtain an understanding of any quasi-reorganizations that may have occurred during the most recent period. 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 (SSAP No. 72) for further discussion). Item #13 of the Note requires disclosure of the dates and amounts of any dividends paid, whether ordinary or extraordinary, that were involved in the quasi-reorganization.

Note 14 – Liabilities, Contingencies and Assessments

This Note is split into seven sections: contingent commitments, assessments, gain contingencies, claims related extra contractual obligation and bad faith losses stemming from lawsuits, product warranties (Property/Casualty insurers only), joint and several liabilities, and all other contingencies. The accounting guidance for contingencies is addressed in SSAP No. 5R and for specific items, in SSAP No. 35R,
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Guaranty Fund and Other Assessments (SSAP 35R); SSAP No. 97, SSAP No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses (SSAP No. 55); and SSAP No. 48.

Contingencies are defined in SSAP No. 5R 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). The Note requires detailed disclosure of guarantees on indebtedness of others, for example a guarantee on the indebtedness of a subsidiary.

As discussed in SSAP No. 5R, 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.

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.

Per SSAP No. 5R, 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.

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.

As discussed in SSAP No. 5R, 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. 5R for disclosure requirements.
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As discussed in SSAP No. 5R, when the insurer has a joint and several liability arrangement, where the total obligation amount is fixed at the reporting dates, it 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.

Note 15 – Leases

This Note is split into two primary sections. Section (A) focuses on the disclosure of items related to lessee arrangements. Section (B) focuses on the disclosure of items related to lessor business activities. Both sections of this Note include two or three parts, but each part of each section simply requires additional details regarding the breakdown and disclosure of the lessee’s or lessor’s arrangements.

The accounting guidance for leases is in SSAP No. 22, Leases (SSAP No. 22). A lease is defined by SSAP No. 22 as 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.

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. 22, 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-lessee's note, if any, increase 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.

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 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 note property-type asset concentrations and examine the lessor’s current and future profitability reliance on its rental income.
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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.

Note 16 – Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

This Note contains four parts, each of which is required by SSAP No. 27, Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk (SSAP No. 27). Part (1) summarizes the face amount of financial instruments with off-balance sheet risk by class of financial instrument. Part (2) discusses the credit risk, market risk, cash requirements of the instrument and the accounting policies related to the instrument. Part (3) discloses the amount of accounting loss the entity would incur in a situation where there was non-performance of the contract terms of the financial instrument and the related collateral or other security supporting the financial instrument. 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.

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. 5R. 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 to Financial Statements.

In the first part 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. The analyst should use the second part of this Note 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.

The analyst should use the third part 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. The fourth part of this Note 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.

**Note 17 – Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities**

This Note is split into three primary sections. Section (A) focuses on the transfer of receivables reported as sales that is required as a result of SSAP No. 42, *Sale of Premium Receivables* (SSAP No. 42). Section (B) focuses on the transfer and servicing of other financial assets that is required as a result of SSAP No. 103. Section (C) is also required by SSAP No. 103 but pertains only to wash sales.

Section (A) of this Note 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 the information required in section (A) 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.

Section (B) of this Note is broken up into six different areas. The first part of section (B) of this Note 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 the information required in this part of the Note to help understand the types of investing and financing contracts the insurer uses to maximize profits and liquidity. The second part of section (B) 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. The third part of section (B) requires an insurer to disclose certain information regarding servicing assets and liabilities that are subsequently measured at fair value. The analyst should use the information required in this part of the Note to help understand the materiality of the servicing process in relation to the insurance operations. The fourth part of section (B) 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 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 the information required in this part of the Note to evaluate the possible impact of adverse outcomes highlighted in the sensitivity analysis or stress test. The fifth part of section (B) requires an insurer to disclose requirements for transfers of financial assets accounted for as secured borrowing. The sixth part of section (B) requires an insurer to disclose any transfers of receivables with recourse. The analyst should use the information required in this part of the Note to gauge the materiality of possible effects of recourse associated with transfers of receivables.

Section (C) of this Note requires an insurer to disclose certain information regarding its use of “wash sales” as defined in SSAP No. 103. The analyst should use the information required in this part of the Note to help understand the purpose and types of various financial contracts the insurer uses.
Note 18 – Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

This Note is split into three primary sections (Title companies do not complete this Note). Section (A) focuses on the profitability of uninsured and partially insured Accident and Health (A&H) plans under administrative services only (ASO) contracts. Section (B) focuses on the profitability of uninsured and partially insured A&H plans for the reporting entities of Administrative Service Contract (ASC) plans. Section (C) focuses on the profitability of Medicare or similarly structured cost-based reimbursement contracts. All three sections of this Note of the Annual Statement Instructions include four or five parts, but each part of each section simply requires additional details regarding the breakdown of the uninsured or partially insured plan’s expenses, fee income, and gain or loss.

The accounting guidance for health entities that operate uninsured plans and partially insured plans is in SSAP No. 47, *Uninsured Plans* (SSAP No. 47). An uninsured A&H plan may be either an ASO plan or an ASC plan. 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 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.

This Note should also be used by the analyst 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 percent of surplus (Title companies do not complete this Note). This Note is required by SSAP No. 53, *Property Casualty Contracts-Premiums* (SSAP No. 53) and SSAP No. 54, *Individual and Group Accident and Health Contracts* (SSAP No. 54). 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, Analyst Reference Guide Level 2 on MGAs and TPAs for a detailed explanation).

The analyst should use the information in this Note 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.

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.

Note 20 – Fair Value Measurements

This Note is split into four sections. 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. In addition, 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.

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.

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 note 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.

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.

Note 21 – Other Items

This Note is split into eight primary sections. Each section is individually unique and is required by various SSAPs, INTs, and other sources. Some of the items are included in this Note on a temporary basis. Because of these reasons, the guidance on this Note is limited to an identification of the items and does not include a discussion of how to use the data.

Section (A) focuses on unusual or infrequent items and is required by SSAP No. 24. Section (B) focuses on troubled debt restructuring for debtors and is required by SSAP No. 36. Section (C) focuses on disclosures of other miscellaneous amounts not recorded in the financial statements that represent assets pledged to others as collateral in accordance with SSAP No. 1. Section (D) focuses on disclosures for business interruption insurance recoveries, including information related to the nature and aggregate amount of losses and recoveries recognized due to business interruption. Section (E) focuses on disclosures for state transferable and non-transferable tax credits. Section (F) focuses on disclosures for subprime mortgage-related risk exposure and related risk management practices. Section (G) discloses information regarding the reporting entity’s use of retained asset accounts for beneficiaries (Life/A&H insurers, Fraternal societies and Health entities only). Section (H) focuses on disclosures for insurance-linked securities (ILS) contacts. The analyst may need to reference the AP&P Manual for further guidance on each particular section.

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. The disclosure in section (A) of this Note allows the analyst to understand the impact that the event or transaction considered unusual or infrequent item 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.

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 the information in this Note 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.
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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.

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.

Section (E) requires the insurer to disclose information regarding state transferable tax credits. The total unused transferable state tax credits represent the entire transferable state tax credits available. The information includes the following: (1) the carrying value of transferable and non-transferable state tax credits gross of any related state tax liabilities and total unused transferable and non-transferable state tax credits by state and in total; (2) the method of estimating utilization of remaining transferable and non-transferable state tax credits or other projected recovery of the current carrying value; (3) the impairment amount recognized by the reporting period, if any; and (4) the identity of state tax credits by transferable and non-transferable classifications, and the admitted and nonadmitted portions of each classification. To the degree the amount of the transferable tax credits is material to the insurer, the analyst should perform a more indepth review.

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, 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.

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 insurer’s entity, (e.g., in a non-insurance subsidiary), affiliated or controlled entity accounted for under SSAP No. 97, Investments in Subsidiary, Controlled and Affiliated Entities, A Replacement of SSAP N. 88, 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.
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Section (H) requires the insurer to disclose information regarding when they receive possible proceeds as the issuer, ceding insurer, or counterparty of insurance-linked securities (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.

Note 22 – Events Subsequent

Subsequent events are required to be disclosed in the financial statements and/or Notes as a result of SSAP No. 9, Subsequent Events (SSAP No. 9). 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 assessment payable under section 9010 of the Federal Affordable Care Act. Type II events are only disclosed in the Notes to Financial Statements.

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 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.

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 December 31, 2013, and thereafter, a reporting entity subject to the assessment of the Federal Affordable Care Act 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
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impact on its risk-based capital 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 December 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 and Authorized Control Level before and after adjustment to reflect the fee assessment 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 chapter in Section III – Annual Procedures – Level 2 Health Care Pursuant to Public Health Service Act.

Note 23 – Reinsurance

This Note is split into ten primary sections and the sections vary by statement type. The analyst should use all of the information provided in this Note to gain a better understanding of the insurer’s reinsurance program and any risk the insurer is exposed to under the program.

• Section (A) requires the insurer to report certain information on ceded reinsurance. (For Property/Casualty and Title insurers that includes any individual unsecured reinsurance recoverables that exceed 3 percent of policyholders’ surplus).

• Section (B) requires the insurer to report certain information on reinsurance recoverables in dispute for Property/Casualty and Title insurers and uncollectable reinsurance for Life/A&H, Fraternal and Health insurers.

• For Property/Casualty and Title insurers, Section (C) requires the insurer to report certain information on reinsurance assumed and ceded commissions. For Life/A&H, Fraternal and Health insurers, Section (C) requires the insurer to report certain information on commutation of ceded reinsurance.

• Section (D) for Life/A&H, Fraternal, and Health insurers, Section (I) for Property/Casualty, and Section (H) for Title requires the insurer to report certain information on a certified reinsurer rating downgrade or status subject to revocation.

• Property/Casualty Sections D through H and J; and for Title insurers Sections D through G are as follows.
  o Section (D) requires the insurer to report certain information on uncollectable reinsurance that was written off during the year.
  o Section (E) requires the insurer to report certain information on commutation of ceded reinsurance.
  o Section (F) requires the insurer to report certain information on the use of retroactive reinsurance.
  o Section (G) requires the insurer to report certain information on reinsurance accounted for as a deposit.
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- Property Casualty Section (H) requires the insurer to disclose transfer of property and casualty run-off agreements.
- Property Casualty Section (J) requires the insurer to disclose retroactive reinsurance agreements covering asbestos and pollution liabilities which qualify for reinsurer aggregation.

- For Life/A&H and Fraternal 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.

- For Life/A&H and Fraternal Section (G) requires disclosure of RBC shortfall by captive reinsurer for entities utilizing captives to assume reserves subject to XXX/AXXX captive framework.

Reinsurance is a vital part of an insurer’s risk management and financial stability. The most common type of reinsurance arrangement used by most health entities is “excess of loss” coverage; however, some HDMI companies may have coinsurance arrangements. 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 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. To assist in accomplishing this, the analyst may consult the following: the financial statements of the reinsurer; Analyst Team designations; regulatory and governmental filings (SEC and insurance department’s Form B); rating agency reports; financial reports on the insurance industry; and other financial sources.

Under SSAP No. 61R, Life, Deposit-Type and Accident and Health Reinsurance (SSAP No. 61R), Uncollectable Reinsurance, “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.”

In addition to using all of the information in this Note to obtain a greater understanding of the insurer’s reinsurance program, the analyst should also consider using specific sections of the Note as follows.

**Property/Casualty and Title Insurers:**

The analyst should use the information provided in section (B) of this Note 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.

The analyst should use the information provided in section (E) of this Note to determine if the insurer has had any commutation of reinsurance. If so, the analyst should determine the financial impact the
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commutation will have on the ceding company (its domestic) and should request a pro-forma financial statement reflecting the effects of the commuted agreement.

The analyst should use the information provided in section (F) of this Note 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. 62R, Property and Casualty Reinsurance, Section 28).

The analyst should use the information provided in section (G) of this Note 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. 62R, Section 35, provides accounting guidance.

The analyst should use the information provided in section (H) (for Property/Casualty insurers only) of this Note to determine if the reporting entity has entered into any agreements that qualify them to receive P&C run-off accounting treatment pursuant to SSAP No. 62R. 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 of insurance or reinsurance.

The analyst should use the information provided in section (J) (for Property/Casualty insurers only) of this Note 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. 62R – Property and Casualty Reinsurance.

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.

Life/A&H, Fraternal and Health Insurers:

The analyst should use the information provided in the second section (B) of this Note 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.

The analyst should use the information provided in the third section (C) of this Note 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.

For Life/A&H and Fraternal insurers, 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.

Note 24 – Retrospectively Rated Contracts and Contracts Subject to Redetermination

This Note requires the insurer to disclose general information regarding its premium volume under retrospectively written contracts (this Note not applicable to Title insurers). The accounting guidance for
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retrospectively rated contracts is addressed in SSAP No. 66. 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.

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 analyst should review the Note to determine whether the reported amount is recorded in compliance with necessary statutory guidance. 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 Affordable Care Act (ACA). For property/casualty companies, the analyst should compare the admitted amount reported in the Note for accrued retrospective premiums to what is recorded on the balance sheet.

Additional guidance regarding Note 24 pertains to the ACA imposing fees and premium stabilization provisions on health insurance entities offering commercial health insurance. This includes imposing an assessment on entities that issue health insurance for each calendar year beginning on or after January 1, 2014. A health entity’s portion of the assessment is paid no later than September 30 of the applicable calendar year (the fee year) beginning in 2014 and is not tax deductible. The amount of the assessment for the health entity is based on the ratio of the amount of an entity’s net health premiums written for any U.S. health risk during the preceding calendar year to the aggregate amount of net health premiums written by all U.S. health insurance providers during the preceding calendar year.

One of the most significant new drivers of uncertainty attributable to the ACA is its premium stabilization programs, which are referred to as the 3Rs – risk adjustment, reinsurance benefits and risk corridors. These programs primarily affect the commercial individual and small-group markets starting in 2014. The impact on a specific health entity will be somewhat dependent on its concentration in those markets.

Each of the premium stabilization programs is designed to provide protection to the health insurance entity by mitigating adverse financial outcomes; however, these programs could have a negative impact as well. Moreover, each program includes a retrospective settlement process. The health entity’s annual financial statements will include estimates of amounts payable or receivable under these programs. 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 accident and health insurance premium which is subject to the ACA risk-sharing provisions. It is also recommended that the analyst identify whether the impact of underestimating the amount of health premium subject to the ACA risk-sharing provision is greater than their level of capital would allow. The analyst should review the health care chapter in Section III – Annual Procedures – Level 2 Health Care Pursuant to Public Health Service Act.
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Any reporting entity that reports accident and health insurance premium and losses on their statement that is subject to the ACA risk-sharing provisions must complete the tables provided within Note 24 for the purpose of disclosure of the impact of risk-sharing provisions of the ACA 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.”)*

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 5–10 percent 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 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.

**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). The analyst should use the information required in this Note to obtain a greater understanding of the insurer’s pooling agreements. 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 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). 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 “arms-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.

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 to which 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.

Note 28 – Health Care Receivables

(For Title insurers only, Note 28 is for Supplemental Reserve and requires disclosure of discounting, the method, rate and amount of discount.)

This Note is divided into two primary sections. Section (A) requires disclosure on pharmaceutical rebate receivables. Section (B) requires the insurer to disclose 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, *Certain Health Care Receivables*
VI. Guidance for Notes to Financial Statements

and Receivables Under Government Insured Plans (SSAP No. 84). Exhibit C—Implementation Guide of SSAP No. 84 provides additional accounting guidance for the practical application of SSAP No. 84.

Section (A) – Pharmaceutical Rebate Receivables

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. 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 following example.

Example:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Estimated Pharmacy Rebates as Reported on Financial Statements</th>
<th>Pharmacy Rebates as Invoiced/Confirmed</th>
<th>Actual Rebates Collected Within 90 Days of Invoicing/Confirmation</th>
<th>Actual Rebates Collected Within 91 to 180 Days of Invoicing/Confirmation</th>
<th>Actual Rebates Collected More Than 180 Days After Invoicing/Confirmation</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/31/2014</td>
<td>$150 (A)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9/30/2014</td>
<td>130 (B)</td>
<td>133 (C)</td>
<td>62 (D)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/30/2014</td>
<td>142</td>
<td>143</td>
<td>138</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>3/31/2014</td>
<td>157</td>
<td>152</td>
<td>150</td>
<td>1</td>
<td>$1</td>
</tr>
<tr>
<td>12/31/2013</td>
<td>125</td>
<td>132</td>
<td>129</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>9/30/2013</td>
<td>123</td>
<td>129</td>
<td>125</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>6/30/2013</td>
<td>112</td>
<td>120</td>
<td>110</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>3/31/2013</td>
<td>110</td>
<td>118</td>
<td>118</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12/31/2012</td>
<td>68</td>
<td>75</td>
<td>69</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>9/30/2012</td>
<td>60</td>
<td>59</td>
<td>58</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>6/30/2012</td>
<td>57</td>
<td>60</td>
<td>49</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>3/31/2012</td>
<td>45</td>
<td>50</td>
<td>48</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

This example assumes a financial statement date of 12/31/2014 and further assumes full implementation of SSAP No. 84 retroactive to 1/1/2012, 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 11/30/2014. Therefore, the company estimated rebates of $130, but will actually receive $133 of rebates for the third quarter.

D. Assuming the $133 was billed on 11/30/2014, 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 12/31/2014 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).

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.

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 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 are not explained in the Note.

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.

Section (B) – Risk-Sharing Receivables

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.

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 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.

Note 29 – Participating Policies

This Note requires the insurer to disclose information on participating contracts (this Note is not applicable to Title insurers). The Note for participating policies is required by SSAP No. 51, *Life Contracts* (SSAP No. 51) and SSAP No. 54.
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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.

Note 30 – Premium Deficiency Reserves

This Note requires the insurer to disclose information on premium deficiency reserves (this Note is not applicable to Title insurers). The Note for premium deficiency reserves is required by SSAP No. 53 and SSAP No. 54.

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.

The remaining Notes are divided into three sections—Property/Casualty; Life/A&H and Fraternal; and Health.

Property/Casualty Insurers:

Note 31 – High Deductible Policies

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 ten percent 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 ten percent that are not anticipated to be collected should also be non-admitted.

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.

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.

**Note 32 – Discounting of Liabilities for Unpaid Losses or Unpaid Loss Adjustment Expenses**

This Note is split into three primary sections. Section (A) requires the insurer to report certain information on reserves that have been discounted using a tabular basis. Section (B) requires the insurer to report certain information on reserves that have been discounted using a non-tabular basis. Section (C) requires the insurer to report certain information if the insurer has made any changes in the assumptions used to discount its reserves. 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 property/casualty 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.

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 percent, 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 percent, 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.

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.

**Note 33 – Asbestos/Environmental Reserves**

This Note is split into six different sections. Each section provides specific information on the insurer’s asbestos and/or environmental (A&E) business. The accounting guidance and disclosure requirements for A&E Reserves are addressed in SSAP No. 65. This Note assists the analyst in determining whether unpaid losses and/or loss adjustment expenses (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.

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 incurred but not reported (IBNR) 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 percent 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**

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. 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.
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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.

Note 35 – Multiple Peril Crop Insurance

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* (SSAP No. 78).

A liability for unearned premium reserve is established to reflect the amount of premium 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.

Note 36 – Financial Guaranty Insurance

The underlying principles for financial guaranty insurance and accounting details are discussed in SSAP No. 60, *Financial Guaranty Insurance* (SSAP No. 60). 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.

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.
VI. Guidance for Notes to Financial Statements

Life, A&H, and Fraternal Insurers:

Note 31 – Reserves for Life Contracts and Annuity Contracts

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 IV. C.2. – Statement of Actuarial Opinion & Regulatory Asset Adequacy Issues Summary Analyst Reference Guide – Life/A&H and Fraternal 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 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 Level 2 Procedures for Life Reserves and Life Reserves Analyst Reference Guide, 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 (SSAP No. 52). 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.

Disclosure of reserve practices required by SSAPs No. 51 and 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.

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.
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.

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.

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 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 Liabilities by Withdrawal Characteristics**

This Note is split into six primary component (A-F) sections; however, for all practical purposes, there are two parts to the Note. Part 1 (components A-E) of 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. Part 2 (component F) of this Note is 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.

As noted above, Part 1 of this Note provides information on the withdrawal characteristics of annuities and deposit-type funds. This information is primarily helpful in identifying an insurer’s interest rate risk and its liquidity risk. The analyst should therefore use the information provided in Part 1 to assist in identifying these risks.

**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 percent 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...
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Note. 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.)

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 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 guaranteed interest contracts, 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.

Note 33 – Premium and Annuity Considerations Deferred and Uncollected

This Note has one primary section. The section 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 two parts: uncollected and deferred premiums and annuity considerations, for each line of business listed above, on a gross basis (part 1) and net of loading (part 2).

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 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.

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.

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.

Note 34 – Separate Accounts

There are three primary sections to this Note. The first section (A) discloses detailed information on the reporting entity’s separate account activity. The second section (B) focuses on the 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 (SSAP No. 56). The third section (C) provides 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.

Part 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.
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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.

Part B of this Note 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 section of the Note 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.

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 percent, with rates greater than 4 percent, 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 percent 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 percent 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.

In Part 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.

**Note 35 – Loss/Claim Adjustment Expenses**

There are four primary parts to this Note. The first part discloses the balance of liabilities for unpaid loss/claim adjustment expenses. The second part discloses incurred loss/claim adjustment expenses. The third part discloses the payment of loss/claim adjustment expenses and the fourth part estimates the average salvage and subrogation. Life and annuity contracts are not subject to this disclosure requirement.

The reporting of claim liabilities and claims adjustment expenses are addressed in SSAP No. 55, *Unpaid Claims, Losses and Loss Adjustment Expenses*. SSAP No. 55 addresses claim adjustment expenses on accident and health 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 accident and health 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.

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.

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 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.

**Health Insurers:**

**Note 31 - Anticipated Salvage and Subrogation**

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.
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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 are consistent with SSAP No. 55 and to determine the impact on the balance sheet of any large recoverable amounts.
VII. Health Insurance Industry
A. Medical Insurance Markets
B. Health Lines of Business
C. Product Types
D. Company Financial Structure
E. Types of Ownership Structures
F. Solvency and Liquidity
VII. Health Insurance Industry – A. 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 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 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 (HMDI), Health Maintenance Organizations (HMO) 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. Many HMDIs tend to provide service benefits via HMO lines of business, but otherwise offer indemnity policies similar to those offered by life and A&H insurers and P&C insurers.

Companies licensed as Life, Accident & Health file the Life/A&H blank and use the Life RBC formula. Some Blue Cross Blue Shield Plans are licensed as Life/A&H carrier, 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 AVR and 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 over 95 percent 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 the laws and regulations specific to Life/A&H insurers such as the Standard

\(^{1}\) 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 and long-term care insurance do not count toward the 95 percent requirement. The 95 percent rule must be passed based on both earned premiums and reserves.
Valuation Law. Life insurers will also be required to perform asset adequacy analysis pursuant to the requirements of the state’s Standard Valuation Law. In contrast to most asset 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).

Property and Casualty companies (P&C) 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/Accident & Health insurers and P&C insurers generally issue indemnity policies, which reimburse policyholders for claims they pay, or make direct payments to providers who have been assigned payments (under the policy), by the policyholder.

Preferred Provider Organizations (PPOs) sometimes resemble HMOs. Generally PPOs contract with providers for discounts. The contracting providers make up the PPO network. The PPO then executes a contract with a health entity and the PPO network providers render health services to policyholders of the health entity. PPOs can also perform medical management such as utilization review and inpatient pre-authorization. PPOs are normally not allowed to actually assume insurance risk for the services provided by its contracted providers. In some states PPOs are required to be licensed by the Insurance Department.

A term that is being used more frequently 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 NAIC HMO Model Act 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. Some states require special licenses for RBEs. Provider groups such as Independent Provider Associations (IPAs), contract with member providers to provide health care services. When IPAs are paid a capitation for services and then pay the contracted providers on a reduced fee-for-service basis, they are assuming insurance risk. If the IPA becomes insolvent because the costs of health care being provided are more than the capitation payments, the health entity is responsible for finding other providers for its members. The individuals who are insured by the health entity may lose access to the physicians that have been treating them and the health entity may have to pay more for health services than contemplated when it establishes its premium rates. This can result in angry policyholders and financial losses for the health entity.

More detail on types of coverage and underlying arrangements is presented in section VI. B. - Health Lines of Business.

2. Health Care Cost Increases - General

Pressures come from many directions such as from new ways to provide health care and from mandated requirements to cover additional services. Health entities in the voluntary market face the financial pressures to keep premiums down while still covering all those that they must or agree to insure. Overall, the cost of health care is increasing much more than general inflation. The cost of any one service increases by the normal inflation associated with the service, plus any additional costs. In recent history, the cost of malpractice insurance has been pointed to as a primary reason that physician, lab, and hospital costs are increasing faster than inflation.
Increasing medical malpractice awards have added to the cost of the actual services being provided. Some also suggest that excess health care (e.g. when providers request more tests than necessary or agree to care requested by the patient even if not justified) may result from defensive medicine to avoid malpractice claims.

The overall cost of health care also increases as the services are utilized more. As individuals and populations age they consume more health care services. Now that the “baby boomers” are passing through middle age, the average age of Americans is rising. Consequently, the average number of services used by Americans is also increasing. As with any industry, use of services increases with advertisement. In the late 1990s, prescription drug advertising began to stimulate increased use of many prescription drugs. Low co-payments for prescriptions that kept the cost to the consumer very low also contributed to higher demand.

New technology adds cost to the health care market in two important ways. First, it provides new and often expensive services to the range of treatments available. Second, the use of long-term treatments as well as new procedures as noted above 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 all of the factors that contribute to overall health care costs, but it is also affected 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, the individual will have more of a tendency to utilize them.

Individuals with high health care costs are more likely to purchase insurance, especially more comprehensive benefit plans, and are less likely to drop their coverage. In a totally voluntary health insurance market, segments of the market would become too expensive as this 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 much 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. Health entities have to be careful that their benefit designs are not appreciably richer than the competition or includes 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 been urged to force health entities to cover health care services that might otherwise not be covered by their policies. 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 $100 deductible. If a person’s medical
expenses are $150, the health entity will pay $50. If the expenses increase by 10 percent in the
next year, to $165, and the deductible has not been changed, then the health entity will pay $65,
an increase of 30 percent over the health entity’s prior-year payment of $50. Since the health
entity’s expense has increased 30 percent, that increase, and not merely the underlying 10 percent
increase, will have to be reflected in premium rates. In general, if the corridor is very small
relative to the overall cost per person, deductible leveraging will have a very small impact; but if
the corridor is large relative to overall cost, the leveraging likewise will be very high. 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.

The combination of the general and insurance issue 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 though various risk
sharing methods including the following:

a. **Premium risk sharing** – the most obvious is experience rating of large employers.
b. **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.
c. **Provider risk sharing** – the use of capitation, withholds, provider discounts and plans to
   encourage quality care through bonuses share the risks and rewards of effective health
   coverage with the providers.
d. **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).

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 fee schedules 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.

The analyst 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 groups from state laws. 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.

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.

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) was signed into law. In addition to the new act, on November 22, 2010, a new regulation implementing a new policy known as the medical loss ratio provision of the Affordable Care Act was issued. This policy requires insurance companies to spend 80 to 85 percent of premium dollars on health and medical care quality improvement or else be required to provide a rebate to their policyholders. The Supplemental Healthcare Exhibit assists regulators in identifying the components that comprise the medical loss ratio calculation. 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.

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 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 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 of the care/benefits that the program requires but is paid a fixed fee by the program (e.g. Medicaid HMOs and Medicare Advantage). These sub-markets involving health entities have different risks than the primary markets (non-government) since the primary markets do not have fiscal constraints. Section VI. B. - Health Lines of Business 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. The analyst 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. 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. The analyst 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 terminate all similar policies, which would entail leaving a market completely for some time. As noted elsewhere, some of the markets have specific additional requirements for guaranteed issue or mandated benefits and premium subsidization. These are described in Section VI. B. - 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 additional distinctions within the primary line of health coverage – comprehensive major medical including medical services provided through an HMO.

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 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, Long-term Care, Specified Disease and Medicare supplement). The contract may cover the insured as well as family members. The renewal provisions of individual contracts are important in that if the insurance is cancelled, many of the insureds may not be able to replace it because of their poor health.

- **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. 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 options for risk sharing, from complete retention of risk through ASO/ASC to high deductible minimum premium policies with stop-loss coverage.
  - **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 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
VII. Health Insurance Industry – B. Health Lines of Business

status of the contract and the manner in which states deal with certificates for out-of-state groups.

➢ 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 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., AARP) or interest group (Sierra Club). Besides primary health coverage, this can include the sale of limited pay/supplemental coverage (“work-place” sales of accident, specified disease, hospital indemnity, etc.), Medicare supplement, disability income, and long-term care 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), Medicaid, Medicare Advantage) as well as the federal Long-Term Care (LTC) insurance 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., Small Employer regulations, Medicare supplement standardized plans, LTC level premium and inflationary protection are key examples).

• Individual - Coverage is frequently underwritten and therefore subject to rate variations based on the applicant’s health, to offset self-selection. States vary allowable underwriting practices and must address the availability of individual coverage for people who meet 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). There are high administrative costs relative to other relationship arrangements, both annually and for acquisition of new business. From a regulatory point-of-view, this market will typically be a smaller portion of the health entity’s total business and may be treated simply as an addition.

One aspect of the risk is to review the health entity’s participation in a state’s provision for offering coverage to the uninsured and HIPAA eligibles. States may use approaches, which do not affect the health entity (e.g., high risk pools, 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.
VII. Health Insurance Industry – B. Health Lines of Business

- **Small Employer** – Variations by state are key in determining the unique risks for this market. What benefit packages must be offered and pricing allowances for demographic differences (e.g., age, sex, location) or health (claims experience and health status) are limited by the states. 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 percent share than a company with a 25 percent 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. 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 also allow purchasing groups or alliances for small groups.

- **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 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 “price/benefit” options. Cafeteria plans are the most frequent bases for presenting these offerings on an annual basis to employees. Current health status will affect the employee’s 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 regulatory oversight may add to administrative costs or limit the areas where the plan 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 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.

- **Medicare Advantage** – This market is primarily for senior citizens and allows the entity to define benefit packages, subject to meeting minimum benefits provided by Medicare. It has increasingly moved toward managed care arrangements. Income comes from the Center for Medicare and 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.

- **Supplemental Coverage** – This coverage is generally sold by another company than the carrier for primary health coverage. It may coordinate (e.g., Medicare supplement), be in addition to (e.g., hospital indemnity) or may be unrelated (e.g., 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. 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 – 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 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 disability income (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 much 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 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).
VII. Health Insurance Industry – C. 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

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. Cosmetic treatments are excluded because they are not medically necessary. There is much debate concerning specific services and whether or not they are experimental 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 are payments, made by the insured person at the time of service, for physician visits and prescription drugs. Co-payments are generally applicable when services are rendered by providers under contract with the health entity. These may or may not be included in maximum out-of-pocket amounts and are not credited to deductibles. Prescription drug co-payments vary depending upon whether or not the drug is generic and may vary by drug classification. 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 services not covered by co-payments and may vary by in-network services and out-of-network services, but are more common for out-of-network service. Individuals may choose not to submit claims to a health entity for reimbursement until meeting their deductible amount, resulting in 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 they 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 claim amounts until the maximum out-of-pocket expense is met. This is often referred to as co-insurance. Normally, the health entity will not make payments based upon the full value of the claim after deductible and coinsurance, but rather uses a schedule of “customary” fees to determine the benefit due. A maximum deductible usually applies for family coverage that is a multiple of the individual maximum. Some policies have an in-network maximum out-of-pocket and an out-of-network maximum out-of-pocket. Before health entities instituted
the policy of two maximums, once an individual met their maximum out-of-pocket they had no further incentive to use contracted providers since the health entity paid 100 percent of the cost.

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 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. Now, 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 indemnity or PPO products with high deductibles. 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 may offer preventative care or other services for a co-payment amount without being subject to deductibles. The result is that some physician and prescription drug services may be available on a co-payment basis, while policies primarily pay for expensive services such as hospital stays and surgeries. In addition to uninsured ASO/ASC plans, other alternatives to insured products have gained popularity as employers try to control benefit costs.

High-deductible plans may be offered in conjunction with Medical Spending (or “Medical Savings”) Accounts (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 plans grew out of employer concern over double digit premium increases for indemnity plans in the early 1970s and are still very common depending on the state. Employers pressuring insurers to reduce costs, and federal legislators’ beliefs that having HMOs available may solve some of the health care cost problem, and has resulted in a growth in managed care plans. A provider based HMO could manage the health care more efficiently and possibly eliminate some of the administrative cost that exists with insurance. Other health entities and self-insured employers then looked at how they could use some of the techniques used by the HMOs to control health care cost increases.

Managed care techniques include the use of a primary care physician as a “gatekeeper” and other 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,
As indemnity plans added more managed care mechanisms and HMOs started to use contracted providers rather than their own 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. Providers are resisting capitations that have led to losses and in some cases provider insolvency. More capitations are limiting the services under the capitation, leaving the health entity with the risk for non-capitated services. Recent capitation agreements are moving 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. Arrangements can 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). The PCP must authorize all or most specialty care and hospitalizations.

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. 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.

Preferred provider organizations (PPOs) are utilized by HMDIs and insurers to bring elements of managed care to their products by contracting for discounted fees from participating providers. They may also perform other managed care functions such as pre-authorization and utilization review.
VII. Health Insurance Industry – D. 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 counterparts. In addition, the financial structure of the ultimate parent, if 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 have been given advantages 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\(^2\), 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 have recently received significant backlash and are not as effective as they once were, and 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 technology 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 principle payments, the lender can demand payment and the health entity could be forced into

\(^2\) RBC requirements will generally increase for the same number of covered lives because of medical trend increases.
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.
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. The analyst 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.

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, should be subject to regulatory approval.

Reinsurance by one affiliate of the others can be used to manage capital and change Risk-Based Capital requirements. This can result in more centralized Risk-Based Capital 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 isn’t enough of an advantage to offer “one stop shopping”.

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VII. Health Insurance Industry – F. 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); and
4. The adequacy of existing capital - the Risk-Based Capital (RBC) formula compares actual capital (in the form of Total Adjusted Capital or 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):
      • 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);
      • 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;

- 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;

- 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; and

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 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 of the 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
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arrangements has been reduced recently with the influence of and the push back from providers and patients.

2. **Reserves, including 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 etc. 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:

   - **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.

   - **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 Administrative Services Only (ASO) or Administrative Services Contract (ASC). In both of these cases the employer is
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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.

- **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.

Risk is transferred to hospitals by the use of DRG payments. 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 complicating circumstances or extreme cases as “outliers”. Additional payments will then be approved for outlier cases.

- **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.

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:

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3 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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- 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), 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., LTC, 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 (are not likely to occur simultaneously) through a “co-variance” calculation.

3. Some states have guaranty funds that are used to take insolvent health entities into receivership and pay claims. The guaranty funds are funded by assessments levied against all health entities that are required by law to participate, which might not include HMOs.

4. For HMOs, most states have adopted some version of the HMO Model Act, 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.
Appendices

A. References
VIII. Appendix – A. References

Publications

• Accounting Practices and Procedures Manual, NAIC
• Annual Statement Instructions, NAIC
• Financial Condition Examiners Handbook, NAIC
• 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
VIII. Appendix – A. References

- 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