NAIC Financial Analysis Solvency Tools

Financial Analysis Handbook
2014 Annual / 2015 Quarterly
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 2014 Annual and 2015 Quarterly Financial Statements. The following summarizes the most significant changes since the prior edition:

**Insurer Profile Summary**
The Level 1 guidance for the insurer profile summary was revised to assist the analyst in developing a high-level overview of the current and prospective solvency of an insurer. An interactive template of the insurer profile summary and heat map are located in I-SITE.

**Level 2—Investments**
Additional guidance and procedures were added to assist the analyst in determining whether concerns exist due to the level of structured notes held by the insurer and gain an understanding of the prospective risks of these investments and the insurer’s level of expertise regarding these types of notes.

**Level 2—Reinsurance**
Guidance and procedures were added to assist the analyst in identifying whether an insurer has any reinsurance transactions with captive reinsurers that pertain to either term life or universal life with secondary guarantees. (Commonly referred to as XXX/AXXX).

**Level 2 – Health Care Pursuant to Public Health Service Act**
Additional guidance and procedures were added to assist the analyst in quarterly review of solvency of insurers who write health insurance as it pertains to the Affordable Care Act (ACA).

**Supplemental – Property/Casualty/Title Actuarial Opinion**
Changes were made to the Property/Casualty/Title Analyst Reference Guide and the Actuarial Opinion Supplemental Procedures to provide for consistency with changes in the Actuarial Opinion Instructions.

**Supplemental – Life/A&H and Fraternal Actuarial Opinion**
Changes were made to the Life/A&H and Fraternal Analyst Reference Guide and the Actuarial Opinion Supplemental Procedures to provide for consistency with changes in the Actuarial Opinion Instructions. These changes result in requirements for appointed actuary reporting that is similar to the Health and Property/Casualty Actuarial Opinion annual statement instructions. The change stipulates that the appointed actuary report to the Board of Directors or Audit Committee.

**Supplemental – Holding Company – Form D – Captive Reinsurance Transactions**
Additional guidance and procedures were added to assist the analyst in identifying and analyzing specific types of captive reinsurance agreements specifically, those agreements where the underlying business ceded is either term life or universal life with secondary guarantees, commonly referred to as XXX/AXXX.
Group-wide Supervision

New guidance and procedures were added to assist the analyst in 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 is managing those risks.

If you have questions regarding the *Financial Analysis Handbook*, contact Jane Koenigsman, Life/Health Financial Analysis Manager at (816) 783-8145, jkoenigsman@naic.org or Andy Daleo, Property/Casualty Financial Analysis Manager at (816) 786-8141, adaleo@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.

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**NOTES**

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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)

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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, 2015. They will be reviewed by the Working Group and considered for adoption and implementation in the next Handbook edition. Send proposals via email to Jane Koenigsman, Life/Health Financial Analysis Manager, jkoenigsman@naic.org, or fax to 816-460-7599; or send to Andy Daleo, Property/Casualty Financial Analysis Manager, adaleo@naic.org, or fax to 816-460-7804. 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.

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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**
These chapters provide a general overview for the analyst concerning regulatory organization, communication, and prioritization.

**Financial Analysis Framework**
The framework discusses resources the analyst should utilize throughout the review process. In addition, the steps of the review process are presented.

**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.
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 – Holding Company and Supervisory College Best Practices
This document provides guidance and best practices for use by state insurance regulators in their regulatory oversight of insurance companies within insurance holding company systems.

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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Organization Chart

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

Chart of State Insurance Department Functional Units

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

Financial Condition Examinations

The insurance code in most states allow the state insurance department to examine insurers as often as the commissioner deems appropriate and requires that each insurer be examined at least once every three to five years (as determined by each state). Financial condition examinations performed by the state insurance departments include full-scope periodic examinations and limited-scope or targeted examinations, which focus on specific accounts and/or issues. The results of a financial condition examination are documented in an examination report that assesses the financial condition of the insurer and sets forth findings of fact (together with citations of pertinent laws, regulations, and rules) with regard to any material adverse findings disclosed by the examination. Examination reports may also include corrective actions required to be taken by the insurer and/or recommendations for improvements. Through the risk-focused surveillance approach, the department gains knowledge about all aspects of the insurer, including its corporate governance, risk management practices, and key business activities, which can be useful to solvency analysis.
Market Conduct Examinations

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

Financial Analysis

Financial analysis provides an in-house desk audit of the Annual Financial Statement and all other supplemental filings made by an insurer. The analyst should refer to other available information as well (including information on the NAIC Financial Data Repository), in order to monitor the insurer’s statutory compliance and solvency on a continuous basis in coordination with the periodic on-site field examination process. As part of the risk-focused surveillance approach, the financial analysis unit responsibilities can include monitoring the state’s domestic insurers, providing updates to the Insurer’s Profile Summary, if applicable (see Analyst Reference Guide for Level 1 Procedures), providing input for the department’s priority score and supervisory plan, and providing department management with timely knowledge of significant events and performing the prospective risk analysis. Refer to the Analyst Reference Guide for Level 1 Procedures for further discussion on prospective risk. As part of the analysis process and the review of the examination report and findings, the analyst should incorporate into his/her analysis information gained about the corporate governance and risk management processes of the insurer. If desired, regulators can request the Insurer’s Profile Summary, if applicable, for non-domestic insurers from the domestic or lead state.

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

Company Licensing and Admissions

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

The Uniform Certificate of Authority Application, also known as the UCAA or Uniform Application, is a process designed to allow insurers to file copies of the same application for admission to numerous states.
I. Introduction – A. Department Organization and Communication

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

Consumer Affairs

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

Enforcement

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

Policy/Forms Analysis

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

Rate Filings

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

Agent Licensing

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

Legal

Legal is generally involved in the review of proposed changes of control of insurers and other holding company transactions and frequently supports the other functions. Legal may also draft statutes and
I. Introduction – A. Department Organization and Communication

regulations to assist the insurance department in regulating insurers, agents, and other licensees; hold administrative hearings between the commissioner and insurers, agents, and other licensees; and represent the department in judicial and other proceedings.

Communication

Communication with other divisions or areas within the department (intra-departmental communication) on a timely basis is an important element of effective solvency surveillance and is essential to the coordination of results of the risk-focused surveillance approach. Upon identifying a problem or concern during the financial analysis process, the financial analyst should communicate this information to other divisions within the department. In addition, other divisions within the department should communicate certain information to the financial analyst so that the analyst has all of the relevant information available regarding the insurer being analyzed. (Refer to the example of an Insurer Profile Summary in the Analyst Reference Guide for Level 1 procedures.)

Communication from the Financial Analyst to Other Divisions or Areas

The analyst may identify concerns as a result of the financial analysis process that, when communicated to the financial condition examinations division, may lead to a targeted or limited scope financial condition examination. In addition, since the analysis process and risk-focused examinations are interactive processes, the analyst should be familiar with the insurer’s current financial condition, including any changes in its operations since the last periodic financial condition examination. Analysts should actively communicate findings from the analysis process to examiners, as this type of communication is beneficial to the financial condition examination staff during the planning of risk-focused examinations and any follow-up. An example of the type of communication may include significant financial variances found in the insurer’s business plan projections. Another example may include a material turnover of high-level management positions. Statutory violations identified as a part of the analysis process should be communicated to the enforcement division for the issuance of appropriate penalties and/or corrective orders against the insurer. Additionally, solvency related concerns, when communicated to the legal division, may result in the restriction, suspension, or revocation of an insurer’s Certificate of Authority.

Communication from Other Divisions or Areas to the Financial Analyst

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

1. Financial condition examination reports that include significant adjustments to the financial information reported to the department, corrective actions required to be taken by the insurer, and/or recommendations for improvements based on examination results. Communication from financial examination staff may also include significant current events, company conditions and issues, industry conditions impacting the insurer, and other financial concerns such as changes in profitability trends, deterioration in asset quality, liquidity or capital adequacy, or changes in investment strategies or reinsurance. Moreover, the risk-focused examination may provide information about the insurer’s prospective risks and the effectiveness of the insurer’s risk management processes.
2. Market conduct examination reports containing corrective actions required to be taken by the insurer as a result of violations in sales, advertising, ratings, and/or claims practices, which might be an indication of financial problems or lead to the risk of financial losses through class action suits or regulatory fines (market conduct examinations).

3. Any relevant information obtained in planning the financial examination stage.

4. An increase in the number or type of complaints filed by policyholders, claimants, employees, agents, or third parties that could indicate liquidity or internal control problems (consumer affairs).

5. Corrective orders and other regulatory actions taken against an insurer and fines and penalties levied (enforcement).

6. New policy form filings or expansion into new lines of business, including high-risk and long-tail lines of business, which might imply planned rapid growth to obtain premiums in order to improve liquidity or cover prior losses (policy/forms analysis).

7. Requests for significant premium rate increases, which might be an indication of insufficient rates to cover losses and expenses in the past (rate filings).

8. An increase in the licensing of agents, including managing general agents or third party administrators, which could indicate planned rapid expansion or relaxed underwriting standards (agent licensing).

9. The use of managing general agents or third party administrators, which might be an indication that the insurer is not in control of its operations (agent licensing).

10. Information that management personnel of an insurer (including officers, directors, or any other persons who directly or indirectly control the operations of the insurer) fail to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such a position (legal).

11. The unexpected resignation of an insurer’s officer(s), director(s), or other key management personnel, which might indicate internal turmoil or dissatisfaction with the insurer’s goals or operating practices (legal).

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

1. Key insurance department officials should possess all relevant information to permit decisions to be made on a timely basis.

2. The department should assure that all levels of staff have the appropriate knowledge, information, and feedback to effectively perform the assigned functions.
I. Introduction – A. Department Organization and Communication

3. Managers within various functional units or divisions should be responsible for the proper internal communications and documentation of decisions and actions taken under their authority.

4. The department should establish procedures to assure that orders and directives are effectively communicated to the appropriate staff and that the staff observes such orders and directives.
The operations of an insurance company often are not limited to one jurisdiction. Therefore, state insurance departments need to coordinate its regulatory efforts with those of other state insurance departments where its insurers do business. The *Troubled Insurance Company Handbook* states that opportunities to coordinate efforts should be sought throughout the entire process, from the monitoring and surveillance of insurers through regulatory actions regarding identified troubled insurers. Coordinated activities may take various forms, including: 1) establishment and maintenance of procedures to communicate information regarding troubled insurers with other state insurance departments; 2) participation on joint examinations of insurers; 3) assignment of specific regulatory tasks to different state insurance departments in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise; and 4) establishment of task forces consisting of personnel from various state insurance departments to carry out coordinated actions. Coordination of actions may also be useful to avoid duplication of individual state insurance department actions that may be counterproductive. Additionally, in some cases, coordination on nonfinancial issues may also be necessary. This is quite common when dealing with health entities, because regulatory agencies such as the Center for Medicare and Medicaid Services (CMS), maintain authority in dealing with issues related to Medicare and Medicaid products.

The NAIC Policy Statement on Financial Regulation Standards indicates that a state insurance department should generally follow and observe the procedures set forth in the *Troubled Insurance Company Handbook*. The *Troubled Insurance Company Handbook* provides guidance regarding communication with other state insurance departments about domestic insurers identified as troubled. Specifically, the standards state:

State statute should allow for the sharing of otherwise confidential information, administrative or judicial orders, or other actions with other state regulatory officials providing that those officials are required, under their law, to maintain its confidentiality. The department should have a documented policy to cooperate and share information with respect to domestic insurers with other state regulators directly and also indirectly through committees established by the NAIC, which may be reviewing and coordinating regulatory oversight and activities. This policy should also include cooperation and sharing of information with respect to domestic insurers subject to delinquency proceedings.

The department should establish and implement procedures to ensure that regulatory actions are reported to the Regulatory Information Retrieval System (RIRS), investigative information is reported to the Special Activities Database (SAD), summary information on consumer complaints is reported to the Complaints Database System (CDS), and that the status of regulatory actions is reported to the Global Receivership Information Database (GRID). These databases are discussed in more detail in Chapter 1 Introduction—NAIC Information of this Handbook.

Effective interdepartmental action requires timely and effective communication among the various state insurance departments. Insurance departments should develop methods of multilateral communication in order to coordinate the prompt sharing of pertinent information regarding troubled insurers that may impact other jurisdictions. Open lines of communication may provide additional information to a department to assist in its surveillance, as well as, provide information to other state insurance departments. Such communications should be established to foster cooperation among the various state insurance departments, so that each department works toward the satisfactory resolution of all troubled insurer situations, regardless of the insurer’s domicile, license, or operating status. Communications to other state insurance departments regarding troubled insurers should be made in an atmosphere of appropriate confidentiality. Knowledge by outsiders of actual or contemplated regulatory activities may cause undue negative consequences to the insurer (e.g., cancellation of policies or unavailability of reinsurance coverage), which may diminish the insurer’s ability to receive assistance or to remain solvent.
The *Troubled Insurance Company Handbook* indicates that the effects on policyholders in all jurisdictions that may result from the actions of a department should be considered. Although the department should consider any adverse consequences that could possibly result from making certain information known to other state departments, those possible disadvantages may be outweighed by the advantages gained from sharing information and working with the other state insurance departments.

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

The NAIC and its various committees, task forces, and working groups may also provide a means for facilitating coordination and communication among the various departments. For example, the NAIC Examination Oversight (E) Task Force can participate in coordinating the efforts of various departments in a troubled insurer situation. An association examination of an insurance company may be requested through the NAIC, as described in the *Financial Condition Examiners Handbook*. The Financial Analysis (E) Working Group functions as a peer review by identifying insurance companies of national significance that are or may be financially troubled and determining whether appropriate regulatory action is being taken. The NAIC may also assist in organizing and facilitating other cooperative regulatory efforts, such as the formation of working groups to address specific troubled insurance company situations.
There is a considerable amount of information available to assist the analyst in analyzing insurance companies. The NAIC maintains financial databases developed from the insurer filings and state insurance department actions, all of which are described in more detail in the next chapter. In addition to the NAIC information, there are a number of external sources of information available from the major rating agencies and industry analysts. The analyst should refer to these sources of information in order to increase his or her knowledge of the insurer’s financial position and to corroborate the financial information filed by the insurer with the NAIC and state insurance departments. These sources of information are all available through direct purchase or subscription order from the rating agencies and/or industry analysts. Following is a discussion of the major sources of external information available.

Rating Agencies

There are five major rating agencies that review insurance companies. Each has its own unique methodology for assigning ratings. The rating agencies also produce other types of financial information that may be helpful to the analyst. The following paragraphs briefly describe each of the major rating agencies and the types of financial information available.

1. **A.M. Best**—The A.M. Best Company (Best) has been rating insurance companies since 1900. The objective of Best’s rating system is to evaluate the factors affecting the overall performance of an insurance company and to provide its opinion as to the company’s relative financial strength and ability to meet its contractual obligations. Best conducts an extensive quantitative and qualitative evaluation of rated insurers based on various sources of information and knowledge of the company accumulated over a period of time. This knowledge is acquired through frequent contacts with company officials, as well as statutory financial statements, special questionnaires, and a variety of other sources. For Health Entity’s, Best’s ratings encompass five categories of health insurance organizations: Commercial Health Insurers, Blue Cross Blue Shield Companies, HMOs, Delta Dental Organizations and Dental HMOs. Best’s Managed Care Reports – HMO provides, in CD-ROM format, five years of key financial data and performance ratios for approximately 700 HMOs operating in the United States. To obtain an A.M. Best rating, a newly rated insurer should have a credible business plan, experienced management, financial sponsorship/support, submit requested financial information, and pay a fee. The ratings are available through Best’s Key Rating Guide and Best’s Ratings Online. Best also publishes Best’s Aggregates and Averages, Best’s Ratings Report, Best’s Key Rating Guide, as well as many other publications, directories, reports, and periodicals.

2. **Fitch**—Fitch Ratings was founded as the Fitch Publishing Company on Dec. 24, 1913. The Company began as publisher of financial statistics and soon became the recognized leader in providing critical financial statistics to the investment community. In 1924, Fitch introduced the “AAA” to “D” ratings scale along with in-depth analysis completed by a staff of investment experts. Fitch’s rating evaluations are qualitative and quantitative and provide two basic types of ratings—insurer financial strength ratings and issuer and fixed income security ratings. The ratings are obtained via an in-depth industry, operational, organizational, management, and financial reviews. The ratings are available through Fitch’s National Ratings List and Fitch Ratings Online.

3. **Moody’s Investors Service**—Moody’s Investors Service was founded in 1900. Moody’s ratings of debt securities include taxable bonds, structured financings, and municipal bonds in the U.S. tax-exempt market. In addition, Moody’s rates U.S. Treasury debt, deposits of banking groups, trillions of dollars of credit risk exposure in derivative markets, and insurance claims. In the insurance sector, Moody’s has been rating the debt securities of insurance companies since the mid-1970s and assigning insurer financial strength ratings since 1986. Moody’s financial strength
ratings reflect its opinion as to an insurer’s ability to discharge senior policyholder obligations and claims. It seeks to measure credit risk (e.g., the risk that an insurer will fail to honor its senior policyholder claims in full and on a timely basis). Moody’s financial strength ratings are based on qualitative analysis. Moody’s disseminates its ratings through various publications and publishes credit opinions on a semi-annual basis with in-depth analysis, industry outlooks, and a statistical handbook published on an annual basis. Moody’s also publishes insurer financial strength ratings lists and insurance industry debt lists monthly.

4. **Standard and Poor’s**—Standard and Poor’s (S&P) has been rating bonds since 1923 and insurance companies’ claims-paying ability since 1983. S&P’s insurer rating activity draws from its expertise and procedures in rating debt issues and utilizes a similar classification framework, but is conducted by professional analysts whose background, experience, and/or training is focused on the insurance industry. S&P sees its role as providing risk assessment of insurers to insurance buyers rather than serving as an adviser to insurers to assist in improving the financial condition and rating. S&P’s claims-paying ability rating is an assessment of an operating insurance company’s financial capacity to meet its policyholder obligations in accordance with its terms. Claims-paying ability ratings are based on a comprehensive quantitative and qualitative financial analysis using various sources of information, including extensive interviews with company management, detailed financial data and projections, market share information, details of the investment portfolio, reinsurance program, and organizational structure.

5. **Weiss Ratings, LLC**, formerly TheStreet.com—TheStreet.com sold the insurance and bank ratings back to Weiss Group in 2010. Martin D. Weiss, founder of Weiss Research, has been publishing newsletters about money markets, interest rates, bank safety, and economic forecasting since 1971. In 1989, Weiss began publishing financial strength ratings of life, health, and annuity insurers and in 1993 they began publishing the financial strength ratings of property/casualty insurers. Weiss’ methodology and rating scale has generated some controversy within the industry. Weiss’ financial strength rating indicates its opinion regarding an insurer’s ability to meet its commitments to its policyholders under current economic conditions. An insurer’s rating is determined based on a detailed analysis of numerous factors that are synthesized into a series of indexes such as capitalization, investment safety, reserve adequacy, profitability, liquidity, and stability. The data for the analysis is obtained primarily from statutory financial statements filed with the NAIC, however, the data is supplemented by information requested from the insurer. Weiss emphasizes that it bases its analysis exclusively on objective, quantifiable information and other financial information provided by the insurers. Unlike other rating agencies, the Weiss Ratings product line does not accept compensation from the companies it rates nor does it allow the rated companies to influence the rating. Weiss supports its insurer rating activities through the sale of its rating information to the public.

**Industry Analysts**

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

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

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

Securities and Exchange Commission (SEC) Filings

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

1. Form 10-K is used to fulfill the SEC’s annual reporting requirements. The 10-K must be filed with the SEC within 90 days after the company’s year-end for a non-accelerated filer. Accelerated filers must file the 10-K 60 or 75 days after their fiscal year-end, depending on whether they are considered a large filer. Information incorporated into the 10-K includes:
   - Item 1 - Business
     - Item 1A - Risk factors
     - Item 1B - Unresolved staff comments
   - Item 2 - Properties
   - Item 3 - Legal proceedings
   - Item 4 - No required information, reserved by the SEC for future rulemaking
   - Item 5 - Market for registrant’s common equity, related stockholder matters and issuer purchases of equity securities
   - Item 6 - Selected financial data
   - Item 7 - Management’s discussion and analysis of financial condition and results of operations
     - Item 7A - Quantitative and qualitative disclosures about market risk
   - Item 8 - Financial statements and supplementary data
   - Item 9 - Changes in and disagreements with accountants on accounting and financial disclosure
     - Item 9A - Controls and procedures
     - Item 9B - Other information
   - Item 10 - Directors, executive officers and corporate governance
   - Item 11 - Executive compensation
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- Item 12 - Security ownership of certain beneficial owners and management and related stockholder matters
- Item 13 - Certain relationships, related transactions and director independence
- Item 14 - Principal accounting fees and services
- Item 15 - Exhibits and financial statement schedules

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

3. *Form 8-K* is used to report material events or corporate changes that have not yet been reported. The 8-K is required after any of the following events occur:
   - Change in control
   - Major acquisition or disposition of assets (for certain acquisitions and dispositions, historical and pro forma financial statements are required)
   - Bankruptcy or receivership
   - Change of independent accountant
   - Resignation of registrant’s directors
   - Change in fiscal year
   - Other events – see SEC’s website for details

**Other External Sources**

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

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

**Financial Analysis Solvency Tools (FAST)**

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

**Scoring System**

The Scoring System consists of a series of ratios, calculated annually and quarterly, for which an insurer scores a given number of points based on certain parameters set for each ratio. Certain insurers writing both life and accident and health insurance meet the requirements for “hybrid” status. For these hybrid insurers, both life and accident and health ratios are available. There are 19 annual ratios and 14 quarterly ratios for life insurers, 18 annual ratios and 18 quarterly ratios for A&H insurers, 16 annual ratios and 13 quarterly ratios for health entities, 22 annual ratios and 14 quarterly ratios for property/casualty insurers, and 17 annual ratios and 13 quarterly ratios for fraternal societies. These ratios focus on an insurer’s financial position, results of operations, cash flow and liquidity, and leverage. Insurers with the highest scores would generally be considered a higher risk of potential insolvency. The Scoring System is designed so that an analyst can screen insurers on a total score basis or analyze each ratio result separately. Annually, the NAIC Financial Analysis and Examination Unit, under the direction of the Financial Analysis Research and Development (E) Working Group, is responsible for ensuring that the Scoring System ratios are current and continue to be relevant to solvency monitoring, and that scoring parameters remain appropriate.

**Financial Profile Reports**

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

**IRIS Ratio Application**

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

The IRIS ratio application uses key financial data from the Annual Financial Statement to calculate ratio results. There are 13 IRIS ratios calculated for property/casualty insurers, 12 for life insurers and 11 for fraternal societies. The calculated results for each insurer are compared to the usual range of results for each ratio. Falling outside the usual range is not considered a failing result. For example, an increase in
surplus or premiums that is larger than usual is not necessarily a problem. Furthermore, in some years it may not be unusual for financially stable insurers to have several ratios with results outside the usual range.

IRIS ratio results are dependent on the accuracy of the Annual Financial Statement filed by insurers. The ratios cannot identify a misstatement of financial condition or the application of improper accounting practices or procedures. In fact, the NAIC warns state insurance departments not to rely on IRIS ratios as the only form of financial surveillance of insurers. IRIS ratios should be used in conjunction with the other NAIC solvency tools.

**Analyst Team System**

The Analyst Team reviews the Annual Financial Statement and ratio results of insurers meeting certain criteria and consists of experienced examiners and analysts from state insurance departments representing all zones of the NAIC. The Analyst Team reviews selected companies, validates automated level designations, and provides brief synopses of their validation findings or provides comments explaining factors that affect the company’s overall financial condition. Companies are selected for validation based upon criteria established by the NAIC Examination Oversight (E) Task Force.

**Jumpstart Reports**

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

1. **Assumed/Ceded Reinsurance Reports**—Verifies reinsurance ceded for an insurer by comparing reserves and premiums ceded per the reinsurance schedules of the insurer being analyzed with reserves and premiums assumed per the assuming insurers’ reinsurance schedules.

2. **Investment CUSIP Exception Report**—Matches the insurer’s Schedule D with the SVO Master File and produces an exception report of all securities with CUSIP numbers not listed on the SVO Master File.

3. **Investment Designation Exception Report**—Matches the insurer’s Schedule D with the SVO Master File and produces an exception report of all securities with SVO designations different from those listed on the SVO Master File.

4. **Investment Market Value Exception Report**—Matches the insurer’s Schedule D with the SVO Master File and produces an exception report of all securities with market values different from those listed on the SVO Master File.

5. **Investment Material Holdings Report**—Produces a listing of all securities owned, by issuer, where the market value of all securities of an individual issuer owned by the insurer is greater than a specified percentage of the insurer’s prior year admitted assets or capital and surplus.

6. **Investment Specified Designation Report**—Produces a listing of all securities owned by an insurer whose designations match a specified designation.
Loss Reserves

Loss reserve analysis for a specific line of business can be performed for property/casualty insurers via I-SITE. The following is a brief discussion of some of the loss reserve reports.

1. **Data Triangles**—Formats Schedule P, Parts 2, 3, and 6 data into a triangle that is traditionally used to analyze loss data.

2. **Age-To-Age Development Factors**—Creates age-to-age development factors in a triangle format for various projection methods.

3. **Loss Ratios**—Computes loss ratios based on premium and loss information by line of business in a triangle format.

4. **Loss Reserve Projections**—Creates a loss projection report by line of business using case reserves or paid numbers using various projection methods.

Regulatory Information Retrieval System (RIRS)

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

Special Activities Database (SAD)

SAD is a confidential computerized database that tracks insurers, individuals, and entities that have been the subject of state insurance department inquiry. SAD is designed to flag entities or individuals of insurance regulatory concern and to provide regulatory contacts for obtaining more detailed information. SAD does not provide all of the details regarding events, dates, or related issues but does provide a summary of each activity involving the insurer. These details should be fully investigated before any further regulatory action is contemplated.

Complaints Database System (CDS)

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

Market Initiative Tracking System (MITS)

MITS tracks information concerning actions state regulators take in investigating the business practices of insurers. This system was designed to capture market initiatives that may impact other jurisdictions. These initiatives may include, but are not limited to, any of the options from the continuum of regulatory responses:

- Applied Regulatory Responses and Enforcement Actions
- Interviews with the Insurer, Correspondence or Information Gathering
- Desk Audits, Insurer Self Audits, or On-Site Audits
- Voluntary Compliance Programs
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- Information Sharing
- Investigation
- Targeted, Comprehensive, and Multi-Jurisdictional Examinations

**Global Receivership Information Database (GRID)**

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

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

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

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

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

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

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

Recognition—The principal focus of solvency measurement is determination of financial condition through analysis of the balance sheet. However, protection of the policyholders can only be maintained through continued monitoring of the financial condition of the insurer. Operating performance is another indicator of an insurer’s ability to maintain itself as a going concern. Accordingly, the income statement is a secondary focus of statutory accounting and should not be diminished in importance to the extent contemplated by a liquidation basis of accounting.
The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than for fulfilling policyholder obligations, or those assets that may be unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet but rather should be charged against surplus when acquired or when availability otherwise becomes questionable.

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

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

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

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

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

There are two main conceptual differences between SAP and GAAP. First, SAP stresses measurement of the ability to pay claims in the future, whereas GAAP stresses measurement of emerging earnings of a business from period to period (e.g., matching revenue to expenses).

The following is a discussion of the more significant specific differences between SAP and GAAP for property/casualty, life/A&H insurers, fraternal societies and health entities:

**Acquisition Costs**—Under Statement of Statutory Accounting Principles (SSAP) No. 71, *Policy Acquisition Costs and Commissions*, all acquisition costs, such as commissions and other costs incurred in acquiring and renewing business, are expensed as they are incurred. Under GAAP, those acquisition costs that are primarily related to, and vary with, the volume of premium income are capitalized as an asset and are then amortized by periodic charges to earnings over the terms of the related policies.

**Valuation of Bonds and Redeemable Preferred Stocks**—Under SSAP No. 26, *Bonds, Excluding Loan-Backed and Structured Securities* and SSAP No. 32, *Investments in Preferred Stock (including investments in preferred stock of subsidiary, controlled, or affiliated entities)*, bonds and redeemable preferred stocks are carried at amortized cost or NAIC values in accordance with the NAIC designation of the securities. Under GAAP, bonds and redeemable preferred stocks are carried at amortized cost only if the insurer has the ability and intent to hold the securities to
maturity and there are no (other than temporary) declines in fair value, otherwise, they are carried at market.

Nonadmitted Assets—Under SSAP No. 4, Assets and Nonadmitted Assets as superseded by SSAP No. 87, Capitalization Policy, An Amendment to SSAP Nos. 4, 19, 29, and 73, assets having economic value, other than those that can be used to fulfill policyholder obligations or other third party interests, should not be recognized on the balance sheet and are, therefore, considered nonadmitted. SSAP No. 4 defines nonadmitted assets as an asset that is accorded limited or no value in statutory reporting, and is one that is either specifically identified as a nonadmitted asset or not specifically identified as an admitted asset within the AP&P Manual. SSAP No. 20, Nonadmitted Assets, specifically identifies the following as nonadmitted assets: deposits in suspended depositories; bills receivable not for premium and loans unsecured or secured by assets that do not qualify as investments; loans on personal security, cash advances to, or in the hands of, officers or agents and travel advances; all non-bankable checks (e.g., non-sufficient funds); trade names and other intangible assets; automobiles, airplanes, and other vehicles; furniture, fixtures, and equipment; and company’s stock as collateral for loan.

Deferred Income Taxes—Under SSAP No. 101, Income Taxes, A Replacement of SSAP No. 10R and SSAP No. 10, deferred income tax assets are limited under admissibility test and amounts over the criterion are nonadmitted. Under GAAP, a valuation allowance is used to reduce the asset to what can be realized. Also, under SSAP No. 101, changes in deferred tax assets and deferred tax liabilities are reported as a separate line in the surplus section. Under GAAP, changes in DTAs and DTLs are recognized in earnings.

Goodwill—Under SSAP No. 68, Business Combinations and Goodwill as superseded by SSAP No. 97, Investments in Subsidiary, Controlled and Affiliated Entities, A Replacement of SSAP No. 88 goodwill represents the difference between the cost of acquiring the entity and the reporting entity’s share of the book value of the acquired entity. Under GAAP, goodwill represents the difference between cost of acquiring the entity and the fair value of the assets less liabilities acquired.

Surplus Notes—Under SSAP No. 41, Surplus Notes, surplus notes meeting certain requirements are considered as surplus. Under GAAP, surplus notes are considered to be debt.

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

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

The following addresses reporting for risk retention groups (RRGs):

State regulators utilize financial analysis tools and RBC standards to evaluate the financial condition of insurance companies. The benchmarks for these tools are based on SAP. Since most states do not require RRGs to follow the same accounting principles when preparing their financial reports, the results may not be as meaningful or reliable and even misrepresented because the tools are being compared to financial data reported under GAAP, modified SAP, and modified GAAP. Additionally, most RRGs formed as captives are not required to comply with the NAIC’s RBC requirements or the insurance holding company statutes, which can affect the traditional methods used to assess the financial condition of an insurer.
I. Introduction – F. Prioritization of Work

The NAIC Policy Statement on Financial Regulation Standards indicates that a state insurance department’s financial analysis process should be priority-based to ensure that potential problem insurers are reviewed promptly and that the prioritization scheme should utilize the NAIC Insurance Regulatory Information System (IRIS) and/or a state insurance department’s own system.

To facilitate the financial analysis process, state insurance departments should establish a system to prioritize or classify insurance companies according to each insurer’s relative stability and the perceived need for analysis. This prioritization system may be either formal, including the assignment of priority designations, or informal in nature. States with a small number of domestic insurers may consider all of its domestic insurers to be priority companies. However, states with a larger number of domestic insurers generally have more formal prioritization systems. In these states, prioritization is necessary because a state insurance department’s financial analysts are not able to thoroughly analyze the financial condition of all insurers immediately upon receipt of the Annual and Quarterly Financial Statements and the supplemental filings.

An insurer’s priority level should be reconsidered as the result of each review performed to determine whether the designation is still appropriate. However, changes in priority levels should only be made after approval by senior insurance department personnel.

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

- Results of the prior-year analysis (including the analysis of the Annual Financial Statement, Quarterly Financial Statements, and the various supplemental filings)
- Whether the insurer was an ATS-validated Level A or B in the prior year and in the NAIC Analyst Team Report
- Adequacy of the insurer’s capital and surplus
- Significant changes in the insurer’s surplus/capital and surplus (based on business type)
- Negative trends in income and/or cash flow
- IRIS ratio results and the NAIC Analyst Team Report
- Annual and quarterly Scoring System results
- Changes in the insurer’s management or board of directors
- Results of the Financial Analysis Handbook
- Issues / Questions identified by the NAIC Financial Analysis (E) Working Group
- Examination reports issued (financial condition and market conduct)
- Information from other divisions or areas of the insurance department
- Independent organization ratings and reports
- Any reports that may be available from the state’s Department of Health or other state agencies with financial solvency oversight responsibilities
- RBC results
- Impact on the public of an insurer’s insolvency
As a general rule, financial statements and other materials pertaining to those insurers that are deemed a high priority should be reviewed before those materials pertaining to lower priority insurers. In addition, the review of high priority insurers might be more in-depth than the review of lower priority insurers.
II. Financial Analysis Framework
II. Financial Analysis Framework

Overview of the Financial Analysis Process

Financial analysis is an ongoing process that can be divided into annual cycles, each of which includes the analysis of the Annual Financial Statement, Quarterly Financial Statements, and the various supplemental filings, such as the Statement of Actuarial Opinion & Actuarial Opinion Summary, Management’s Discussion and Analysis (MD&A), Audited Financial Report, and Holding Company filings. The financial analysis process is designed to assist the analyst in reviewing and analyzing insurers throughout the annual cycle in a logical manner, focusing on areas of concern pertaining to the particular insurers being analyzed. The end result of this process is a financial analysis of each insurer specifically tailored to the concerns of that insurer as a result of its unique investments, underwriting, reserving, and operations. Some of the financial analysis procedures are to be completed for all domestic insurers, while other procedures will only be completed if concerns are noted.

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1. Based on the characteristics of a state’s domestic industry, the state insurance department determines when and to what extent the Level 2 Procedures for annual and quarterly, or any similar analysis designed to meet the same objectives, should be performed for areas that are significant to the insurer.

2. The completion of applicable management considerations procedures or similar analysis is recommended for all multi-state insurers, based on the level of concern an analyst may have with management performance and the driving forces behind operations.

3. The completion of the supplemental procedures or similar analysis is recommended for all multi-state insurers.

4. The completion of the applicable holding company procedures or similar analysis is recommended for all multi-state insurers, if the insurer is part of a holding company system.

5. Applicable to lead state only.

The following provides an overview of the Handbook’s analysis process for an annual cycle, which focuses on the various documents filed with the insurance department by an insurer. The annual cycle is also presented in flowchart format at the end of this section.
II. Financial Analysis Framework

Annual Financial Statement

An insurer is required to file an Annual Financial Statement with its state of domicile, the NAIC, and all jurisdictions in which the insurer is authorized to transact business by March 1 of each year for the 12 months ended December 31 of the previous year. The Annual Financial Statement information is loaded onto the NAIC database, at which time the Annual Scoring System and IRIS ratios are calculated and the NAIC Annual Financial Profile Report and Handbook results are generated. All of this information is available to the state insurance departments via I-SITE.

The analysis of the Annual and Quarterly Financial Statements have been divided into two levels. Level 1 Procedures are to be performed for all domestic insurers. Level 2 Procedures may be completed as a result of concerns identified by Level 1 Procedures at the state insurance department’s discretion, based on the materiality of the concerns noted and its prior knowledge of the insurer. At any level of analysis, the department may determine that there is no further concern or may proceed directly to regulatory action. Following is a detailed discussion of each level of annual financial statement analysis.

Level 1 Annual Analysis

Insurance department staff should be aware that an insurance department may choose to utilize the Handbook or a set of procedures that are substantially similar as outlined within the Accreditation Guidelines. If the insurance department chooses to utilize the Handbook, the Level 1 procedures should be completed. It is important to note that the depth of review will depend on the complexity and financial strength as well as known risks of the insurer. Therefore, the insurance department may consider a tailored set of procedures that addresses the specific risks of the insurer.

The Level 1 Procedures consist of an overall analysis of the insurer and its operations. As part of the Level 1 Procedures, the analyst should review the NAIC’s I-SITE Analyst Team System Report, Annual Scoring System Report, IRIS ratios, and the information included in the NAIC Annual Financial Profile Report for the insurer. In addition, the analyst should perform the procedures included in Level 1 or any similar analysis designed to meet the same objectives. Procedures included in Level 1 require the analyst to review the analysis performed during the prior year and to perform an overall review of the Annual Financial Statement, including a review of the General Interrogatories and Notes to Financial Statements. Other reports to be reviewed are the Audited Financial Report, Statement of Actuarial Opinion, MD&A, Holding Company filings, and examination report and findings when they are filed.

The analyst should ensure that those insurers identified as having significant concerns as a result of the Level 1 Procedures or any other levels, will be analyzed on a priority basis for future filings. Those insurers with the highest priority should receive the most in-depth review. The analyst should consider utilizing these prioritization tools: Analyst Team System Report, the Annual Scoring System Report, the Risk-Based Capital (RBC) Report, and IRIS ratios.

There are five elements of the risk-focused surveillance cycle:

1) Risk-Focused Examination—addresses the need to identify key functional activities, risks, controls, and establish procedures and conduct an examination.
2) Off-Site Focused Financial Analysis—includes the use of all financial tools, such as ratio analysis.
3) Internal/External Changes—reviews any overall modifications to the insurer, such as corporate structure or management changes.
4) Priority System—used to establish a priority of insurer reviews.
5) Supervisory Plan—addresses the overall oversight of the insurer.
II. Financial Analysis Framework

As part of the risk-focused surveillance approach, the analyst should work with the examination staff to assess the quality and reliability of corporate governance in order to identify, assess and manage the risk environment facing the insurer. This assessment will assist in identifying current or prospective solvency risk areas. Refer to Analyst Reference Guide for Level 1 Procedures for further discussion on prospective risk. By understanding the corporate governance structure and assessing 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, including the code of conduct established in cooperation with the board. To assist in this assessment, analysts may utilize:

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

At the conclusion of the Level 1 Procedures, the analyst must determine whether to proceed to the Level 2 Procedures. This determination should be approved in accordance with the state departmental procedures. State insurance departments can make this decision in a variety of ways. For example, in some states, Level 2 Procedures may be completed for all domestic insurers. Other states may require certain portions (e.g., investments, reserves, or reinsurance) of the Level 2 Procedures to be completed for all domestic insurers. Still other states may require Level 2 Procedures to be completed only for those domestic insurers that meet certain criteria established by the state insurance department. The department could also determine that additional procedures found in Level 2 be completed per regulatory action or required by state insurance law, regulation, or department policy. Alternatively, the analysis may be concluded with only the completion of the Level 1 Procedures. At the completion of the analysis process, including any Level 1, 2, or Supplemental Procedures, the analyst should update the Insurer’s Profile Summary; (see Analyst Reference Guide for Level 1 Procedures).

Level 2 Annual Analysis

Because of the importance of financial analysis in the state’s overall financial regulation and solvency surveillance process, the NAIC recommends that consideration be given to performing some portion of the Level 2 Procedures for multi-state domestic insurers. The NAIC believes that Level 2 Procedures (or applicable sections) should be performed for multi-state domestic insurers that have unresolved concerns that were identified as a result of prior analysis. Other factors, such as the insurer’s past regulatory history, accuracy of filing, age of insurer, stability of business plan, and knowledge of insurer’s operations, may affect the extent to which sections within Level 2 Procedures are considered necessary.

The Level 2 Procedures have been designed to identify potential areas of concern regarding the financial position and operations of the insurer, primarily through the use of ratio and trend analysis. The Level 2 Procedures are divided into sections that focus on key areas (e.g., investments, reserves, reinsurance, income statement, etc.) and utilize information available from the Annual Financial Statement filed by the insurer. Each section includes one or more procedures that concentrate on a particular issue of possible concern. In addition, each procedure includes one or more questions designed to assist the analyst in determining whether or not there is a concern regarding a particular issue that would require additional analysis in that area. If the analyst has questions regarding procedures included in any of the sections of the Level 2 Procedures, refer to the Analysts Reference Guide for guidance of the procedures.

At the end of each section of the Level 2 Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the sections, determine whether one or more of the additional procedures in this section should be completed if concern exist, and describe the rationale for this
II. Financial Analysis Framework

recommendation or recommend proceeding directly to other regulatory action. It may be appropriate that the information be reviewed and approved prior to the analyst completing any of the additional procedures in this section. In addition, at the conclusion of an analysis, a management report that summarizes the results of the analysis performed, including the priority level assigned to each insurer, should be prepared and distributed to senior insurance department personnel.

The additional Level 2 Annual Procedures are designed to assist the analyst in focusing on those areas of the Level 2 Annual Procedures where specific concerns exist. If the analyst has questions regarding procedures included in any of the additional procedures, refer to the Analysts Reference Guide for further guidance.

Some of the additional procedures in Level 2 require the analyst to obtain additional information from the insurer that is not available from the Annual Financial Statement. Therefore, it is important that the analyst’s proposed procedures be discussed with and approved by the analyst’s supervisor prior to completion of the procedures. At this time, consideration of more substantive regulatory action may be warranted for a more efficient utilization of department resources.

At the end of each section of the Level 2 Procedures, the analyst is asked to develop and document an overall summary and conclusion and indicate any recommendations for further action based on the procedures performed. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer’s business plan, requiring additional interim reporting from the insurer, referring concerns to the examination section for a targeted examination, engaging an independent expert to assist in determining whether a problem exists, meeting with the insurer’s management, obtaining a corrective plan from the insurer, etc. At the conclusion of the Level 2 Procedures, a management report should be prepared and distributed to senior insurance department personnel. As discussed previously, the management report should summarize the results of the analysis performed, any recommendations for further action, and any adjustment to the priority level of the insurer.

It is important for the analyst’s supervisor to be actively involved in each level of the financial analysis performed. It is also important that the review and supervision be performed on a timely basis.

Quarterly Financial Statements

An insurer is required to file Quarterly Financial Statements for the first, second, and third quarters with the state of domicile, the NAIC, and in most instances, all states in which the insurer is authorized to do business by May 15, Aug. 15, and Nov. 15, respectively. The Quarterly Financial Statement is loaded onto the NAIC database, at which time the Quarterly Scoring System ratios are calculated and the Quarterly Financial Profile Report is generated. This information is available to the state departments via I-SITE.

The Level 1 Quarterly Procedures are to be completed for all domestic insurers. Separate procedures exist for troubled and non-troubled insurers. As part of the Quarterly Financial Statement review, the analyst should also review all levels of procedures completed for annual and any prior quarterly procedures that were previously completed. In addition, the analyst should review the Quarterly Financial Profile Report, Quarterly Scoring System Report, and the Quarterly Financial Statement. The Level 1 Quarterly Procedures are designed to identify potential areas of concern regarding the financial position and operations of the insurer, primarily through the use of ratio and trend analysis, and to indicate significant fluctuations from the prior quarter, prior quarter-to-date, or prior year-end. The analyst will make the
II. Financial Analysis Framework

same determinations as for the annual review process, whether to proceed with additional analysis or other procedures.

The Level 2 Quarterly Procedures are divided into sections, each focusing on a key area for a more in-depth review (similar to the Level 2 Annual Procedures), and utilize information available from the Quarterly Financial Statements filed by the insurer. Each section includes one or more procedures designed to assist the analyst in determining whether there is a concern in a particular area that would require more in-depth analysis, and a determination similar to those required in the annual procedures. If the analyst has questions regarding procedures included in any of the sections for the quarterly procedures, refer to the Analysts Reference Guide for further guidance.

As part of the risk-focused surveillance approach, the analyst should work with the examination staff to assess the quality and reliability of corporate governance as discussed previously in the Annual Financial Statement section.

At the end of each section of the Level 2 Quarterly Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the procedures performed, recommend whether one or more of the additional procedures within Level 2 for this section should be completed (if not completed during the analysis of the Annual Financial Statement), and describe the rationale for the recommendation or recommend other substantive regulatory action. The analyst should also document any correspondence or follow-up with the insurer. This information should be reviewed and approved by the analyst’s supervisor prior to the analyst completing any of the additional procedures within Level 2. In addition, at the conclusion of an analysis, a management report that summarizes the results of the analysis performed, including the priority level assigned to each insurer, should be prepared and distributed to senior department personnel. If results for the Level 1 non-troubled automated systems calculation indicates a full Level 1 quarterly review should be done and it is not, then the analyst should justify and document the reason(s) why.

Management Considerations

The Management Considerations Supplemental Procedures review may be completed for domestic insurers if the Level 1 analysis indicated further analysis was necessary. The Management Considerations Supplemental Procedures encompass the following analysis areas:

- Corporate governance
- Compliance with state statutes, accounting and reporting
- Reputational risk
- Legal/fraud
- Strategic business plans, financial projections, and other operating considerations
- Risk management

Depending on the level of concern with management performance and the driving forces behind operations, it may not be necessary to complete all of the procedures within the Management Considerations Analysis Supplemental Procedures.

Audited Financial Report

Nearly all insurers are required to file, as a supplement to the Annual Financial Statement, an Audited Statutory Financial Report completed by an independent auditor, the auditor’s letter of qualifications, and, if applicable, a report of significant deficiencies in the insurer’s internal control structure. These reports are to be filed with the state of domicile, the NAIC, and all states in which the insurer is authorized to do
II. Financial Analysis Framework

business by June 1 and August 1 of each year as of the 12 months ended December 31 of the previous year.

The Audited Financial Report Supplemental Procedures are to be completed for all domestic insurers if Level 1 Procedures indicated further review was necessary. The Supplemental Procedures for the Audited Financial Report are designed to assist the analyst in reviewing the audited financial statements, auditor’s letter of qualifications, and other reports filed to determine that they meet the requirements of the Annual Statement Instructions. They also assure that amounts in the audited financial statements agree with the Annual Financial Statement filed with the state insurance department and identify significant information and explanatory language included in the auditor’s opinion or the Notes to the Audited Financial Statements.

At the end of the Audited Financial Report Supplemental Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the information in the Audited Financial Report and to indicate recommendations for further action, if any, based on the procedures performed. Recommendations for further action might include contacting the insurer for explanations or additional information from either the insurer or the independent CPA, obtaining the insurer’s business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the insurer’s management, or obtaining a corrective plan.

Statement of Actuarial Opinion & Actuarial Opinion Summary or Regulatory Asset Adequacy Issues Summary

Insurers are required to file a supplement to the Annual Financial Statement—a Statement of Actuarial Opinion—with the state of domicile, the NAIC, and all states in which the insurer is authorized to transact business by March 1 of each year covering the reserves as of December 31 of the previous year. A qualified actuary must complete the Statement of Actuarial Opinion.

The Statement of Actuarial Opinion review is to be completed for all domestic insurers as part of the Level 1 Procedures and, if indicated, the analyst should complete the Statement of Actuarial Opinion Supplemental Procedures. If the Level 1 Procedures indicate further analysis is necessary, the analyst could review the reserves and reinsurance section of the Level 2 Procedures. The Statement of Actuarial Opinion & Actuarial Opinion Summary or Regulatory Asset Adequacy Issues Summary (RAAIS) Supplemental Procedures have been designed to assist the analyst in reviewing the Statement of Actuarial Opinion to determine that it meets the requirements of the Annual Statement Instructions, that reserve amounts per the Actuarial Opinion agree with the reserve amounts per the Annual Financial Statement filed with the state insurance department, and to identify significant information and explanatory language regarding the insurer that has been emphasized by the qualified actuary. The procedures with regard to the Actuarial Opinion Summary assist the analyst in reviewing reserve practices.

At the end of the Statement of Actuarial Opinion & Actuarial Opinion Summary or RAAIS Supplemental Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the information in the Statement of Actuarial Opinion & Actuarial Opinion Summary or RAAIS and to indicate any recommendations for further action based on the procedures performed. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer’s business plan, requiring additional interim reporting from the insurer, referring concerns to the examination section for a targeted examination, consulting with an in-house actuary, engaging an independent actuary to assist in determining whether a problem exists, meeting with the insurer’s management, or obtaining a corrective plan from the insurer.
Management’s Discussion and Analysis

An insurer is required to file as a supplement to the Annual Financial Statement an MD&A with the state of domicile, the NAIC, and all states in which the insurer is authorized to do business by April 1 of each year. The purpose of this narrative document is to assist the analyst in understanding the insurer’s financial condition, change in financial condition, liquidity, loss reserves, prospective information, off-balance sheet arrangements, participation in high yield financings, highly leveraged transactions or non-investment grade loans and investments, and preliminary merger/acquisition negotiations.

The MD&A Supplemental Procedures may be completed for all domestic insurers if the Level 1 Procedures indicated further review is necessary. The analyst should review the Annual Procedures completed and complete the MD&A Supplemental Procedures. The MD&A review should be completed at the time of the Annual Financial Statement review if possible. The MD&A Supplemental Procedures are designed to assist the analyst in reviewing the MD&A to determine that the information included meets the requirements of the Annual Statement Instructions and to identify concerns as a result of the information provided.

Upon completion of the MD&A Supplemental Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the information in the MD&A and to indicate any recommendations for further action based on the procedures performed. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer’s business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the insurer’s management, or obtaining a corrective plan from the insurer.

Flow Charts

The following flow charts illustrate the annual cycle of the financial analysis process. The flow charts generally indicate that a “Yes” response results in further analysis. However, if an insurer’s RBC is below 200 percent, a state department may determine it is necessary to take the required legal action immediately prior to any further analysis.
II. Financial Analysis Framework

**Annual Financial Statement**

*Level 1 Analysis***
- Review the Scoring System report
- Review the IRIS ratios
- Review the Company Financial Profile, RBC ratio, and ATS
- Complete the Level 1 Procedures

Are there any new or unresolved concerns as a result of the completion of the Level 1 Analysis?
- Yes
- No

**Level 2 Analysis**
- Complete the Level 2 Procedures for those areas where material concerns exist
- Prepare a management report summarizing the Level 2 Procedures results
- Complete the Supplemental Procedures for those areas where material concerns exist

Are there any new or unresolved concerns as a result of the completion of the Level 2 Analysis?
- Yes
- No

**Additional Level 2 Analysis**
- Complete the Additional Level 2 Procedures for those areas where material concerns exist
- Prepare a management report summarizing the Additional Level 2 Procedures results

Are there any new or unresolved concerns as a result of the completion of the Additional Level 2 Analysis?
- Yes
- No

**Recommendations for Further Action**
- Request additional information from the insurer
- Obtain the insurer's business plan
- Request additional interim reporting
- Perform target examination
- Engage an independent expert
- Meet with the insurer's management
- Obtain a corrective plan from the insurer
- Other

* Received by March 1.
** All domestics receive Level 1 Analysis. Perform Level 2 Annual Procedures for significant areas.
*** Recommend completing Supplemental Procedures for multi-state insurers.
II. Financial Analysis Framework

**Statement of Actuarial Opinion & Actuarial Opinion Summary or RAAIS**

- Review the reserves and the reinsurance sections of the Level 2 Procedures
- Review the reserves and the reinsurance sections of the Level 2 Additional Procedures (if completed)
- Complete the Supplemental Procedures for the Statement of Actuarial Opinion & Actuarial Opinion Summary or RAAIS

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**Recommendations for Further Action**

- Request additional information from the insurer
- Obtain the insurer's business plan
- Request additional interim reporting
- Perform target examination
- Engage an independent expert
- Meet with the insurer's management
- Obtain a corrective plan from the insurer
- Other

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* Received by March 1
** Received by state March 15 (not filed with NAIC)
II. Financial Analysis Framework

Management's Discussion & Analysis*

**MD&A Analysis**
- Review the Level 2 Annual Procedures
- Review the Level 2 Additional Procedures
- Complete the MD&A Supplemental Procedures

Are there any new or unresolved concerns as a result of the completion of the MD&A Supplemental Procedures?

* Yes
  - Request additional information from the insurer
  - Obtain the insurer's business plan
  - Request additional interim reporting
  - Perform target examination
  - Engage an independent expert
  - Meet with the insurer's management
  - Obtain a corrective plan from the insurer
  - Other

* No further analysis is required.

* Received by April 1.
II. Financial Analysis Framework

**Audited Financial Report**
- Review the Level 2 Annual Procedures
- Review the Level 2 Additional Procedures
- Complete the Audited Financial Report Supplemental Procedures

Are there any new or unresolved concerns as a result of the completion of the Audited Financial Report Supplemental Procedures?

**Recommendations for Further Action**
- Request additional information from the insurer
- Obtain the insurer's business plan
- Request additional interim reporting
- Perform target examination
- Engage an independent expert
- Meet with the insurer's management
- Obtain a corrective plan from the insurer
- Other

* Received by June 1.
Holding Company System Analysis

The Holding Company System Analysis Supplemental Procedures review should be completed for domestic insurers. The depth of the holding company analysis of an insurer in a holding company system will depend on the characteristics (e.g., sophistication, complexity, financial strength) of the holding company system, availability of information, and existing potential issues and problems found during review of the holding company filings. Insurance department staff may use holding company procedures developed by the department or obtained from the Handbook, and these may be tailored to the group under review based on its characteristics. Lead state and non-lead state responsibilities are defined in the Analyst Reference Guide for Holding Company Procedures. The Holding Company System Analysis Supplemental Procedures encompass the following analysis areas:

- Holding company system structure
- Supplemental forms

The following checklists are included within the Holding Company System Analysis Supplemental Procedures:

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

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

Form B
The Form B review is to be completed for all insurers that are members of a holding company system if Level 1 analysis indicated further procedures were necessary. The analyst should review the affiliated transactions section of the Level 2 Annual Procedures, if completed, and complete the Form B Supplemental Procedures. The Form B Supplemental Procedures are designed to assist the analyst in reviewing Form B to determine that the appropriate information has been filed and whether concerns exist regarding the financial position of the ultimate controlling person or any of the affiliated transactions or agreements.

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

Form E or Other Required Information on Competitive Impact
The Form E or other review of competitive impact is to be completed for all pre-acquisition notifications regarding the potential competitive impact of a proposed merger or acquisition by a non-domiciliary insurer doing business in the state or by a domestic insurer. Form E or other required information must be filed with the domestic state. The insurer may also be required to file documents with the Federal Trade Commission and the U.S. Department of Justice under the Hart-Scott-Rodino Act. The analyst should review the transaction and all applicable documents and complete the Form E Supplemental Procedures, when necessary.
II. Financial Analysis Framework

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

At the end of the Holding Company System Analysis Supplemental Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the information reviewed and to indicate any recommendations for further action based on the procedures performed. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer’s business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the insurer’s management, or obtaining a corrective plan from the insurer.

Group-wide Supervision

The Group-wide Supervision Procedures establish the guidance for the analysis of insurance company holding systems. This includes a risk-focused approach to group regulation where specific risks that are relevant to insurance holding company structures are addressed. The Group-wide Supervision, Holding Company System Analysis Procedures encompass the following analysis areas:

- Understanding the holding company system
- Evaluate the overall financial condition of the holding company system
- Lead state and interstate communication
- Identify and understand affiliated risks within the holding company system
- Additional procedures on key risk areas

The following is included in the Group-wide Supervision Procedures:

Form F
The Form F review is to be completed in conjunction with the review of Form B. The analyst should identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The Form F is filed with the lead state commissioner of the insurance holding company system for every insurer subject to registration under the NAIC Insurance Holding Company System Regulatory Act (#440).

Captives and/or Insurers Filing on a U.S. GAAP Basis
These procedures are designed for insurers filing on a U.S. GAAP (or modified GAAP) basis, after the completion of the traditional Level 1 Procedures. The procedures provide guidance on the review of a GAAP filer on a statutory blank and address the following areas:

- Management assessment
- Balance Sheet assessment
- Operations assessment
- Investment practices
- Review of disclosures
- Assessment of results from prioritization and analytical tools
III. Annual/Quarterly Procedures and Analyst Reference Guide

A. Level 1 (All Statement Types)
   1. Insurer Profile Summary Template

B. Level 2: Property/Casualty
   1. Investments
      1a. Investments – Primer on Derivatives
   2. Unpaid Losses and LAE
   3. Income Statement and Surplus
   4. Risk-Based Capital
   5. Cash Flow and Liquidity
   6. Reinsurance
   7. Affiliated Transactions
   8. MGAs and TPAs

C. Level 2: Life/A&H (and Fraternal for Investments only)
   1. Investments
      1a. Investments – Primer on Derivatives
   2. Life Reserves
   3. Accident and Health Reserves
   4. Annuity Reserves
   5. Income Statement and Surplus
   6. Health Care Pursuant to Public Health Service Act
   7. Risk-Based Capital
   8. Cash Flow and Liquidity
   9. Reinsurance
  10. Affiliated Transactions
  11. MGAs and TPAs
  12. Separate Accounts

D. Level 2: Health
   1. Investments
   2. Other Assets
   3. Health Reserves and Liabilities
   4. Other Provider Liabilities
   5. Income Statement and Surplus
   6. Health Care Pursuant to Public Health Service Act
   7. Risk-Based Capital
   8. Cash Flow and Liquidity
   9. Risk Transfer Other than Reinsurance
  10. Reinsurance
  11. Affiliated Transactions
  12. TPAs, IPAs and MGAs
Instructions

Insurance department staff should be aware that an insurance department may choose to utilize the Handbook or a set of procedures that are substantially similar as outlined within the Accreditation Guidelines. If the insurance department chooses to utilize the Handbook, the Level 1 procedures should be completed. It is important to note that the depth of review will depend on the complexity and financial strength as well as known risks of the insurer. Therefore, the insurance department may consider a tailored set of procedures that addresses the specific risks of the insurer.

The analyst may choose to document the results of the review following each applicable procedure or within the summary and conclusions.

Background Analysis

1. Review the analysis performed on the insurer for the prior year and prior quarters.
   a. Indicate the state’s priority designation or any prioritization tool result (if applicable) as of the last review and start of the current review:
      - State’s Priority Designation _____
      - Scoring System Result _____
      - IRIS Ratio Result _____
      - Analyst Team System Validated Level _____
      - RBC Ratio and Trend Test _____
      - Hazardous Financial Condition Regulation _____
   b. Were there any issues, concerns or prospective risks noted in previous annual or quarterly analysis completed in the prior year? If “yes,” discuss the issues, concerns or prospective risks, the follow-up conducted, and include any correspondence with the insurer, along with any conclusions. (Consider the prospective risks previously identified in the scope of the current analysis.)
   c. Review the Insurer Profile Summary, including the Supervisory Plan, if applicable, and document any areas of concern that impact the current analysis.

2. Review any inter-departmental communication, as well as communication with other state insurance departments and the insurer. Note any unusual items or areas that indicate further review or follow-up is necessary.

3. Review General Interrogatories, Part 1, #5.1 and #5.2. Has the insurer been a party to a merger or consolidation? If “yes,” review the list of the companies involved in the merger/consolidation, noting any observations. Also, ensure Form A or additional filings have been approved.

4. Review General Interrogatories, Part 1, #6.1 and #6.2. Has 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? If “yes,” review the reason(s) stated for the revocation or suspension, noting any observations.

5. Are there any changes in the state’s statutes and/or regulations that could impact the insurer’s financial position or reporting? If “yes,” to the extent information is available, has the insurer failed to comply with the new state’s statutes and regulations enacted during the period?
III. Annual Procedures – A. Level 1 (All Statement Types)

6. Review the most recent report from a credit rating provider. Note the current financial strength and credit ratings and briefly discuss the explanation of the ratings or any change in the ratings.

7. Review any industry reports, news releases and emerging issues that have the potential to negatively impact the insurer.

8. 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.
   a. If significant changes in business plan or philosophy have occurred, assess the insurer’s ability to attain the expectations of the business plan.
   b. If actual results are not consistent with management’s expectations, provide a summary of the differences.

Management Assessment

9. Review the Annual Financial Statement, Jurat page
   a. Did the insurer fail to properly execute and notarize the Jurat page?
   b. Has there been any change(s) in officers, directors, or trustees since the previous Annual Financial Statement filing (indicated by “#” after the name)? If “yes,” indicate the position(s) in which the change(s) occurred. Review the Biographical Affidavit(s) for any new officers, directors, or trustees indicated above and note any areas of concern that would indicate further review is necessary. In conducting such review, also consider whether officers, directors and trustees are suitable (e.g., does the individual have the appropriate background and experience to perform the duties expected of him/her?) for the positions they hold within the insurer. Any suitability and other governance-related concerns identified should be communicated in writing to other relevant regulators both domestically and internationally.

   - President
   - Secretary
   - Treasurer
   - Vice Presidents (number: ____)
   - Directors or Trustees (number: ____)
   - Other

   c. Follow-up on any previously identified corporate governance issues, assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in business culture or business plan.

Balance Sheet Assessment

   a. Is surplus/capital and surplus (based on business type) below the statutory minimum amount required?
   b. For life/A&H insurers and fraternal societies, is surplus/capital and surplus (based on business type) less than 5 percent of total admitted assets (excluding separate accounts)?
III. Annual Procedures – A. Level 1 (All Statement Types)

c. Has surplus/capital and surplus (based on business type):
   i. Increased by more than 25 percent or declined by more than 15 percent from the prior year-end for property/casualty and title insurers?
   ii. Changed by more than +/- 20 percent from the prior year for life/A&H insurers and fraternal societies?
   iii. Increased by more than 40 percent or declined by more than 10 percent from the prior year for health entities?

Display the percentage change and the ending surplus/capital and surplus for each of the past five years.

d. Is the current year RBC ratio (total adjusted capital divided by authorized control level risk-based capital [for fraternal societies, total adjusted capital is divided by 50 percent of calculated risk-based capital] shown in the Annual Financial Statement, Five-Year Historical Data) less than or equal to 250 percent? Display the RBC ratio for each of the past five years. (excludes title insurers)

e. Did the insurer fail the RBC Trend Test in the current year? Display the results of the RBC Trend Test for each of the past five years. (excludes title insurers)

f. Has there been any change in surplus notes compared to the prior year-end? If “yes,” indicate the current and prior year-end balances and the amount of the change. Also review any notes issued, principal or interest paid, or any other changes that have been made and whether any necessary approvals were obtained.

g. For property/casualty and life/A&H insurers, has there been any change in capital notes compared to the prior year-end? If “yes,” indicate the current and prior year-end balances and the amount of the change. Also review any notes issued, principal or interest paid, or any other changes that have been made and whether any necessary approvals were obtained.

h. Is the amount of any individual non-invested asset category greater than 10 percent of total admitted assets (excluding separate accounts)? If “yes,” indicate the asset category and amount.

i. Has any individual asset category that is greater than 5 percent of total admitted assets (excluding separate accounts) changed by more than +/- 20 percent from the prior year-end? If “yes,” indicate the asset category, current year-end balance, and the percentage change from the prior year-end. Also consider shifts within individual asset categories (e.g., between investment grade and non-investment grade bonds) and between publicly traded and privately placed securities.

j. Is the amount of any individual liability category greater than 10 percent of total liabilities (excluding separate accounts), excluding the following lines:
   i. Losses, loss adjustment expenses, and unearned premiums (property/casualty insurers)?
   ii. Aggregate reserve for life contracts, aggregate reserve for accident and health contracts and liability for deposit-type contracts (life/A&H insurers and fraternal societies)?
iii. Claims unpaid, aggregate policy reserves and aggregate claim reserves (health entities)? Or

iv. Known claims reserve and statutory premium reserve (title insurers)?

If “yes,” indicate the liability category and amount.

k. Has any individual liability category that is greater than 5 percent of total liabilities (excluding separate accounts) changed by more than +/- 20 percent from the prior year-end? If “yes,” indicate the liability category, current year-end balance, and the percentage change from the prior year-end.

l. For property/casualty and title insurers, is the ratio of total liabilities to surplus greater than 350 percent?

m. For fraternal societies, did the society report outstanding assessments in the form of liens against policy benefits that have increased surplus? If “yes:”

i. Review the detail provided in General Interrogatories, Part 2, #27.2, and any information the department has on the nature and duration of the liens. Document any concerns.

ii. Were new assessments imposed in the current year?

iii. Assess the materiality of outstanding assessments:
Total Liens as a percentage of total current year surplus___%

11. For title insurers, review the five-year trend for the liquidity ratio within the Financial Profile Report and document any unusual fluctuations.

a. Have liquid assets increased greater than 50 percent or decreased by more than 15 percent compared to the prior year-end?

b. Is the liquidity ratio greater than 105 percent?

Operations Assessment

12. Review the Annual Financial Statement, Statement of Income page (for property/casualty and title), Summary of Operations (for life/A&H and fraternal), and Statement of Revenue and Expenses (for health).

a. Change in Net Income (Loss):

i. For property/casualty and title insurers, if net income (loss) exceeded +/- 10 percent of surplus, has the net income (loss) increased by more than 30 percent or decreased by more than 15 percent from the prior year-end?

ii. For life/A&H insurers, fraternal societies and health entities, if the absolute value of current year net income (loss) exceeds 5 percent of surplus/capital and surplus (based on business type), has the net income (loss) decreased by more than 20 percent or increased by more than 40 percent from the prior year?

Display the percentage change in net income (loss) and the actual net income (loss) results for each of the past five years.

b. Has any individual income or expense category, for which the current or prior year balance was greater than 5 percent of surplus/capital and surplus (based on business
III. Annual Procedures – A. Level 1 (All Statement Types)

type), changed by more than +/- 20 percent from the prior year-end? If “yes,” indicate the percentage change from the prior year-end, the income or expense category, and the current year-end balance.

c. For life/A&H insurers, fraternal societies and health entities, has any individual capital and surplus account category changed by more than +/- 10 percent from prior year-end? If “yes,” indicate the capital and surplus category, current year-end balance change and the percent change from the prior year.

d. Are net unrealized capital gains/(losses) more than 10 percent (5 percent for health insurers) of prior year-end surplus/capital and surplus (based on business type)?

For Title Insurers (12e. – 12i.):

e. Is the combined ratio greater than 105 percent or less than 80 percent?

f. Has the combined ratio increased more than 10 points or decreased more than 25 points compared to the prior year?

g. Has there been a +/- 25 percent change in premiums earned compared to the prior year?

h. Has there been a +/- 25 percent change in losses and loss adjustment expenses incurred compared to the prior year?

i. Has there been a +/- 25 percent change in operating expenses incurred compared to the prior year?

13. Review the Annual Financial Statement, Cash Flow page. Is current year net cash from operations negative? Display the net cash from operations for each of the past five years.

a. For title insurers, if net cash from operations is negative, determine the underlying reasons and calculate the net cash from operations to surplus ratio.

14. For health entities, review of the Medicare Supplement Insurance Experience Exhibit (filed March 1st), the Long-Term Care Experience Exhibit Reporting Form (filed April 1st) and the Accident and Health Policy Experience Exhibit (filed April 1st). Note any unusual items or areas that indicate further review is warranted?

15. Evaluate any material cessions as reported in Schedule F, Part 3 - Ceded Reinsurance (for property/casualty and title insurers), and Schedule S, Part 3 - Reinsurance Ceded (for life/A&H insurers, health entities and fraternal societies) and review all General Interrogatories and Notes to Financials pertaining to reinsurance and note any areas of concern.

16. For title insurers, review the Annual Financial Statement, Operations and Investment Exhibit - Summary of Title Insurance Premiums Written and Related Revenues.

a. Have direct premiums written increased or decreased by more than +/- 25 percent compared to the prior year-end?

i. Has the percentage of total direct premiums written through direct operations changed by more than +/- 10 percent compared to the prior year-end?

ii. Has the percentage of total direct premiums written through non-affiliated agency operations changed by more than +/- 10 percent compared to the prior year-end?
iii. Has the percentage of total direct premiums written through affiliated agency operations changed by more than +/- 10 percent compared to the prior year-end?

17. For title insurers, review the Annual Financial Statement, Schedule T - Exhibit of Premiums Written by States and Territories.
   a. Has there been a significant change of +/- 50 percent in direct premiums written in any one state/territory where direct premiums written exceed 10 percent of total direct premiums written?
   b. If premiums are being written in any new state/territory, does any new state/territory account for more than 5 percent of total direct premiums written?

Investment Practices

18. Evaluate the insurer’s investment management practices.
   a. Review General Interrogatories, Part 1, #16. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof?
   b. Review General Interrogatories, Part 1, #24.01 and 24.02. Were any securities owned that the insurer has exclusive control of, not in the actual possession of the insurer, other than securities lending programs?
   c. Review General Interrogatories, Part 1, #25.1 and 25.2. Were any assets owned not exclusively under the control of the insurer? If “yes,” indicate the amount at December 31 of the current year.
   d. Review General Interrogatories, Part 1, #21.1 and #21.2. Were any assets subject to a contractual obligation to transfer to another party without the liability for such obligation being reported? If “yes,” indicate the amount at December 31 of the current year.

19. Review the Annual Financial Statement, Summary Investment Schedule. Note any unusual valuation methods or areas that indicate further review is necessary.

20. Review the Supplemental Investment Risks Interrogatories. Note any unusual items or areas that would indicate a non-diversified portfolio or inadequate liquidity.

21. Review the Annual Financial Statement, Schedule E, Part 3 - Special Deposits. Is the book/adjusted carrying value of total special deposits greater than 10 percent of assets?

22. For title insurers, determine whether affiliated investments are significant.
   a. Is the total of all investments in affiliates (Five-Year Historical Data) greater than 20 percent of surplus?
   b. Has the total of all investments in affiliates changed by greater than +/- 20 percent from the prior year-end?
   c. Has there been a shift in any affiliated investment category of more than +/- 10 percent from the prior year-end?
   d. Are affiliated investments in violation of state statutes?
Review of Disclosures

    a. Have any Notes required per the Annual Statement Instructions been omitted? If so, list the Notes omitted.
    b. Provide an explanation for any unusual or significant items.

24. Review the Annual Financial Statement, General Interrogatories and Schedule P Interrogatories (for property/casualty and title insurers) and note any unusual responses.

Assessment of Latest Examination Report and Results

25. Review General Interrogatories, Part 1, #3 and determine if a financial examination report was released by the domiciliary state since the last review.
    a. As of what balance sheet date was the latest financial examination of the insurer?
    b. As of what balance sheet date was the latest financial examination report available from either the state of domicile or the insurer?
    c. As of what release date was the latest financial examination report available from either the state of domicile or the insurer, and what state department or departments completed the Financial Examination Report?
    d. Have any financial statement adjustments within the latest financial examination report not been accounted for in a subsequent financial statement filed with the Department?
    e. Have any of the recommendations within the latest financial examination report not been complied with?

If “yes,” or if follow-up was required from the review of the examination report in a previous analysis period, complete the following procedures:

f. If the answer to 25.d or 25.e is “yes,” follow up with the insurer regarding the implementation of recommendations in the Financial Examination Report.

g. Assess the current and future impact of any financial statement adjustments on the insurer’s financial condition.

26. During the review of the latest state examination report, the results from that examination and communication with the examiner-in-charge (for domestic insurers), note any risks, including prospective risks, that indicate further review is essential?

27. Follow-up and document any management letter comments that should be addressed in the current period, if applicable.

Assessment of Results from Prioritization and Analytical Tools

28. Review the insurer’s NAIC Annual Scoring results. (excludes title insurers)
    a. Indicate the insurer’s total score: _____
    b. Provide an explanation on each individual ratio result that received a score of 50 points or more.
III. Annual Procedures – A. Level 1 (All Statement Types)

29. Review the insurer’s IRIS ratio results. (excludes health entities and title insurers)
   a. Indicate the number of ratio results that fell outside the usual range: _____
   b. Provide an explanation in the comment section on each of the ratios that fell outside the usual range.

30. Review and understand the assigned Analyst Team System Validated Level. (excludes title insurers)

31. Review the Financial Profile Report and provide an explanation for any unusual or significant fluctuations or trends noted.

32. Review any market conduct information, including information available from the state’s market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee), and the NAIC market analysis tools and databases (MAP, ETS, MARS, RIRS, SAD, MITS, MCAS, and Complaints). Note any unusual items that translate into financial risks or indicate further review and/or additional communication is needed with the insurance department’s market analysis staff.

Assessment of Supplemental Filings

33. Review the Statement of Actuarial Opinion (SAO) and the Regulatory Asset Adequacy Issues Summary (RAAIS) (for life insurers and fraternal societies) or the Summary of Actuarial Opinion (for property/casualty and title insurers), and document any unusual items or areas that indicate further review is necessary.

34. Review the Management’s Discussion and Analysis and note any unusual items or areas that indicate further review is necessary (April 1st Filing)?

35. Review the Audited Financial Report and note any unusual items or areas that indicate further review is essential (June 1st Filing)?

36. Review the most recent Annual Financial Statement of the insurer’s holding company and its subsidiaries and holding company filings (such as Forms A, B, D, E (or other required information), F (if required), Extraordinary Dividend/Distribution, and SEC forms 10-K and 8-K) if available.
   a. Note any new or unusual items or areas of concern found during review that may potentially impact the insurer.
   b. If other insurers within the group exist, note any communication with the domestic state insurance departments for those affiliated insurers.

Recommendation for Further Analysis (excludes title insurers)

Based on the Level 1 procedures performed, does the analyst recommend that the Level 2 or Supplemental Annual Procedures or other procedures listed below be completed? If “yes,” indicate the sections that the analyst recommends be completed:
A. Perform Level 2 Procedures:

- All Sections
- Investments
- Unpaid Losses and LAE (P&C)
- Life Reserves (Life/A&H)
- Accident and Health Reserves (Life/A&H)
- Annuity Reserves (Life/A&H)
- Health Reserves and Liabilities (Health)
- Other Assets (Health)
- Other Provider Liabilities (Health)
- Income Statement and Surplus
- Health Care Pursuant to Public Health Service Act (Life/A&H and Health)
- Risk-Based Capital
- Cash Flow and Liquidity
- Risk Transfer Other than Reinsurance (Health)
- Reinsurance
- Affiliated Transactions
- MGAs, IPAs and TPAs
- Separate Accounts (Life/A&H)

B. Perform Supplemental Procedures:

- Management Considerations
- Annual Audited Financial Report
- Actuarial Opinion/Summary (and RAAIS for Life/A&H Insurers and Fraternal Societies)
- Management’s Discussion & Analysis
- Holding Company Analysis
- Form A
- Form B
- Form D
- Form E (or other required information)
- Extraordinary Dividend/Distribution
- Captives and/or Insurers Filing on U.S. GAAP (P&C)
- Group-Wide Supervision Procedures (Lead State Only)

C. Request and review the current business plan and financial projections.

i. If significant changes in the business plan or philosophy have occurred, assess the insurer’s ability to attain these expectations.

ii. Determine if actual results are tracking with projections and note any significant variances and the reason(s).
Summary and Conclusion

After completion of any Level 2 or additional procedures, develop and document an overall summary and conclusion based on the findings. In developing a conclusion, consider the above procedures, as well as any other factors that, in the analyst’s judgment, are relevant to evaluating the insurer’s overall financial condition. The discussion should include details regarding the insurer’s strengths and weaknesses. Consider and document the prospective risks of the insurer based on the analysis performed. Documentation of prospective risks should be used to identify future areas for analysis and to facilitate communication with the examiners. In addition, update the Insurer Profile Summary, including the Supervisory Plan, if applicable, for the results of the analysis performed.

During the continual monitoring process of the insurer, consider the prospective risks based on the current knowledge of the insurer as a result of the completion of the Level 1 Procedures. See the Level 1 Analyst Reference Guide for examples of prospective risk.

Does the analyst recommend that the priority designation of the insurer be changed as a result of the procedures performed? Justify the recommended priority designation.

Analyst ___________________________ Date __________

Comments as a result of supervisory review.

Reviewer ___________________________ Date __________

Correspondence

Document any follow-up regarding the Level 1, 2, and Supplemental Procedures.
III. Quarterly Procedures – A. Level 1 (excludes Title)

Instructions

Insurance department staff should be aware that an insurance department may choose to utilize the Handbook or a set of procedures that are substantially similar as outlined within the Accreditation Guidelines. If the insurance department chooses to utilize the Handbook, the Level 1 procedures should be completed. It is important to note that the depth of review will depend on the complexity and financial strength as well as known risks of the insurer. Therefore, the insurance department may consider a tailored set of procedures that addresses the specific risks of the insurer.

The analyst may choose to document the results of the review following each applicable procedure or within the summary and conclusions.

Background Analysis

1. Review the analyses performed on the insurer for the prior year and prior quarters.
   a. Indicate the state’s priority designation or any prioritization tool result as of the last review and start of the current review:

<table>
<thead>
<tr>
<th>State’s Priority Designation</th>
<th>PYE</th>
<th>PQTQD</th>
<th>CQ</th>
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<tbody>
<tr>
<td>Scoring System Result</td>
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<tr>
<td>IRIS Ratio Result</td>
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<td>Analyst Team System Validated Level</td>
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<td>RBC Ratio and Trend Test</td>
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<tr>
<td>Hazardous Financial Condition Regulation</td>
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</tbody>
</table>

   b. Were there any issues, concerns or prospective risks noted in previous annual or quarterly analysis completed in the current year? If “yes,” discuss the issues, concerns or prospective risks, the follow-up conducted, and include any correspondence with the insurer, along with any conclusions. (Consider the prospective risks previously identified in the scope of the current analysis.)
   c. Below is a list of supplemental filings to the Annual Financial Statement. Have any been received or reviewed since the last analysis? If “yes,” complete or review the corresponding procedures related to these items.
      - Financial Examination Report
      - Audited Financial Report
      - Actuarial Opinion
      - MD&A
      - Holding Company Form(s)

   Review any other items received from the insurer or related to the insurer since the last analysis, and comment on them as necessary.
   d. Review the Insurer Profile Summary, including the Supervisory Plan, if applicable, and document any areas of concern that impact the current analysis.
III. Quarterly Procedures – A. Level 1 (excludes Title)

2. Review any inter-departmental communication, as well as communication with other state insurance departments and the insurer. Note any unusual items or areas that indicate further review or follow-up is necessary.

3. Review General Interrogatories, Part 1, #4.1. Has the insurer been a party to a merger or consolidation? If “yes,” review the list of the companies involved in the merger/consolidation, noting any observations. Also, ensure Form A or additional filings have been approved.

4. Review General Interrogatories, Part 1, #7.1. Has 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? If “yes,” document the reason(s) stated for the revocation or suspension, noting any observations.

5. Are there any changes in the statutes and/or regulations that could impact the insurer’s financial position or reporting? If “yes,” to the extent information is available, has the insurer failed to comply with the new state’s statutes and regulations enacted during the period?

6. Review the most recent report from a credit rating provider. Note the current financial strength and credit ratings, and briefly discuss the explanation of the ratings or any change in the ratings.

7. Review any industry reports, news releases and emerging issues that have the potential to negatively impact the insurer.

8. 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.
   a. If significant changes in business plan or philosophy have occurred, assess the insurer’s ability to attain the expectations of the business plan.
   b. If actual results are not consistent with management’s expectations, provide a summary of the differences.

Management Assessment

9. Review the Quarterly Financial Statement, Jurat page.
   a. Did the insurer fail to properly execute and notarize the Jurat page?
   b. Has there been any change(s) in officers, directors, or trustees since the previous Annual Financial Statement (indicated by “#” after the name)? If “yes,” indicate the position(s) in which the change(s) occurred. Review the Biographical Affidavit(s) for any new officers, directors, or trustees indicated above and note any areas of concern that would indicate further review is necessary. In conducting such review, also consider whether officers, directors and trustees are suitable (e.g., does the individual have the appropriate background and experience to perform the duties expected of him/her?) for the position they hold within the insurer. Any suitability and other governance-related concerns identified should be communicated in writing to other relevant regulators both domestically and internationally.
      ☐ President
      ☐ Secretary
      ☐ Treasurer

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III. Quarterly Procedures – A. Level 1 (excludes Title)

- Vice Presidents (number: ___)
- Directors or Trustees (number: ___)
- Other __________________

c. Follow-up on any previously identified corporate governance issues, assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in business culture or business plan.

Balance Sheet Assessment

10. Review the Quarterly Financial Statement, Assets and Liabilities, Surplus and Other Funds (capital and surplus for health entities), and the Quarterly Financial Profile Report.

   a. Is surplus/capital and surplus (based on business type) below the statutory minimum amount required?

   b. Has surplus/capital and surplus (based on business type):

      i. Increased by more than 25 percent or declined by more than 15 percent from the prior year-end for property and casualty insurers?

      ii. Changed by more than +/- 20 percent from the prior year-end for life/A&H insurers and fraternal societies?

      iii. Increased by more than 40 percent or declined by more than 10 percent from prior year-end for health entities?

      If “yes,” indicate the current quarter balance and the percentage change from the prior year-end.

   c. Given the current level of RBC and any significant balance sheet or operational changes, consider the impact to RBC.

   d. Has the insurer issued any capital or surplus notes during the quarter? If “yes,” review any notes issued, principal or interest paid, or any other changes made, and whether any necessary approvals were obtained.

   e. Is the amount of any individual asset category, other than cash and invested assets, greater than 10 percent of total admitted assets (excluding separate accounts)? If “yes,” indicate the asset category and amount.

   f. Has any individual asset category, for which the current or prior year-end balance was greater than 5 percent of total assets (excluding separate accounts), changed by more than +/- 20 percent from the prior year-end? If “yes,” indicate the asset category, current balance, and the percentage change from the prior year-end.

   g. Is the amount of any individual liability category greater than 10 percent of total liabilities (excluding separate accounts), excluding the following lines:

      i. Losses, LAE, and unearned premiums for property and casualty insurers.

      ii. Aggregate reserve for life contracts, aggregate reserve for accident and health contracts, and liability for deposit-type contracts for life/A&H and fraternal insurers.

III. Quarterly Procedures – A. Level 1 (excludes Title)

iii. Claims unpaid, aggregate policy reserves and aggregate claim reserves for health entities.

If “yes,” indicate the liability category and amount.

h. Has any individual liability category, for which the current or prior year-end balance was greater than 5 percent of total liabilities (excluding separate accounts), changed by more than +/- 20 percent from the prior year-end? If “yes,” indicate the liability category, current balance, and the percentage change from the prior year-end.

i. For life/A&H insurers and fraternal societies, is (capital and) surplus less than 5 percent of total admitted assets (excluding separate accounts)?

j. For health entities, have any of the asset and liquidity ratios in the Quarterly Financial Profile Report changed by greater than +/-10 percentage points from the prior year-end? If “yes,” indicate the ratio, current results, and the percentage point change from the prior year-end.

Operations Assessment


a. If the absolute value of net income (loss) exceeds 5 percent of surplus/capital and surplus (based on business type), has it:

i. Changed by more than +/- 20 percent from the prior year-to-date for property and casualty insurers?

ii. Decreased by more than 20 percent or increased by more than 40 percent from the prior year-to-date for life/A&H insurers and fraternal societies?

iii. Decreased by more than 20 percent or increased by more than 40 percent from the prior year-to-date for health entities?

If “yes,” indicate the current quarter balance and the percentage change from the prior year-to-date.

b. Has any individual income or expense category, for which the current or prior year-to-date balance was greater than 5 percent of surplus/capital and surplus (based on business type), changed by more than +/-20 percent from the prior year-to-date? If “yes,” indicate the line item, current year-to-date balance, and the percentage change from the prior year-to-date.

For Property/Casualty Insurers:

c. Have any of the profitability ratios (pure loss, pure LAE, expense, dividend, or combined) changed by more than +/- 10 percentage points from the prior year-to-date? If “yes,” indicate the ratio, current result, and the percentage point change.

For Life/A&H Insurers and Fraternal Societies:

d. Has any individual direct premiums and deposit-type contract funds category changed by more than +/-20 percent from the prior year-to-date? If “yes,” indicate the premium category, current year-to-date balance, and the percentage change from the prior year-to-date.

e. Are net unrealized capital gains/(losses) greater than 10 percent of prior year-end capital and surplus?
III. Quarterly Procedures – A. Level 1 (excludes Title)

For Health Entities:

f. Have earned premiums for any individual premium category changed by greater than +/- 20 percent from the prior year-to-date? If “yes,” indicate the premium category, current year-to-date balance, and the percentage change from the prior year-to-date.

g. Are net unrealized capital gains/(losses) greater than 5 percent of prior year-end capital and surplus?

h. Have any of the profitability ratios (medical loss, administrative expense, combined, profit margin) in the Financial Profile Report changed by greater than +/-10 percentage points from the prior year-end? If “yes,” indicate the ratio, current results, and the percentage point change from the prior year-end.

i. Have any of the leverage ratios in the Financial Profile Report changed by greater than +/-10 percentage points from the prior year-end? If “yes,” indicate the ratio, current results, and the percentage point change from the prior year-end.

j. Have any of the enrollment ratios in the Financial Profile Report changed by greater than +/-10 percentage points from the prior year-end? If “yes,” indicate the ratio, current results, and the percentage point change from the prior year-end.

No. 12 – 15 for Property/Casualty Insurers:

12. Review the Quarterly Financial Statement, Cash Flow. Is net cash from operations negative?

13. Has the liquidity ratio changed by more than +/- 10 percentage points from the prior year-end? If “yes,” indicate the percentage point change from the prior year-end and current liquidity ratio.

14. Have any of the leverage ratios (rolling GPW/PHS, rolling NPW/PHS, Paid Reinsurance Recoverable/PHS, or Reserves/PHS) changed by more than +/-10 percentage points from the prior year-end? If “yes,” indicate the ratio, current result, and the percentage point change from the prior year-end.

15. Has direct, assumed, ceded or net premiums written changed by more than +/- 20 percent from the prior year-to-date? If “yes,” indicate the category, current balance, and the percentage change from the prior year-to-date.

Investment Practices

16. Review Schedule D, Part 1B - Acquisitions, Dispositions and Non-Trading Activity During the Current Quarter for all Bonds and Preferred Stock by Rating Class.

   a. Has the percentage of investment or noninvestment-grade bonds to total bonds at the end of the quarter changed by more than +/-10 percentage points from the beginning of the quarter?

   b. Has the percentage of investment or noninvestment-grade preferred stock to total preferred stock at the end of the quarter changed by more than +/-10 percentage points from the beginning of the quarter?
III. Quarterly Procedures – A. Level 1 (excludes Title)

Review of Disclosures

17. Review the Quarterly Financial Statement, Notes to Financial Statements, General Interrogatories, Supplemental Exhibits and Schedules, noting any unusual responses.

Assessment of Results from Prioritization & Analytical Tools

18. Review the I-SITE Quarterly Financial Profile Report. Were any unusual trends noted based on your review?

19. Review the insurer’s Quarterly Scoring ratio results.
   a. Indicate the insurer’s total score: _____
   b. Provide an explanation on each individual ratio result that received a score of 50 points or more.

20. During a review of market conduct information (including information available from the state’s market analysis department or data available on I-SITE, including MAP, ETS, MARS, RIRS, SAD, MITS, MCAS and the Complaints Database), note any unusual items that indicate further review and/or additional communication is needed with the department’s market analysis staff.

Assessment of Latest Examination Report and Results

21. Review General Interrogatories, Part 1, #6 and determine if a Financial Examination Report was released by the domiciliary state since the last review.
   a. As of what balance sheet date is/was the latest financial examination of the insurer?
   b. As of what balance sheet date is the latest Financial Examination Report available from either the state of domicile or the insurer?
   c. As of what release date is the latest Financial Examination Report available from either the state of domicile or the insurer, and what state department or departments completed the Financial Examination Report?
   d. Have any financial statement adjustments within the latest Financial Examination Report not been accounted for in a subsequent financial statement filed with the Department?
   e. Have any of the recommendations within the latest Financial Examination Report not been complied with?

If “yes,” or if follow-up was required from the review of the examination report in a previous analysis period, complete the following procedures:

f. If the answer to either 21.d or 21.e is “yes,” follow-up with the insurer regarding the implementation of recommendations in the Financial Examination Report.

g. During the review of the latest state examination report, the results from that examination and communication with the examiner-in-charge (for domestic insurers), note any items or areas that indicate further review is warranted.

h. Follow-up and document on any management letter comments that should be addressed in the current period, if applicable.
### Recommendation for Further Analysis

Based on the Level 1 Procedures performed, does the analyst recommend that any Level 2 or Supplemental Procedures be completed? If “yes,” indicate the sections that the analyst recommends be completed:

<table>
<thead>
<tr>
<th>A. Perform Level 2 Procedures:</th>
<th></th>
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<tbody>
<tr>
<td>All Sections</td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td></td>
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<tr>
<td>Unpaid Losses and LAE (P&amp;C)</td>
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<td>Life Reserves (life)</td>
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<td>Accident and Health Reserves (life)</td>
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<td>Annuity Reserves (life)</td>
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</tr>
<tr>
<td>Health Reserves and Liabilities (health)</td>
<td></td>
</tr>
<tr>
<td>Other Assets (health)</td>
<td></td>
</tr>
<tr>
<td>Other Provider Liabilities (health)</td>
<td></td>
</tr>
<tr>
<td>Income Statement and Surplus</td>
<td></td>
</tr>
<tr>
<td>Cash Flow and Liquidity</td>
<td></td>
</tr>
<tr>
<td>Risk Transfer Other Than Reinsurance (health)</td>
<td></td>
</tr>
<tr>
<td>Reinsurance</td>
<td></td>
</tr>
<tr>
<td>Affiliated Transactions</td>
<td></td>
</tr>
<tr>
<td>MGAs, TPAs and IPAs</td>
<td></td>
</tr>
<tr>
<td>Separate Accounts (life)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Perform Supplemental Procedures:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Management Considerations</td>
<td></td>
</tr>
<tr>
<td>Annual Audited Financial Report</td>
<td></td>
</tr>
<tr>
<td>Actuarial Opinion/Summary (and RAAIS for L/H Insurers and Fraternal Societies)</td>
<td></td>
</tr>
<tr>
<td>Management’s Discussion &amp; Analysis</td>
<td></td>
</tr>
<tr>
<td>Holding Company System Analysis</td>
<td></td>
</tr>
<tr>
<td>Form A</td>
<td></td>
</tr>
<tr>
<td>Form B</td>
<td></td>
</tr>
<tr>
<td>Form D</td>
<td></td>
</tr>
<tr>
<td>Form E (or Other Required Information)</td>
<td></td>
</tr>
<tr>
<td>Extraordinary Dividends/Distributions</td>
<td></td>
</tr>
<tr>
<td>Captives and/or Insurers Filing on GAAP (P&amp;C)</td>
<td></td>
</tr>
<tr>
<td>Group-wide Supervision Procedures (Lead State Only)</td>
<td></td>
</tr>
</tbody>
</table>
III. Quarterly Procedures – A. Level 1 (excludes Title)

C. Request and review the current business plan and financial projections.
   
   i. If significant changes in the business plan or philosophy have occurred, assess the insurer’s ability to attain these expectations.
   
   ii. Determine if actual results are tracking with projections and note any significant variances and the reason(s).

Summary and Conclusion

After completion of any Level 2 Procedures, and Supplemental Procedures, develop and document an overall summary and conclusion based on the findings. In developing a conclusion, consider the above procedures, as well as any other factors that, in the analyst’s judgment, are relevant to evaluating the insurer’s overall financial condition. The discussion should include details regarding the insurer’s strengths and weaknesses. Consider and document the prospective risks of the insurer based on the analysis performed. Documentation of prospective risks should be used to identify future areas for analysis and to facilitate communication with the examiners. In addition, update the Insurer Profile Summary, including the Supervisory Plan, if applicable, for the results of the analysis performed.

During the continual monitoring process of the insurer, consider the prospective risks based on the current knowledge of the insurer as a result of the completion of the Level 1 Procedures. See the Level 1 Analyst Reference Guide for examples of prospective risks.

Does the analyst recommend that the priority designation of the insurer be changed as a result of the procedures performed? Justify the recommended priority designation.

   Analyst ________________ Date ________

Comments as a result of supervisory review.

   Reviewer _______________ Date ________

Correspondence

Document any follow-up regarding the Level 1, 2, and Supplemental Procedures.
A. Non-Troubled insurers will receive an automated review each quarter. Troubled insurers will receive a full review each quarter.

Each quarter, non-troubled insurers should be assessed based on the results of the following automated system. Based on the results of the automated system, you may need to proceed with a full Level 1 review. Also consider any other information that may not be reflected in the quarterly statement but may be known or noted in the analysis file or insurer profile summary, which could impact the company on a prospective basis prior to relying solely on an automated review.

B. If any of the following criteria is met, the insurer may be assigned a full Level 1 quarterly review:

1. The insurer is a troubled insurer.
2. Prior year RBC is less than 250 percent (excluding RRGs)
3. Prior year triggered the RBC Trend Test (excluding RRGs)
4. ATS Levels A and B companies
5. Scoring System result greater than or equal to:
   • 450 for property/casualty insurers;
   • 350 for life insurers;
   • 300 for A&H insurers;
   • 325 for health entities; or
   • 315 for fraternal societies.

C. Based on the results of the automated system calculations, a full Level 1 quarterly review may be completed if the insurer has the following number of “yes” responses from the automated calculations:

   • 4 or more for property/casualty insurers and health entities;
   • 3 or more for life/A&H insurers; or
   • 2 or more for fraternal societies.

Any automated results in D where the denominator is 0 returned a “yes” response.

Special note: For companies that have not filed a prior year-end or quarterly statement (e.g., either a new start-up insurer or exempt from filing), all responses in section D will default to a “yes.” In this scenario, it is recommended the analyst perform a full Level 1 review.

D. Automated system calculations:

1. Are unassigned funds negative?
2. Has surplus/capital and surplus (based on business type) increased ≥ 12.5 percent (for first quarter), 25 percent (for second quarter), or 37.5 percent (for third quarter)?
III. Quarterly Procedures – A. Level 1 Non-Troubled Insurers (excludes Title)

3. Has surplus/capital and surplus (based on business type) decreased ≥ 5 percent (for first quarter), 10 percent (for second quarter), or 15 percent (for third quarter)?

4. Has any individual asset category that is greater than 5 percent of surplus/capital and surplus (based on business type) changed by more than +/- 10 percent from the prior year-end?

5. Has any individual liability category that is greater than 5 percent of surplus/capital and surplus (based on business type) changed by more than +/-10 percent from the prior year-end?

6. Are affiliated investments greater than or equal to 75 percent of surplus/capital and surplus (based on business type), OR unrealized capital loss greater than 15 percent of prior year-end surplus/capital and surplus (based on business type)?

7. Does the net loss exceed 20 percent of surplus/capital and surplus (based on business type)?

8. For property/casualty insurers and health entities, is the combined ratio greater than or equal to 100 percent?

9. Has net premiums written changed by more than +/- 5 percent (for first quarter), +/- 10 percent (for second quarter), or +/- 15 percent (for third quarter) from the prior year-to-date?

NOTE: A default “no” response will be returned for insurers with no net retention.

**Recommendation for further analysis**

Does the automated system indicate a full Level 1 analysis should be performed?

- If “yes,” complete a full Level 1 analysis, or if a full Level 1 analysis was not completed, justify and document the reason(s).

- If “no,” no further actions are required.
Financial Analyst Role

During the risk-focused surveillance approach, the financial analyst role is to provide continuous off-site monitoring of an insurer’s financial condition, monitor internal/external changes relating to all aspects of the insurer, maintain a prioritization system, and work with the examination staff to develop an ongoing Supervisory Plan as well as update the Insurer Profile Summary, if applicable.

Overview of Level 1

The objective of Level 1 is to perform a sufficient level of analysis on all domestic insurers in order to derive an overall assessment that highlights areas where a more detailed analysis, as found in Level 2, may be necessary. As part of the Level 1 analysis, the analyst will review the insurer’s Annual Scoring System Report, IRIS ratios (for property/casualty, life and fraternal), Analyst Team Validated Level, RBC results, and the information included in the Financial Profile Report. The Level 1 procedures require the analyst to review the prior year analysis of the insurer and to perform a general review of the current year’s Annual Financial Statement along with an assessment of supplemental filings, including the Audited Financial Report, Statement of Actuarial Opinion & Actuarial Summary Report (or Regulatory Asset Adequacy Issues Summary), Management’s Discussion and Analysis (MD&A), and the various holding company filings, (e.g., 10-K, Form A, etc.).

The analyst should have a firm understanding of the following risk classifications:

- **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 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.

Prospective Risks

A prospective risk is a residual risk that impacts future operations of an insurer. These anticipated risks arise due to assessments of company management and/or operations or risks associated with future
business plans. Types of risks may include, for example underwriting, investments, claims, and reinsurance. The analyst’s understanding of the above nine risk classifications includes an assessment of the level of that risk and the ability of the insurer to appropriately manage the risk during the current period and prospectively. These prospective risks require assessment and identification of how they may evolve related to the insurer’s overall risk profile. Understanding how risks that may or may not appear urgent now will potentially impact future operations and how management plans to address those risks is key to prospective risk analysis. The assessment of these nine risk classifications both currently and prospectively should be part of the quantitative and qualitative analysis completed within the Level 1, 2 and Supplemental Procedures. All insurers have prospective risks. It is highly unlikely that an insurer would be identified as having no 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 for domestic insurers and communicate those risks to the respective examiners.

(Communication is discussed further below and also in the Department Organization and Communication Chapter of this Handbook).

The following are a few examples of prospective risks:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Prospective Risks Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example #1 - Unprofitable Line of Business</td>
<td>• The potential for continued and worsening claims experience, which will strain capital. • Other profitable lines that may not be able to continue to offset losses. • Underwriting and reserving standards might not be appropriate on the unprofitable line.</td>
</tr>
<tr>
<td>• Overall, the insurer is profitable, reported increasing surplus and is a non-priority. • The insurer writes multiple lines of business; however, one line continually reports increasing negative claims experience and operating losses, which are offset by income from other lines.</td>
<td></td>
</tr>
<tr>
<td>Example #2 - Surrender Benefits</td>
<td>• Negative impact of continued increasing surrenders. • Market decline results in the need for policyholder cash, resulting in the potential negative impact or a “run on the bank” scenario. • That liquid assets are insufficient to meet surrender benefits resulting in insufficient cash from operations. • Poor asset-liability matching and the potential negative impact.</td>
</tr>
<tr>
<td>• The ratio of surrenders to net premiums is trending upward but not yet in an unusual range. • The insurer has a high percentage of policies that are withdrawable with little or no fee.</td>
<td></td>
</tr>
<tr>
<td>Example #3 - Reinsurance</td>
<td>• Diminishing credit quality of the reinsurer. • Collectability of recoverables. • Changes in collateral are inadequate. • If the reinsurance contract is terminated, any reliance on surplus aid would have a negative impact on capital.</td>
</tr>
<tr>
<td>• Insurer cedes via quota share to only two reinsurers. • Ceded premium written to gross premium written exceeds 50%. • Well capitalized insurer.</td>
<td></td>
</tr>
</tbody>
</table>
### III. Analyst Reference Guide – A. Level 1

#### Scenario

<table>
<thead>
<tr>
<th>Example #5 - Underwriting/Written Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Insurer utilizes only one MGA/TPA that underwrites more than 50% of the Company’s business.</td>
</tr>
</tbody>
</table>

#### Prospective Risks Identified

| • Underwriting standards that are poor and may result in future poor loss experience. |
| • Controls are inadequate. |
| • Expense structure of MGA/TPA agreement may become high. |

#### Example #6 - Geographic Concentration of Business

| • High quality insurer that is well capitalized and has been profitable over the past five years. |
| • Concentrated writings in the Florida home market. |

#### Prospective Risks Identified

| • Catastrophe exposure. |

#### Example #7 - Acquisitions

| • Insurer is a newly acquired insurer in a group where the parent company has acquired three new insurance companies in the past three years. |

#### Prospective Risks Identified

| • Claims handling issues due to systems not integrated. |
| • Change(s) in business philosophy and culture. |
| • Staffing issues due to change in control. |
| • Accounting roll-up if systems are not integrated. |

#### Example #8 - Significant Premium Growth

| • Premium has increased on average 135% each year for the past three years; however, the insurer is well capitalized. |
| • The insurer plans to expand into five new states and projects premium growth of 50% per year for next five years. |

#### Prospective Risks Identified

| • Insufficient capital & surplus to support growth (i.e., leverage). |
| • Inappropriate/unrealistic assumptions used in projections. |
| • Underwriting standards are inadequate. |

At the conclusion of the Level 1 Procedures, the analyst is asked to document an overall summary and conclusion regarding the financial condition of the insurer as well as the insurer’s strengths and weaknesses, and to determine whether the insurer is considered a priority company, and whether one or more of the procedures in the Level 2 Annual Procedures should be completed. Because some items, such as the Audited Financial Report and the various holding company filings are not required to be filed until after most of the annual review is completed, the analyst will document a conclusion based on the Level 1 Annual Procedures and the current analysis of the insurer. The Audited Financial Report and the various holding company filings should be reviewed upon receipt, and if additional concerns are noted, the conclusion or the first quarter conclusion should be revised to reflect the most recent information. Similarly, as the analyst completes the Level 2 Procedures, the Level 1 Summary and Conclusion should be reviewed and revised as necessary with any follow-up information or similar updates made to the first quarter summary and conclusion. At the completion of the analysis process, including any Level 1, 2, or Supplemental Procedures, the analyst should identify and document the prospective risks and update the Insurer Profile Summary and communicate the analysis findings and prospective risks with financial examination staff.
Insurer Profile Summary

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

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

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

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

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

The following provides an example of the template of an Insurer Profile Summary (The interactive template of the insurer profile summary and heat map are located in I-SITE below the Level 1 procedures link):
Insurer Profile Summary

ABC is an independently owned property and casualty insurance organization based in state X that specializes primarily in writing private passenger automobile insurance coverage. Through its subsidiaries, DEF Insurance Company, GHI Insurance Company, JKL Underwriters, and MNO Premium Finance Company, the group offers a variety of insurance related services including premium finance and claims processing.

REGULATORY ACTIONS

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

FINANCIAL SNAPSHOT (SUMMARY DATA) – OPTIONAL

<table>
<thead>
<tr>
<th>Assets and Liabilities</th>
<th>20XX</th>
<th>20XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Invested Assets</td>
<td>219</td>
<td>253</td>
</tr>
<tr>
<td>Other Assets</td>
<td>111</td>
<td>131</td>
</tr>
<tr>
<td>TOTAL ASSETS</td>
<td>330</td>
<td>384</td>
</tr>
<tr>
<td>LIABILITIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance reserves</td>
<td>97</td>
<td>95</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>169</td>
<td>193</td>
</tr>
<tr>
<td>TOTAL LIABILITIES</td>
<td>266</td>
<td>288</td>
</tr>
<tr>
<td>Capital and Surplus</td>
<td>64</td>
<td>96</td>
</tr>
<tr>
<td>TOTAL LIABILITIES AND C&amp;S</td>
<td>330</td>
<td>384</td>
</tr>
<tr>
<td>Operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premiums</td>
<td>218</td>
<td>233</td>
</tr>
<tr>
<td>Investment income (net of gains/losses)</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Other income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total revenues</td>
<td>219</td>
<td>241</td>
</tr>
<tr>
<td>LOSSES, BENEFITS AND EXPENSES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policyholder Benefits</td>
<td>177</td>
<td>157</td>
</tr>
<tr>
<td>Expenses</td>
<td>77</td>
<td>80</td>
</tr>
<tr>
<td>Total losses, benefits and expenses</td>
<td>254</td>
<td>237</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>NET INCOME</td>
<td>(35)</td>
<td>2</td>
</tr>
</tbody>
</table>
BRANDED RISK ASSESSMENTS

Summarize your assessment of the branded risk classifications for the insurer based upon both quantitative (e.g., 5 year trending of key ratios) and qualitative information. An assessment of each significant individual risk component (including prospective risks) relevant to the classification should be provided by indicating either “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.

The following is an interactive map. Click and drag the risk classification to the appropriate section of the risk classification heat map after assessing the trend in each individual category.
III. Analyst Reference Guide – A. Level 1

Credit: This risk is considered moderate, driven primarily by a fairly conservative investment mix (96.4% of bonds are NAIC 1 with 28% US government, 14% US states, most of the rest high quality corporates) and limited exposure to equities, offset by a relatively high amount of real estate ($33 million), growing agent balances ($99 million) and significant reinsurance recoverables (paid and unpaid) of $81 million. However, the reinsurance recoverables are diversified across a number of highly rated reinsurers.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
<tr>
<td>Real Estate-Home Office</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Agent Balances and Uncoll Prem</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
</tbody>
</table>

Overall Credit Assessment: Moderate Concern Overall Trend: ↑

Legal: The Company has a vested interest in the outcome of the case of GEI v. Virtual Imaging which is before the State Supreme Court. This case pertains to a change in statutes, effective January 1, 2008, that affected the manner in which insurers, including the Company, have paid claims. Subsequent to the statutory change, cases have been brought and trial courts have concurred that the statutes and resulting payments are ambiguities in the statutes. These cases are collectively known as the “Fee Schedule” matter. The Company began receiving lawsuits on this matter in May 2010, some of which were closed at high cost. Since that time, the Company has modified its strategy for handling these cases and has received multiple trial victories from juries that ruled no further payments were owed to the plaintiffs. Exam results indicate that the Company’s legal team tracks and monitors outstanding lawsuits and involves experienced external counsel in representing the Company in these matters.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of legal counsel</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Fee Schedule lawsuits</td>
<td></td>
<td></td>
<td>↓</td>
</tr>
</tbody>
</table>

Overall Legal Assessment: Moderate Concern Overall Trend: ↓

Liquidity: The Company is subject to high liquidity risk due to the lines of business written and the corresponding need to meet short-term obligations. The Company’s high exposure to the volatile PIP market and related losses has reversed the trend of improved liquidity in recent years. Trends in the Company’s five-year liquidity ratio are shown in the following chart, which was indicating improvements before a negative shift in the current year:

<table>
<thead>
<tr>
<th>Liquidity Ratio</th>
<th>CY</th>
<th>PY</th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>108.5%</td>
<td>98.3%</td>
<td>101.4%</td>
<td>107.1%</td>
<td>113.0%</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>Exposure to PIP Market</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Liquidity Ratio</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
</tbody>
</table>

Overall Liquidity Assessment: Moderate Concern Overall Trend: ↔
Market: Market risk includes equity risks, changes in credit spreads, and also interest rate risks. Most of these risks are not inherently significant to the Company due to its relatively conservative investment portfolio and relatively short-term policies (typically 6 months or 1 year), which allow the Company to reprice fairly easily to align with shifts in the market. However, as shown during the financial crisis, some of the Company’s products are more sensitive to general economic downturns, which can impact the Company’s performance.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td></td>
<td></td>
<td>⇔</td>
</tr>
<tr>
<td>Changes in Credit Spreads</td>
<td></td>
<td></td>
<td>⇔</td>
</tr>
<tr>
<td>Economic Downturn</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
</tbody>
</table>

Overall Market Assessment: Moderate Concern

Overall Trend: ⇔

Operational: The results of the last exam indicated that the Company has a reliable IT environment and effective internal controls in most areas. However, concerns were raised regarding segregation of duty issues relating to the handling of claims and cash disbursements during the last exam. In addition, a recent news report indicated that one of the Company’s independent agents has been charged with committing fraudulent activities. Due to the Company’s heavy reliance on independent agents to generate business and manage policyholder relations, even though the report might be an isolated incident it represents a moderate concern in this category.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT Environment</td>
<td></td>
<td></td>
<td>⇔</td>
</tr>
<tr>
<td>Segregation of Duties</td>
<td></td>
<td></td>
<td>⇔</td>
</tr>
<tr>
<td>Agent Fraud</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
</tbody>
</table>

Overall Operational Assessment: Moderate Concern

Overall Trend: ⇔

Pricing/Underwriting: Although the Company is primarily engaged in short-term products (6 months or 1 year), it is subject to highly competitive price pressure and has shown historically weak underwriting results. Underwriting results have shown a negative trend over the past 6 periods as losses incurred continue to rise, a sign that pricing pressures are influencing the bottom line. The Company appears to be utilizing cash flow underwriting as a way to bolster earnings through investment income, which leads to a concern regarding the adequacy/appropriateness of rates used by the Company. In addition, the last financial exam noted a lack of documented underwriting guidelines at the Company, which is in the process of being corrected. However, the lack of documented, detailed underwriting guidelines represents a moderate concern in this area. Overall, this risk category represents a significant ongoing concern for the Company.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underwriting Guidelines</td>
<td></td>
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<tr>
<td>Rate Adequacy</td>
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Overall Pricing/Underwriting Assessment: Moderate Concern

Overall Trend: ↑
Reputation: The Company’s business is not rating sensitive, but the Company is highly dependent upon business produced by agents. As noted above, a recent concern has been identified regarding potential fraud committed by one of the Company’s agents. In addition, findings of a recent market conduct examination lead to numerous violations. These violations related to claims handling issues, such as failure to comply with timely payments and denial of legitimate claims. Although the Company has disputed these findings, gross writings continue to suffer as several agents have stopped writing on behalf of the Company.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
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</thead>
<tbody>
<tr>
<td>Agent Fraud</td>
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<tr>
<td>Market Conduct</td>
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<tr>
<td>Findings</td>
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Overall Reputation Assessment: Moderate Concern  
Overall Trend: ↑

Reserving: The Company is subject to high reserving risk, as shown in the following reserve trending of information. The Company historically has been overly optimistic in the forecasting of future liabilities and reserving, where actual reported results have failed to meet projections. The types of business written and geographic regions in which coverage is provided leave the Company vulnerable to high losses and a greater than industry average risk for adverse reserve development.

<table>
<thead>
<tr>
<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>204.1%</td>
<td>132.3%</td>
<td>168.0%</td>
<td>235.2%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
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<tbody>
<tr>
<td>Lines of Business</td>
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<tr>
<td>Loss Development</td>
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</table>

Overall Reserving Assessment: Moderate Concern  
Overall Trend: ↑

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

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

- The Company indicated in its Form F that it was changing its mix of business in states other than State X and Y. This could create a risk as the Company has only been writing in the other states for a few years, therefore there is limited historical development available for these states. This should be considered in the context of the targeted examination.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expansion in new jurisdictions</td>
<td></td>
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<td>↑</td>
</tr>
<tr>
<td>Profitability/capital concerns</td>
<td></td>
<td></td>
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</table>

Overall Strategic Assessment: Significant Concern  
Overall Trend: ↑
Other: The following other issues have been identified that don’t clearly fit into one of the branded risk classifications highlighted above:

- The company has consistently been out of compliance with one or more laws, regulations or requirements of the Department and other states.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect statutory financial statements</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
<tr>
<td>Lack of knowledge or laws</td>
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</table>

Overall Strategic Assessment: Significant Concern

Overall Trend: ↑

IMPACT OF HOLDING COMPANY ON INSURER

Summarize the evaluation of the impact of the holding company system on the domestic insurer.

The group is highly dependent upon cash flows from the various entities, including ABC, to make payments on the holding company debt used to help finance past transactions associated with the growth of the group. The Form F provides more specific information on necessary cash flows expected in the near term. Others risk from the non-insurers is not significant. See non-lead state Holding Company analysis for further discussion.

OVERALL CONCLUSION AND PRIORITY RATING

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

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

SUPERVISORY PLAN

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

- Obtain further detail regarding the impact of proposed rate increases and monitor through monthly financial reporting.
- Obtain further detail regarding the insurer’s liquidity strategy.
- Assess the reasonableness of the Company’s business plan as soon as it is received, given the inability to execute the most recent strategy. Consider attending board meetings to reflect the concern regarding the future viability of the Company.

Examination Follow-Up

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

Continual Review Process

The previously-mentioned review of the Audited Financial Report and the Holding Company System Analysis Procedures highlights the importance of a continual review process. This ongoing review process is obvious in these cases but is also necessary in other areas. For example, to the extent that an analyst completes the Level 1 Procedures for an insurer and has concerns with its liquidity, the analyst would complete the Level 2 Procedures - Cash Flow and Liquidity. Upon completion of the Level 2 Procedures, the analyst may have further concerns and would complete the additional Level 2 Procedures - Cash Flow and Liquidity. This analysis may result in questions posed to the insurer and additional information being supplied to the analyst.

In some cases, the state may choose to perform a more in-depth analysis of the insurer’s reserves, such as a targeted examination. This is just one of the many recommendations that could result from the ongoing analysis of an insurer. Other recommendations include: 1) requesting additional information from the insurer, 2) obtaining the insurer’s business plan, 3) requesting additional interim reporting, 4) engaging an independent expert, 5) meeting with the insurer’s management, and 6) obtaining a corrective action plan from the insurer. These specific recommendations are included in the Financial Analysis Framework section of this Handbook and represent just a few of the potential actions that could result from the ongoing analysis of an insurer. Regardless of the final outcome, the results of ongoing analysis should be documented in the appropriate level of the analysis, including the Level 1 Summary and Conclusion, if applicable.

Financial Examination Assessment

In performing the procedures related to financial examinations, 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 is crucial during the consideration of these procedures. The analyst should also consider the insurer’s corporate governance, which includes the assessment of the risk environment facing the insurer in order to identify current or
III. Analyst Reference Guide – A. Level 1

Prospective solvency risks, oversight provided by the board of directors, and the effectiveness of management, including the code of conduct established by the board.

The fundamental purposes of a full-scope financial condition examination report are: 1) to assess the financial condition of the company; and 2) to set forth findings of fact (together with citations of pertinent laws, regulations and rules) with regard to any material adverse findings disclosed by the examination. The report on examination should be structured and written to communicate to regulatory officials examination findings of regulatory importance. Management letter comments are considered to be examination workpapers and can be used to present results and observations noted during the examination.

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

Management letter comments generally contain the following information: 1) a concise statement of the problem found; 2) the factors which caused or created the problem; 3) the materiality of the problem and its effect on the financial statements; 4) the financial condition of the insurer or the insurer’s operations; and 5) the examiner’s recommendation to the insurer 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 domiciliary state insurance department. Periodically, after a financial examination report has been issued, inquiries should be made to the insurer to determine the extent to which corrective actions have been taken on report recommendations and findings. Because the examiners have usually moved on to another examination, many states utilize the financial analysts to perform this function. A lack of satisfactory corrective action by the insurer may be cause for further regulatory action.

Risk-Focused Examinations

The concept of risk in the risk-focused examination encompasses not only risk as of the examination date, but risks that extend or commence during the time in which the examination was conducted, and risks which are anticipated to arise or extend past the point of completion of the examination. Risks in addition to the financial reporting risks may be reviewed as part of the examination process.

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

- Phase 1 – Understand the Company and Identify Key Functional Activities to be Reviewed—Researching key business processes and business units.
- Phase 2 – Identify and Assess Inherent Risk in Activities - these risks include credit, market, pricing/underwriting, reserving, liquidity, operational, legal, strategic and reputational.
- Phase 3 – Identify and Evaluate Risk Mitigation Strategies/Controls - these strategies/controls include management oversight, policies and procedures, risk measurement, control monitoring, and compliance with laws.
- Phase 4 – Determine Residual Risk—once this risk is determined, the examiner can determine where to focus resources most effectively.
Phase 5 – Establish/Conduct Detail Examination Procedures - upon completion of risk assessment, determine nature and extent of detail examination procedures to be performed.

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 risk-focused examinations are to:

- Assess 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. To assist in this assessment, examiners may utilize board and audit committee minutes; lists of critical management and operating committees, their members and meeting frequencies; and Sarbanes-Oxley filings and initiatives, as applicable.

- Assess the risks that a company’s surplus is materially misstated.

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

Communication between 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 to focus their next review.

**Discussion of Level 1 Annual Procedures**

The Level 1 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of focus in the Level 1 Annual Procedures include the overall analysis of the insurer and its operations. The following provides a brief description of the purpose of each procedure.

**Background Analysis**

*Procedure #1* provides guidance to the analyst in determining if any conclusions reached in prior year analysis of the insurer should be considered in the work to be completed for the current year. Areas of concern noted in the prior year should be reviewed carefully in the current year. Insurers who were classified as priority companies in the prior year - either by the state’s priority designation, the Scoring System results, IRIS ratios (for property/casualty, life and fraternal), the Analyst Team System Validated Level, the RBC ratio and RBC Trend Test, or the Hazardous Financial Condition Regulation - should be reviewed carefully in the current year. The analyst should use their state’s definition/criteria for determining the hazardous financial condition of an insurer. The analyst should review the Insurer Profile.
Summary, including the Supervisory Plan, if applicable, for any concerns or risks that may require additional attention during the current analysis being performed.

Procedure #2 alerts the analyst to review all inter-departmental communication as well as communication with other state insurance departments and the insurer. Internal communication may include departments such as examination, licensing and admissions, consumer affairs, rate filings, policy/forms analysis, agents’ licensing, legal, and market conduct. It may be necessary to communicate with other state departments if a multi-state domestic insurer writes a significant amount of business in other states. Additional communication with the insurer throughout the year should be reviewed to identify any items or areas that may require special attention during the analysis process. Refer to the introductory chapters for further discussion on internal and external communication.

Procedure #3 directs the analyst to determine whether the insurer was a party to a merger or consolidation, which can have a significant impact on the ongoing operations of the insurer. This procedure also directs the analyst to determine if significant changes in the organizational structure or management have taken place. While organizational changes alone may not indicate a problem, knowledge of the change may help the analyst understand the insurer’s future plans and goals. Additionally, the analyst should verify that Form A or additional filings have been approved.

Procedure #4 requires the analyst to review General Interrogatories, Part 1, #6.1 and #6.2, to determine whether the insurer had any Certificates of Authority, licenses or registrations (including corporate registration if applicable) suspended or revoked by any governmental entity during the reporting period and investigate the reason(s) for the action(s).

Procedure #5 directs the analyst to identify if there are recent changes in the state’s statutes and regulations that could have an impact on the insurer’s financial position or reporting. If so, to the extent that information is available regarding the new statute or regulation, the analyst should determine if the insurer has failed to comply with the new state statutes and/or regulations that have been enacted during the period.

Procedure #6 requires the analyst to review the most recent rating agency report. In many cases, a rating agency downgrade may have an impact on the insurer’s ability to generate new business or to retain existing business. Also, consider the impact to the company’s current reinsurance and the insurer’s ability to obtain future reinsurance. The significance of the impact of a downgrade is generally dependent upon the type of product sold by the insurer and the level of the rating given by the agency.

Procedure #7 directs the analyst to review any industry reports, news releases or any emerging issues that have the potential to negatively impact the insurer. An example might include regulatory or media scrutiny of certain insurance lines of business, whether related to market conduct or financial issues. Another example would be changes in the economic environment that may negatively impact investment returns or result in material capital losses.

Procedure #8 directs the analyst to review the business plan of the insurer if it is available from recent surveillance activity, such as previous analysis or examinations, and if a review of the business plan is considered necessary based on the insurer’s priority designation and financial condition. If reviewed, the analyst should assess if the plan is consistent with current operations and expectations of projected results. For example, consider if the insurer is writing more or less premium or different lines of business outlined in the plan. Consider if the plan is consistent with changes in the markets or geographical areas where business is being written, or new licenses obtained to write business. The analyst should assess significant variances in the business plan through review of the plan and/or through communication with the insurer.
If a business plan is not available or current and, based on the analysis performed, the analyst feels it is necessary to request a business plan and recommend further analysis in this area; a procedure exists at the end of Level 1 within the “Recommendations for Further Analysis” section.

Management Assessment

Procedure #9 assists the analyst in determining if changes in the insurer’s management or board of directors have occurred. Changes such as these can have a significant impact on the ongoing operations of the insurer and management philosophy. Changes in the board of directors may also indicate changes in the audit committee. When assessing management, the analyst should take into consideration not only the changes in management but also the analyst’s and examiner’s knowledge about the current management team and any concerns that may exist regarding management. While management changes alone may not indicate a problem, knowledge of these changes may help the analyst understand other potential problems.

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

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

Balance Sheet Assessment

Procedure #10 directs the analyst in identifying significant changes in an insurer’s assets, liabilities, and surplus/capital and surplus (based on business type). Specific attention should be given to asset risk, receivables and recoverables, and changes in investment philosophy as well as reserves and reserve adequacy. The procedure also assists the analyst in determining if the overall amount of surplus/capital and surplus continues to meet Risk-Based Capital (RBC) requirements. RBC creates a minimum standard for surplus/capital and surplus. Generally, an analyst should be careful not to extend the use of the RBC. For example, an insurer with a 600 percent RBC ratio is not necessarily stronger than an insurer with a 500 percent RBC ratio.

Procedure #11 assists the analyst in evaluating the insurer’s overall liquidity position. The calculation of liquidity compares the insurer’s adjusted liabilities with its liquid assets available to fund such liabilities in the future. Any value that is greater than 100 percent indicates that the insurer has more liabilities than liquid assets.
Operations Assessment

Procedure #12 assists the analyst in identifying significant changes in an insurer’s Statement of Income for property/casualty, Summary of Operations for life, and Statement of Revenue and Expenses for health. Shifts in net income could indicate a change in premiums earned, a change in losses incurred, or other more complex issues that require further investigation. For this reason, it is critical that the analyst understand material changes within each income and expense category. The analyst should evaluate the title insurer’s operating performance by reviewing the combined ratio with the majority of the emphasis on monitoring the overall expense structure.

Procedure #13 assists the analyst in identifying unusual results in an insurer’s Cash Flow. During the review of the Cash Flow statement, the analyst should understand shifts in cash inflows and cash outflows that impact cash from operations. The analyst should also investigate investment acquisitions and dispositions, the insurer’s investment strategies, and the origin of other sources of cash.

Procedure #14 (health entities) requires the analyst to review the supplemental filings, Medicare Supplement Insurance Experience Exhibit (filed March 1st), the Long-Term Care Experience Exhibit Reporting Form (filed April 1st) and the Accident and Health Policy Experience Exhibit (filed April 1st). These supplemental filings provide added information, and may assist the analyst in understanding inforce, premium, and claims for certain lines of business.

Procedure #15 requires the analyst to identify material ceded reinsurance as reported in Schedule F, Part 3 - Ceded Reinsurance for property/casualty and Schedule S, Part 3 - Reinsurance Ceded for life insurers and health entities, and review all General Interrogatories and Notes to Financial Statements pertaining to reinsurance. The analyst should understand the insurer’s reinsurance programs and identify any credit risks. In addition, the analyst should be aware of the types of collateral held for reinsurance with unauthorized reinsurers.

Procedures #16 and 17 assists the analyst in determining whether concerns exist regarding changes in the volume of premiums written or the method in which premiums are produced as well as shifts in geographic writings.

Investment Practices

Procedure #18 assists the analyst in identifying unusual investment management practices of the insurer. These steps are specifically designed to assist the analyst in determining if the insurer has proper control over its investments.

Procedure #19 requires the analyst to review the Summary Investment Schedule to determine if the insurer uses any unusual methods for valuing its invested assets. The Summary Investment Schedule provides a comparison between the gross investment holdings, as valued in accordance with the AP&P Manual, and the admitted assets, as valued in accordance with the state of domicile’s basis of accounting. This schedule should be reviewed in conjunction with Note #1 of the Notes to Financial Statements - Summary of Significant Accounting Policies, Section A.

Procedure #20 requires the analyst to review the Supplemental Investment Risks Interrogatories to determine whether the insurer’s investment portfolio is adequately diversified with the appropriate level of liquidity to meet cash flow requirements.

Procedure #21 assists the analyst in determining the amount of assets held as deposits with the states. These deposits are placed with the states to secure the settlement of the insurer’s obligations to
policyholders, claimants, and others. Insurers with greater than 10 percent of assets held as deposits with states may hold greater liquidity risk in certain situations.

*Procedure #22* assists the analyst in determining whether investments in affiliates are significant. When investments in affiliates are significant, it is important for the analyst to review and understand the underlying financial statements of the affiliates and the overall purpose of the affiliated relationship.

**Review of Disclosures**

*Procedure #23* requires the analyst to review the Notes to Financial Statements to assist in identifying any relevant quantitative and qualitative information.

*Procedure #24* requires the analyst to review the General Interrogatories and (for property/casualty insurers) Schedule P Interrogatories to assist in identifying any unusual responses.

**Assessment of Latest Examination Report and Results**

*Procedures #25, 26, and 27* assist the analyst in gathering specific information related to the insurer’s most recent financial examination. During a review of the examination report, the analyst should note any items or areas that indicate further review is necessary. This might include such things as internal control issues, risk management, information technology, or other issues that could impact the insurer’s priority. The analyst should also review the management letter comments, which may include risks or progress on issues that the analyst should give attention to while the current analysis is being performed. Effective communication between the analyst and the examination staff is important in developing a good understanding of the insurer’s management and financial position. As an example, the examination staff may have specific information on the reliability of the insurer’s financial reporting. In addition, the analyst may want to utilize the Financial Exam Electronic Tracking System (FEETS) on I-SITE. The analyst should consider the impact, if any, of the Financial Examination Report findings on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (e.g., complete additional supplemental procedures).

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

*Procedure #28* requires the analyst to review and comment on the Annual Scoring System ratio results of the insurer, which can assist in identifying any unusual financial results.

*Procedure #29* requires the analyst to review the IRIS ratios of the insurer (for property/casualty, life and fraternal), which can assist in identifying any unusual financial results.

*Procedure #30* requires the analyst to review and understand the assigned Analyst Team System Validated Level, documented within the ATS Report and the ATS Validated Level Report on I-SITE. In addition, the analyst can reference the *ATS Procedures Manual* and ATS Level Definitions documents on I-SITE. The Analyst Team typically completes the validation process by mid-April.

*Procedure #31* requires the analyst to review the Annual Financial Profile Report, which can assist in identifying unusual trends and results.

*Procedure #32* alerts the analyst to review any communication from the state’s market analysis unit, including the results of market conduct exams as well as information drawn from the review of 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 the Complaints database. Analysts should review any market conduct issues identified by 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. For example, large fines levied by states, suspensions or revocations of licenses, market conduct exam settlements (whether financial or other), or other regulatory actions taken based on market conduct violations may have a material impact on the financial solvency of the insurer.

Assessment of Supplemental Filings

Procedure #33 requires the analyst to review the Statement of Actuarial Opinion to assess the adequacy of the insurer’s reserves. See the Statement of Actuarial Opinion Supplemental Procedures for additional guidance in this area.

Procedure #34 requires the analyst to review the MD&A, which can provide additional information to the analysis of the insurer. See the MD&A Supplemental Procedures for additional guidance.

Procedure #35 requires the analyst to review the Audited Financial Report, which helps to assess the reliance placed on the validity of the insurer’s financial statements. The Audited Financial Report also contains additional financial information that is generally not included in the Annual Financial Statement and can be helpful to the analyst. See the Audited Financial Report Supplemental Procedures for additional guidance.

Procedure #36 requires the analyst to review the most recent financial statement of the holding company, as filed in the SEC 10-K Report. In addition, the analyst should review Forms A, B, D, E, F (if required) and Extraordinary Dividend/Distributions, if available. If there are affiliated insurers within the holding company system, the analyst should document communication with the domestic departments of insurance for those affiliated insurers.

Discussion of Level 1 Quarterly Procedures

The Level 1 Quarterly Procedures are designed to help the analyst perform a general review of the insurer and its operations. The quarterly procedures are similar to the annual procedures because they are mostly broad-based questions; however, the quarterly procedures include questions that focus primarily on changes from the prior year. At the conclusion of the Level 1 Quarterly Procedures, the analyst is asked to review the following: 1) develop and document an overall summary and conclusion regarding the financial condition of the insurer; 2) determine whether the insurer be considered a priority company and 3) indicate whether one or more of the procedures in Level 2 Quarterly Procedures should be completed. As with the annual review, the Quarterly Level 1 Summary and Conclusion should be reviewed and revised as necessary when subsequent procedures and follow-up with insurer are completed.

Discussion of Level 1 Quarterly Procedures for Non-Troubled Insurers

The Level 1 Quarterly Procedures for Non-Troubled Insurers are designed to help the analyst perform a quantitative review of the insurer and its operations. The analyst should use their state’s guidelines and policy for determining whether an insurer is considered to be a troubled insurer to answer procedure B.1. The non-troubled quarterly procedures include key broad-based questions and questions that focus primarily on changes from the prior year.
Special note: For companies that have not filed a prior year-end or quarterly statement (e.g., either a new start-up insurer or exempt from filing), all responses in section D will default to a “Yes.” In this scenario, it is recommended the analyst perform a full Level 1 review.

**Discussion of Non-Routine Analysis**

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

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

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

- **Focused analysis on asset quality where insurers hold higher amounts of riskier assets.** The analyst should not only consider exposure to individual default events but also aggregate exposure. Additional review or explanation from the insurer may be requested when high amounts of other-than-temporary impairments, unrealized losses and/or large variances between book and market value are reported. The analyst should review the value of affiliated investments and assess indirect exposure to economic events that may result in the decline in the affiliated holdings. Analysts may consider other sources of analysis or information to assist in the review of investments. For example, an analyst may consider requesting assistance from the NAIC Capital Markets Bureau.

- **Analysts should consider the impact of tightened short-term credit markets on insurers or groups who depend on commercial paper, overnight repos, dollar repos, etc.** Another area that could be impacted by changes in credit markets is the insurer’s ability to obtain letters of credit (LOC) provided for XXX (life reserves) or other reinsurance reserves, and the costs of those LOCs for an insurer dependent on LOCs.

- **If the insurer engages in securities lending,** the analyst may consider requesting detailed information about the program to review the types of assets (risk and duration match) within the program, gain an understanding of the structure and terms of the program, and, if material, monitor monthly changes in the program.

- **Certain insurance products may be impacted more than others in an economic downturn.** The analyst should consider the impact to an insurer that writes a material amount of products that are more likely to be accelerated (e.g., funding agreements, guaranteed interest contract–GICs) or where the liability can be accelerated (e.g., variable annuities, living benefit/death benefit on variable annuities).
The analyst should consider the level of sensitivity of the insurer to ratings downgrades and the possible impact on the insurer or the group. For example, its ability to market new business or the impact of rating downgrades on any debt covenants. If an insurer is downgraded, the analyst may consider monitoring surrenders, new business sales, and any changes in the insurer’s business plans.

Where liquidity is a concern, the analyst may also consider requesting interim reporting from the insurer on areas of risk specific to that insurer. For example, surrender activity, high-risk investment exposures, GICs, capital and surplus, available liquidity, available credit facilities and capital losses.

Where significant concerns exist, the state may consider requesting the insurer to perform stress testing on the possible future impacts of additional equity losses, defaults, or other areas relevant to the situation.

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

- Implement disaster reporting requests to appropriate insurers and monitor claims exposure during future periods following the event.
- Identify insurers and reinsurers with material exposure.
- Implement appropriate procedures to identify fraudulent activities.
- Perform an in-depth analysis of liquidity to ensure timely payment of claims.
- Engage legal staff to ensure appropriate claims payment practices.
1. Determine whether the insurer’s investment portfolio appears to be adequately diversified to avoid concentration of investments by type or issue.

   a. Is the total of industrial and miscellaneous bonds owned greater than 25 percent of total net admitted assets?

   b. Does the insurer own residential mortgage-backed securities, commercial mortgage-backed securities or other loan-backed and structured securities greater than 20 percent of total net admitted assets?

   c. Are foreign bonds owned greater than 5 percent of total net admitted assets? If the insurer’s investments include a significant amount of foreign bonds, consider the insurer’s potential foreign currency exposure from bonds denominated in a foreign currency.

   d. Are preferred stocks owned greater than 10 percent of total net admitted assets?

   e. Are common stocks owned greater than 20 percent of total net admitted assets?

   f. Are mortgage loans owned greater than 5 percent of total net admitted assets?

   g. Is real estate owned, including home office real estate, greater than 5 percent of total net admitted assets?

   h. Are total derivatives greater than +/- 5 percent of total net admitted assets?

   i. Is the counterparty exposure or potential exposure of derivative instruments open greater than 5 percent of total net admitted assets?

   j. Are other invested assets (Schedule BA) greater than 5 percent of total net admitted assets?

   k. Are aggregate write-ins for invested assets greater than 5 percent of total net admitted assets?

   l. Are affiliated investments greater than 10 percent of total net admitted assets?

   m. Is any one single investment (excluding federal issues and affiliated investments) greater than 3 percent of total net admitted assets?

   n. Has the insurer failed to comply with state-specific investment laws, regulations, or guidelines for diversity and limitations? Document any concerns in the comment section.

Additional procedures and prospective risk considerations, if further concerns exist:

   o. Compare the insurer’s distribution of cash and invested assets to total assets in the Financial Profile Report to industry averages, and determine any significant deviations.

   p. Request a copy of the insurer’s formal investment plan that discusses investment objectives and strategy with specific guidelines as to quality, maturity, and diversification of investments and:

      i. Evaluate whether the investment plan appears to result in investments and practices that are appropriate for the insurer based on the types of business written and its liquidity and cash flow needs.

      ii. Determine whether the insurer appears to be adhering to their investment plan.
q. Review the maturity distribution of bonds in Schedule D, Part 1A, Section 1 - Quality and Maturity Distribution of All Bonds Owned, and consider the liquidity of the insurer’s investments to determine whether its investment portfolio appears reasonable based on the types of business written.

r. If there are concerns regarding liquidity or cash flows, consider having a cash flow analysis performed by an actuary.

2. Determine whether there are concerns due to the level of investment in certain types of securities that tend to be riskier and/or less liquid than publicly traded investment grade bonds, stocks, and cash and short-term investments.

   a. Determine whether there are concerns due to the level of investment in non-investment grade bonds.

      i. Is the ratio of non-investment grade bonds to surplus greater than 10 percent?

      ii. If non-investment grade bonds exceed 5 percent of surplus, have such investments increased by greater than 10 percent over the prior year?

   Additional procedures and prospective risk considerations, if further concerns exist:

   iii. Review Schedule D, Part 1A, Section 1 - Quality and Maturity Distribution of All Bonds Owned, and compare the insurer’s holdings of non-investment grade bonds to the limitations included in the NAIC Investments in Medium Grade and Lower Grade Obligations Model Regulation (#340).

      A. Determine whether the aggregate amount of all bonds owned that are rated 3, 4, 5, or 6 by the SVO are less than 20 percent of total net admitted assets.

      B. Determine whether the aggregate amount of all bonds owned that are rated 4, 5, or 6 by the SVO are less than 10 percent of total net admitted assets.

      C. Determine whether the aggregate amount of all bonds owned that are rated 5 or 6 by the SVO are less than 3 percent of total net admitted assets.

      D. Determine whether the aggregate amount of all bonds owned that are rated 6 by the SVO are less than 1 percent of total net admitted assets.

   iv. Request a copy of the insurer’s plan for investing in non-investment grade bonds and review the guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location.

   v. Determine whether the insurer appears to be adhering to its plan for investing in non-investment grade bonds.

   vi. For the more significant non-investment grade bonds, request from the insurer the following current information regarding the issuer to determine the issuer’s financial position and ability to repay its debt:

      • Audited Financial Statement.
III. Annual Procedures - B.1. Level 2 Investments (Property/Casualty)

- Report from an NAIC credit rating provider (CRP) (e.g., Moody’s Investors Service, Standard & Poor’s, A.M. Best, Dominion Bond Rating Service (DBRS), Fitch Ratings, Real Point, LLC (CMBS only) or Kroll Bond Rating Agency.)

b. Review Schedule D, Part 1A, Section 2 - Maturity Distribution of All Bonds Owned, to determine whether there are concerns due to the level of investment in residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS) or other loan-backed and structured securities (LBaSS).

  i. Is the ratio of RMBS, CMBS and LBaSS owned to surplus greater than 50 percent?
  ii. If investments in RMBS, CMBS and LBaSS exceed 15 percent of surplus, have these investments increased by greater than 20 percent over the prior year?
  iii. Is the ratio of RMBS to surplus greater than 5 percent?

   Additional procedures and prospective risk considerations, if further concerns exist:

  iv. Review the RMBS, CMBS and LBaSS categories in Schedule D, Part 1 - Long-Term Bonds Owned, for bonds with a book/adjusted carrying value significantly in excess of par value, which could result in a loss being realized if bond prepayments occur faster than anticipated.
  v. Review the RMBS, CMBS, LBaSS categories in Schedule D, Part 1 - Long-Term Bonds Owned, for bonds with an unusually high effective yield.
  vi. Request information from the insurer regarding the percentage distribution of the amounts of each type of RMBS held, planned amortization class, support bonds, interest-only tranches, and principal-only tranches to evaluate the level of prepayment risk in the portfolio.
  vii. Request and examine information from the insurer regarding the estimated prepayment speeds on its RMBS.

   A document is available in the link at the top of the Financial Analysis Handbook Reports page on I-SITE that discusses mortgage-backed securities and their pricing/valuation, prepayment models, measures of prepayments, extension risk and contraction risk, average life, option-adjusted spread, effective duration, and convexity.
  viii. Request information from the insurer regarding its background and expertise in structured securities of its investment advisers (in-house and/or contractual) and its analytical systems capabilities. Determine whether the advisers and systems are adequate to allow the insurer to continuously monitor its structured securities investments.
  ix. Consider having the commercial mortgage obligations modeled by an actuary as part of a cash flow analysis.

c. Determine whether there are concerns due to the level of investment in privately placed bonds.

  i. Is the ratio of privately placed bonds to surplus greater than 15 percent?
  ii. If privately placed bonds exceed 5 percent of surplus, have such investments increased by greater than 15 percent over the prior year?
Additional procedures and prospective risk considerations, if further concerns exist:

iii. Review Schedule D, Part 1A, Section 1—Quality and Maturity Distribution of All Bonds Owned and determine the following:
   A. The total amount of privately placed bonds owned.
   B. The issue types of privately placed bonds.
   C. The NAIC designations of the privately placed bonds.
   D. The maturity distribution of the privately placed bonds.
   E. The amount of total privately placed bonds that are freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

iv. For the more significant privately placed bonds, request from the insurer current audited financial information regarding the issuer and evaluate the issuer’s financial position and ability to repay its debt.

d. Determine whether there are concerns due to the level of investment in structured notes.

i. Are investments in structured notes greater than 10% of capital and surplus plus AVR [Exclude AVR for P&C and Health statement types]?

ii. Review Note 5 and Schedule D, Part 1, to identify the types of structured notes and the interest rate reported.

iii. Review the most recent financial examination for any risks noted.

iv. Inquire of the insurer:
   A. Has management adequately reviewed the structured note portfolio and do they understand the underlying yields, cash flows and their volatility?
   B. Gain an understanding of the concentration by collateral type, subordination in the overall structure of the structured note transactions, and any trend analysis management has performed on the underlying assets to ensure appropriate valuation of the structured note.
   C. Gain an understanding of management’s process for valuing the structured notes so as to assess if the notes are valued appropriately.
   D. What is the insurer’s intended use of these structured notes and purpose within the insurer’s portfolio?
   E. Does management have an appropriate level of expertise with this type of security?
   F. Does the insurer have controls implemented to mitigate the risks associated with this investment type?

e. Determine whether there are concerns due to the level of investment in real estate and mortgage loans.

i. Review General Interrogatories, Part 1, #12.1. Does the insurer own any securities of a real estate holding company or otherwise hold real estate indirectly?

ii. Is the ratio of total real estate and mortgage loans to surplus greater than 15 percent?
iii. If total real estate and mortgage loans exceed 10 percent of surplus, have such investments increased by greater than 15 percent over the prior year?

Additional procedures and prospective risk considerations, if further concerns exist:

iv. Review Schedule A, Part 1 - Real Estate Owned to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the book/adjusted carrying value and reported fair value of the property, and the year of the last appraisal.

v. Review Schedule A, Part 1 - Real Estate Owned and:
   A. Investigate any instances where a property has a book/adjusted carrying value in excess of its cost.
   B. Request information from the insurer regarding any increases by adjustment in book/adjusted carrying value during the year.
   C. For any properties owned that have a book/adjusted carrying value in excess of fair value, determine whether the asset should be written down.

vi. Review Schedule B, Part 1 - Mortgage Loans Owned and:
   A. Compare the book value of each loan to the value of the land and buildings mortgaged to determine whether the mortgage loans are adequately collateralized.
   B. Request information from the insurer regarding any increases by adjustment in book value during the year.
   C. Determine whether any of the mortgage loans are to an officer, director, parent, subsidiary, or affiliate.

f. Determine whether there are concerns due to the level of investment in other long-term invested assets (Schedule BA).
   i. Is the ratio of other long-term invested assets to surplus greater than 10 percent?
   ii. If other long-term invested assets exceed 5 percent of surplus, have such investments increased by greater than 10 percent over the prior year?

Additional procedures and prospective risk considerations, if further concerns exist:

iii. Review Schedule BA, Part 1 - Other Long-Term Invested Assets Owned to determine the amount and types of other invested assets owned and whether they are properly categorized as other invested assets.

iv. Request information from the insurer to support significant increases by adjustments in book/adjusted carrying values during the year.

v. Request the current Audited Financial Statement and other documents (partnership agreements, etc.) necessary to support the book/adjusted carrying value of the insurer’s investment(s) in partnerships and joint ventures.

vi. Request information necessary to support the book/adjusted carrying value of significant other invested assets other than partnerships and joint ventures.

vii. Request information necessary to determine the fair value of collateral to the amount loaned to ensure the loan is adequately collateralized.
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g. Is the company aware of any market conditions that could threaten the value of the company’s investment portfolio (e.g. subprime mortgage market)? If so, provide an explanation.

3. Determine whether the purchase or sale of all investments were approved by the board of directors and whether all securities owned as of December 31 of the current year, over which the insurer had exclusive control and actual possession, except as shown in Schedule E, Part 3 - Special Deposits.

a. Review General Interrogatories, Part 1, #16. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof? Provide details.

b. Review General Interrogatories, Part 1, #24.01 and #24.02. Are any stocks, bonds and other securities owned, over which the insurer has exclusive control, not in the actual possession of the insurer, other than securities lending programs?

c. Review General Interrogatories, Part 1, #25.1 and #25.2. Are any stocks, bonds or other assets owned by the insurer not exclusively under the control of the insurer?

d. Review the summary detail on restricted assets provided in the Notes to Financial Statements, Note #5-H. Are there any assets that are greater than 10 percent of invested assets? Provide details.

Additional procedures and prospective risk considerations, if further concerns exist:

e. Request a copy of the insurer’s investment plan to determine who is authorized to purchase and sell investments and what approvals are required for investment transactions.

f. If the insurer has securities under its exclusive control that are not in its actual possession, review General Interrogatories, Part 1, #24.01 to determine the reason the securities are not in the insurer’s possession, who holds the securities, and whether they qualify as admitted assets of the insurer.

g. If the insurer owns assets that are not under its exclusive control, review General Interrogatories, Part 1, #25.1 to determine the reason the assets are not under the insurer’s exclusive control, who holds the assets, and whether they qualify as admitted assets of the insurer.

4. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office (SVO).


i. Has the insurer failed to follow the filing requirements of the Purposes and Procedures Manual of the Securities Valuation Office?

ii. If the answer to 4ai is “yes,” document the exceptions listed in General Interrogatories, Part 1, #32.2.

b. Review Schedule D, Part 1 - Bonds and Schedule D, Part 2 - Preferred Stocks and Common Stocks. Does it appear that the insurer is not complying with the requirement to submit securities to the SVO for a valuation, i.e., there are securities that were acquired prior to the current year with a “Z” suffix after the NAIC designation and/or there is a
significant number of securities that were acquired during the current year with a “Z” suffix after the NAIC designation?

Additional procedures and prospective risk considerations, if further concerns exist:

c. Review Schedule D, Part 1 - Long-Term Bonds Owned to determine whether all bonds with an NAIC designation of 3, 4, 5, or 6 (non-investment grade bonds) have been valued at the lesser of book/adjusted carrying value or fair value and all other bonds have been valued at book/adjusted carrying value.

d. Review Schedule D, Part 2 - Preferred Stocks and Common Stocks Owned, to determine whether sinking fund preferred stocks have been valued at cost and all other stocks have been valued at fair value.

e. If securities are listed in Schedule D, Part 1 - Long-Term Bonds Owned or Schedule D, Part 2 - Preferred Stocks and Common Stocks Owned with a “Z” suffix after the NAIC designation:
   i. Request verification from the insurer that the securities have been submitted to and subsequently valued by the SVO.
   ii. Compare the price or designation actually received from the SVO to that included in the Annual Financial Statement for significant securities.

f. For each of the securities listed in Schedule D, Part 1 - Long-Term Bonds Owned, Schedule D, Part 2 - Preferred Stocks and Common Stocks Owned, and Schedule DA, Part 1 - Short-Term Investments Owned, compare the CUSIP number, NAIC designation, and fair value included in the Annual Financial Statement to information on the SVO master file using Examination Jumpstart Investment Analysis, and contact the insurer to follow up on any exceptions noted.

5. Determine whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value.

a. Review General Interrogatories, Part 1, #30, which shows the aggregate statement value and the aggregate fair value of bonds and preferred stocks owned. Is the cumulative excess of the statement value over the fair value of bonds and preferred stocks owned greater than 10 percent of the statement value of bonds and preferred stocks owned?

b. Is the cumulative excess of the statement value over the fair value of bonds and preferred stocks owned greater than 20 percent of surplus?

Additional procedures and prospective risk considerations, if further concerns exist:

c. Review Schedule D, Part 1 - Long-Term Bonds Owned and Schedule D, Part 2 - Preferred Stocks and Common Stocks Owned, or request additional information from the insurer to determine which individual securities have a book/adjusted carrying value significantly in excess of their fair value. For those securities:
   i. Verify the NAIC designation assigned and determine whether it has been recently updated by the SVO.
   ii. Determine the current rating by an NAIC CRP (e.g., Moody’s Investor’s Service, Standard and Poor’s, A.M. Best, Dominion Bond Rating Service (DBRS), Fitch Ratings, Real Point, LLC (CMBS Only) or Kroll Bond Rating Agency).
iii. Determine whether there has been an other-than-temporary decline of the fair value.

d. Request information from the insurer regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

6. Determine whether the fair value of common stock is significantly greater than or less than the cost.

   a. Review Schedule D, Part 2, Section 2 - Common Stocks. Is the aggregate fair value of common stock below the actual cost?
      i. If the answer to 6a is “yes,” is the difference greater than 10 percent of surplus?

   b. Review Schedule D, Part 2, Section 2 - Common Stocks. Is the aggregate actual cost of common stock below the fair value?
      i. If the answer to 6b is “yes,” is the difference greater than 10 percent of surplus?

   c. If an investment in one issue of common stock exceeds 5 percent of invested assets, does the fair value of the common stock exceed the actual cost by greater than 30 percent, or is the fair value less than the actual cost by greater than 20 percent?

Additional procedures and prospective risk considerations, if further concerns exist:

   d. Review Schedule D, Part 2, Section 2 - Common Stocks. Is the aggregate fair value of common stock below the actual cost?
      i. If the stock is listed on a market or exchange (designated by the symbol L or U), such as the New York Stock Exchange, the American Stock Exchange, the NASDAQ National Market system, or a foreign exchange, verify the price and total fair value.
      ii. If the stock is designated “A” (unit price of the share has been analytically determined by the SVO), determine whether the rating has been updated recently by the SVO.
      iii. Determine whether there has been an other-than-temporary decline in the fair value of the common stock.

   e. Request information from the insurer regarding investment strategies and short-term cash flow needs to determine whether common stock with a cost significantly in excess of its fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

7. Determine whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year.

   a. Review Schedule D, Part 3 - Long-Term Bonds and Stocks Acquired During Current Year and Schedule D, Part 5 - Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year. Were significant amounts of bonds or stocks purchased near the beginning or the end of the year? If so, determine the types of securities purchased and the vendors used for those purchases. Refer to the Financial
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Summary Investment Activity section of the insurer’s Financial Profile for information regarding long-term bonds and stocks acquired near the beginning or the end of the year.

b. Review the Annual Financial Statement, Liabilities, Surplus and Other Funds page. Is payable for securities greater than 10 percent of invested assets?

c. Review Schedule D, Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D, Part 5 - Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year. Were significant amounts of bonds or stocks disposed of near the beginning or the end of the year? If so, determine the types of securities sold and the purchasers of those securities. Refer to the Financial Summary Investment Activity section of the insurer’s Financial Profile for information regarding long-term bonds and stocks sold, redeemed or otherwise disposed of near the end of the year.

d. Based on the results of 7a and 7c above, determine whether the insurer might have engaged in “window dressing” of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end).

e. Review the Annual Financial Statement, Assets page. Is receivables for securities greater than 10 percent of invested assets?

f. Review Schedule D, Part 5 - Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Current Year. Were significant amounts of bonds or stocks acquired near the beginning of the year and disposed of near the end of the year? If so, determine the types of securities purchased, the vendors used for those purchases and the purchasers of those securities. Refer to the Financial Summary Investment Activity section of the insurer’s Financial Profile for information regarding long-term bonds and stocks acquired near the beginning of the year and disposed of near the end of the year.

8. Determine whether concerns exist due to significant turnover of long-term bonds, preferred stocks, or common stocks during the year.

a. Review Schedule D, Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D, Part 5 - Long-Term Bonds and Stocks Acquired During Current Year.

i. Is the long-term bond turnover ratio greater than 50 percent?

ii. Is the stock turnover ratio greater than 50 percent?

iii. Is the total long-term bond and stock turnover ratio greater than 50 percent?

iv. Determine the amount of bonds and stocks disposed of during the current year.

Additional procedures and prospective risk considerations, if further concerns exist:

b. Review Schedule D, Part 3 - Long-Term Bonds and Stocks Acquired During Current Year.

i. Determine the quality of bonds acquired, noting any “Z” rated (not yet rated by the SVO) securities. Also note any NAIC designations of 3, 4, 5, or 6 (non-investment grade bonds).

ii. Determine the quality of preferred and common stocks acquired. Evaluate any “U” (unlisted) or “A” (analytically determined) rated stocks.
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c. Determine that all brokers used by the company for investment transactions are licensed and in good standing with the SEC.

d. High turnover of investments can result in realized capital gains. Review the Exhibit of Capital Gains (Losses) to determine the degree of reliance on capital gains to increase surplus or to offset underwriting losses.

9. Determine whether there are concerns due to the level of investment in derivative instruments.

a. Review the Notes to Financial Statements, #1, #5, and #8, General Interrogatories, Part 1, #24 - 26, Assets (line 7), Liabilities (line 20), Exhibit of Net Investment Income, Exhibit of Capital Gains and Losses, Schedule DB - all parts, MD&A, and the Audited Financial Report. Is the insurer engaging in derivative activity?

If the answer to 9a is “no,” do not proceed with the derivative procedures and skip to the conclusion of the investment section.

b. Determine whether derivative holdings at year-end are significant.

Review Schedule DB, Parts A, B, and C, Section 1. Is the total book adjusted carrying value at year-end greater than 10 percent of surplus? If “yes,” list the total book/adjusted carrying value and percentage of surplus for hedging effective, hedging other, replication, income generation, and total derivative transactions.

c. Review the Exhibit of Net Investment Income. Is the ratio of derivative investment income to net investment income greater than 5 percent?

d. Review the Exhibit of Capital Gains and Losses.

i. Is the amount of realized capital loss attributed to derivatives greater than the amount of any gain attributed to derivatives?

ii. If 9di above is “yes,” is the amount of realized capital loss attributed to derivatives greater than 10 percent of surplus?

e. Review Schedule DB - Part A, Section 2, columns 22, 23, and 24, and Schedule DB - Part B, Section 2, columns 16, 17, and 18. If the sum of the aggregate gains and losses at disposal results in aggregate net losses on derivatives, then is the absolute value of these losses greater than 10 percent of surplus? If “yes,” list the net gain/loss and percentage of surplus for recognized, used to adjust basis, and deferred.

f. Review Schedule DB, Part D, Section 1 - Counterparty Exposure for Derivative Instruments Open. Is the ratio of total off balance sheet exposure to surplus greater than 10 percent?

Additional procedures and prospective risk considerations, if further concerns exist:

g. Request and review a comprehensive description of the insurer’s hedge program in order to gain an understanding of the insurer’s use of derivative instruments to hedge against the risk of a change in value, yield, price, cash flow, quantity, or degree of exposure with respect to assets, liabilities, or future cash flows that the insurer has acquired or incurred or anticipates acquiring or incurring and:

i. Evaluate whether the hedge program appears to result in hedges that are appropriate for the insurer based on its assets, liabilities, and cash flow risks.
III. Annual Procedures - B.1. Level 2 Investments (Property/Casualty)

ii. Determine whether the insurer appears to be adhering to the description of the hedge program.

h. Review Schedule DB - Derivative Instruments. For significant derivative instruments that are open at year-end, request the following information from the insurer:
   i. A description of the methodology used to verify the continued effectiveness of the hedge provided.
   ii. A description of the methodology to determine the fair value.
   iii. A description of the determination of the book/adjusted carrying value.

i. Consider having the insurer’s derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. 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 insurer’s investments 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 examination section for targeted examination
- Engage an independent appraiser to value particular investments
- Engage an independent actuary to perform cash flow analysis
- 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 ____
III. Quarterly Procedures – B.1. Level 2 Investments (Property/Casualty)

1. Determine whether the insurer’s investment portfolio appears to be adequately diversified to avoid concentration of investments by type or issue.
   a. Are preferred stocks owned greater than 10 percent of total net admitted assets?
   b. Are common stocks owned greater than 20 percent of total net admitted assets?
   c. Are non-investment grade bonds owned greater than 3.5 percent of total net admitted assets?
   d. Are mortgage loans owned greater than 5 percent of total net admitted assets?
   e. Is real estate owned, including home office real estate, greater than 5 percent of total net admitted assets?
   f. Are other invested assets (Schedule BA) greater than 5 percent of total net admitted assets?
   g. Are aggregate write-ins for invested assets greater than 5 percent of total net admitted assets?
   h. Are affiliated investments greater than 10 percent of total net admitted assets?

2. Determine whether the insurer has increased its holdings in investments that tend to be riskier and/or less liquid than investment grade bonds, stocks, cash, and short-term investments.
   a. If non-investment grade bonds exceed 5 percent of surplus, have such investments increased by greater than 10 percent over the prior year-end?
   b. If total real estate and mortgage loans exceed 10 percent of surplus, have such investments increased by greater than 15 percent over the prior year-end?
   c. If other invested assets (Schedule BA) exceed 5 percent of surplus, have such investments increased by greater than 10 percent over the prior year-end?
   d. If aggregate write-ins for invested assets exceed 10 percent of surplus, have such investments increased by greater than 20 percent over the prior year-end?
   e. If affiliated investments exceed 10 percent of surplus, have such investments increased by greater than 20 percent over the prior year-end?

3. Determine whether the insurer increased its holdings in derivatives that tend to be riskier and/or less liquid than investment grade bonds, stocks, cash, and short-term investments.
   a. Review Schedule DB, Part A, Section 1 - Showing all Options, Caps, Floors, Collars, Swaps and Forwards Open as of Current Statement Date. Is the total book/adjusted carrying value greater than 10 percent of surplus? If “yes,” list the book/adjusted carrying value and percentage of surplus for hedging, replication, income generation, other, and total derivative transactions.
   b. Review Schedule DB, Part B, Section 1 - Showing Future Contracts Open as of the Current Statement Date. Is the total book/adjusted carrying value greater than 10 percent of surplus? If “yes,” list the book/adjusted carrying value and percentage of surplus for hedging, replication, income generation, other, and total derivative transactions.
III. Quarterly Procedures – B.1. Level 2 Investments (Property/Casualty)

c. Review Schedule DB, Part D, Section 1 - Counterparty Exposure for Derivative Investments Open as of Current Statement Date. Is the total book/adjusted carrying value net of collateral greater than 10 percent of surplus? If “yes,” list the percentage of surplus for total derivatives and the book/adjusted carrying value net of collateral.

d. Review detail provided in Schedule DB columns for Description of Items Hedged or used for Income Generation or Replicated, Types of Risk(s), to determine if the insurers detailed use of derivatives appears to be consistent with the overall strategy that the reporting entity has described elsewhere. Where the detail reported in Schedule DB differs from other information provided by the insurer, request further clarifying information from the reporting entity.

e. Review detail provided in Schedule DB columns for Hedge Effectiveness at Inception and at Quarter-End. Note anything unusual or any variances from the insurer’s current hedging program description.

4. Determine whether all securities owned are under the control of the insurer and in the insurer’s possession. Review General Interrogatories, Part 1, #11.1. Were any of the assets of the insurer loaned, placed under option agreement, or otherwise made available for use by another person (excluding securities under securities lending agreements)?

5. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office (SVO).


i. Has the insurer failed to follow the filing requirements of the Purposes and Procedures Manual of the Securities Valuation Office?

ii. If the answer to 5a(i) is “yes,” document the exceptions listed in General Interrogatories, Part 1, #18.2.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. 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 insurer’s investments under the specific circumstances involved.

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer _______________ Date ________
Overview

Insurers receive premiums from policyholders today in exchange for a promise to pay covered losses in the future. The premiums, net of operating expenses paid, along with surplus funds, are invested in a variety of different types of investments until they are needed to pay losses. State insurance laws regulate an insurer’s investments and prescribe the types of investments that may be acquired by insurers. These laws generally provide limitations on investments by type and issue. In most states, however, a large portion of the insurer’s assets may be invested at the discretion of management or the board of directors, as long as it’s within the statutory limits. An insurer may become financially troubled if it invests heavily in speculative or high-risk investments that later result in losses, or if it invests in securities with maturities that are inappropriately matched with its liabilities.

Investment income is often a key component in the pricing of long-tail liability lines of business. In some cases, management may be pressured into strategies to maximize investment yields when losses are higher than anticipated at the time the products were priced. Higher investment yields generally involve greater risk and ownership of investments that are questionable in quality or value.

Another important investment consideration is the proper matching of assets and liabilities. An insurer must manage its investment portfolio to match investment maturities with its cash flow need to pay losses. Poor matching may result in the insurer being forced to liquidate long-term investments at a loss to provide the currently needed cash flows.

Investment risk may also involve a failure to adequately diversify an investment portfolio. A concentration of assets in one type of investment may not adequately spread the investment risk and may result in more volatile investment returns. A high concentration of investments that are not readily marketable may also indicate increased investment risk and may raise concerns as to the value of the investments.

Historically, property/casualty insurers have invested primarily in bonds and common stocks. While this still holds true, the industry’s approach to investments has changed significantly over time. In the past, insurers were primarily concerned with the preservation of capital and generally invested in high quality bonds and stocks. However, insurers are now focusing more on investment returns. This change in focus has prompted some insurers to turn to assets of higher risk and lower quality in exchange for higher investment yields. Some property/casualty insurers currently have significant investments in non-investment grade bonds, privately placed bonds, residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS) and other loan-backed and structured securities (LBaSS). Investments today are much more complex and sophisticated than they were in the past. This requires insurers to have investment advisors (in-house and/or contractual) with appropriate background and expertise, as well as analytical systems that are capable of continually monitoring the constantly changing marketplace.

As a result, investment analysis is more important today than it was in the past. The principal areas of concern to the analyst in reviewing an insurer’s investment portfolio are: 1) diversification, 2) liquidity, 3) quality, 4) valuation, and 5) asset/liability matching. First, an insurer’s investment portfolio should be adequately diversified to prevent concentration of investments by type or issue. Second, the investment portfolio should be structured in such a way that it is appropriately liquid to allow for the cash flows necessary to cover the insurer’s policyholders’ commitments as they become due. Sufficient assets should be readily convertible to cash, and the sale of necessary assets should not involve significant losses caused by changes in the market. Third, default or credit risk is a function of investment quality. As the quality of an investment decreases, the probability that principal will be returned and that the expected
yield will be realized tends to decrease. Fourth, invested assets are generally valued at cost or amortized cost except for common stocks and non-sinking fund preferred stocks, which are valued at their fair value. The analyst should track investments that may need to be written down to fair value due to other than temporary declines in value.

Although investments have been more of a concern in the past analyses of life insurers than property/casualty insurers, many property/casualty insurers are now investing in riskier investments. The analyst should be alert for property/casualty insurers with concentrations of investments that are riskier and/or less liquid than traditional bonds and common stocks. The analyst should also evaluate whether these investments are appropriate for the insurer based on the lines of business written and the insurer’s liquidity and cash flow needs.

**Discussion of Level 2 Annual Procedures**

The Level 2 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of concern regarding an insurer’s investment portfolio are diversification, liquidity, quality, valuation and asset/liability matching. Most of the procedures are designed to assist the analyst in identifying undue concentrations of investments by type or issue and investments that have been improperly valued in the Annual Financial Statement.

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. The analyst should also consider the insurer’s corporate governance, which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors, and the effectiveness of management, including the code of conduct established by the board of directors.

*Procedure #1* assists the analyst in determining whether the insurer’s investment portfolio appears to be adequately diversified to avoid concentration of investments by type or issue. The ratios within the procedure are a measure of diversity of the insurer’s investment portfolio by type of investment. The results of these ratios may provide some indication of the insurer’s liquidity. Ratios are included for most types of investments, except for government and agency bonds and cash and short-term investments, which are generally highly liquid.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding whether the insurer’s investment portfolio is adequately diversified in order to avoid concentration of investments by type or issue. The analyst should consider determining whether the insurer’s investment portfolio is in compliance with the investment limitations and diversification requirements per the state’s insurance laws. The analyst might also review the percentage distribution of assets in the Annual Profile Report for significant shifts in the mix of investments owned during the past five years. The analyst should compare the insurer’s distribution of invested assets to industry averages to determine significant deviations. In addition, the analyst might also want to request a copy of the insurer’s formal adopted investment plan. This should be evaluated to determine if the plan appears to result in investments that are appropriate for the insurer based on the lines of business written and its liquidity and cash flow needs, and to determine whether the insurer appears to be adhering to its plan. The analyst might also review Schedule D, Part 1A—Quality and Maturity Distribution of All Bonds Owned, to evaluate the quality and maturity distribution of all
III. Analyst Reference Guide - B.1. Level 2 Investments (Property/Casualty)

bonds owned and consider the liquidity of the insurer’s investments to help determine whether the
insurer’s investment portfolio appears reasonable based on the line(s) of business written. If the analyst
has concerns regarding liquidity or cash flows, he or she should consider reviewing the Statement of
Actuarial Opinion for comments regarding cash flow testing performed and the results obtained; or
consider having a cash flow analysis performed by an actuary.

Procedure #2 assists the analyst in determining whether concerns exist regarding the level of investment
in certain types of securities that tend to be riskier and/or less liquid than publicly traded bonds and
stocks, and cash and short-term investments. Although most property/casualty insurers tend to invest
primarily in publicly traded bonds and stocks, there are some insurers with significant concentrations of
riskier investments.

Procedure #2a assists the analyst in determining whether concerns exist due to the level of investment in
non-investment grade bonds. Bonds that have NAIC designations of 3, 4, 5, or 6 by the Securities
Valuation Office (SVO) are considered non-investment grade bonds and represent a significantly higher
credit or default risk than do investment grade bonds. In addition, the prices of non-investment grade
bonds are frequently more volatile than the prices of investment grade bonds. The NAIC has adopted a
Model Regulation on Investments in Medium Grade and Lower Grade Obligations. The Model
Regulation establishes limitations on the concentration of non-investment grade bonds because of
concerns that changes in economic conditions and other market variables could adversely affect insurers
that have a high concentration of these types of bonds.

Additional procedures, including prospective risk, are also available if the level of concern warrants
further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the level of investment in non-
investment grade bonds. The analyst should consider reviewing Schedule D, Part 1A, Section 1—Quality
and Maturity Distribution of All Bonds Owned, and compare the insurer’s holdings of non-investment
grade bonds to the limitations included in the NAIC’s Investments in Medium Grade and Lower Grade
Obligations Model Regulation by NAIC designation. The insurer should have a plan for investing in non-
investment grade bonds that has guidelines for the quality of issues invested in and diversification
standards pertaining to issuer, industry, duration, liquidity, and geographic location. The analyst might
consider requesting a copy of this plan from the insurer to determine whether they appear to be adhering
to the plan. For the more significant non-investment grade bonds, the analyst might also consider
requesting from the insurer audited financial statements and a rating agency report for the issuer of the
bonds to assess the issuer’s current financial position and ability to repay its debt.

Procedure #2b assists the analyst in determining whether concerns exist due to the level of investment in
RMBS, CMBS and LBaSS securities. Of the structured securities, residential mortgage backed securities
are generally the most complex and volatile. Residential mortgage backed securities convert a pool of
mortgage loans into a series of securities that have expected maturities that vary significantly from the
underlying pool as a result of slicing the pool into numerous tranches with different repayment
characteristics. These securities are either issued or backed by the U. S. government, carry very little
credit risk, and are commonly stated at par value. As a result, many of these securities are designated
investment grade category 1 by the SVO. However, the credit rating does not consider the prepayment or
interest-rate risk inherent in these investments. If the underlying mortgage loans are repaid by the
borrowers faster or slower than anticipated, the repayment streams will be affected, and the expected
durations will either contract or extend. Thus, the cash flows on these investments are much more
unpredictable than those for more traditional bonds and mortgage pass-through certificates. If the
prepayments are significantly faster than anticipated, and the insurer had paid a large premium when it
was acquired, the insurer could experience a significant loss on the investment even though the par value was received. In addition, cash flows are harder to match with corresponding payments on losses. This leads to the risk that prepayments may not be able to be reinvested in investments earning comparable yields in order to support liability payment streams.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the level of investment in RMBS. The analyst should consider reviewing the RMBS, CMBS and LBaSS securities categories in Schedule D, Part 1—Long-Term Bonds Owned for bonds with a book/adjusted carrying value that is significantly in excess of par value that could result in a loss being realized if bond prepayments occur faster than anticipated. The analyst should also consider reviewing a listing of the effective yield on each of the insurer’s RMBS, CMBS and LBaSS securities. The effective yield on most debt securities is generally linked to its credit risk and duration. However, significant prepayment risk can also increase the effective yield.

There are many different types of RMBS, each having different characteristics and inherent risks. Therefore, the analyst might consider requesting information from the insurer regarding the amount of each type held, e.g., planned amortization class, support bonds, interest only and principal only, to help evaluate the risk of the portfolio.

The analyst might consider requesting information from the insurer regarding estimated prepayment speeds on its RMBS. Several standardized forms of calculating the rate of prepayments of a mortgage security exist in the market. The Constant Prepayment Rate and the Standard Prepayment Model of the Bond Market Association are the most common models used to measure prepayments. The analyst should consider further analysis in those instances that prepayment risk appears high.

Procedure #2c assists the analyst in determining whether concerns exist due to the level of investment in privately placed bonds. Significant investment in privately placed bonds may cause concerns regarding the insurer’s liquidity because many of these types of investments cannot be resold. Those that can be resold frequently have restrictions as to whom they can be sold to. Also, there is no structured market for privately placed bonds like there is for publicly traded bonds. Therefore, even if the privately placed bonds can be sold, it may be difficult to find a willing buyer. Insurance companies commonly purchase these debt obligations in order to avoid the uncertainties of the market, to engage in private negotiations, and to avoid SEC restrictions.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the level of investment in privately placed bonds. The analyst should consider reviewing Schedule D, Part 1A, Section 1—Quality and Maturity Distribution of All Bonds Owned to determine the amount, issue type, NAIC designation, maturity distribution of privately placed bonds, and the amount of privately placed bonds that are freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A. For the more significant privately placed bonds, the analyst should also consider requesting from the insurer current audited financial information regarding the issuer to evaluate the issuer’s financial position and ability to repay its debt.
Procedure #2d assists the analyst in determining whether concerns exist due to the level of structured notes held by the insurer. If the amount is material as compared to the insurer’s capital and surplus plus AVR, the analyst should consider steps to gain a better understanding of the prospective risks of these investments and the insurer’s level of investment expertise regarding these types of notes.

The analyst should refer to the FAQ guidance of the Blanks (E) Working Group at the following link, www.naic.org/documents/committees_e_app_blanks_related_structured_notes_faq.pdf for the definition of structured notes and information about different types of structured notes.

Structured Notes are issuer bonds where the cash flows are based upon a referenced asset and not the issuer credit. These Notes differ from structured securities in that they do not have a related trust and as such, are not valued in accordance with SSAP 43R, but instead are valued in accordance with SSAP 26. Mortgage reference securities are examples of these Structured Notes and most recently this type of security has been issued by FHLMC (e.g., STACR) and FNMA. These mortgage referenced securities are not filing exempt (FE) and the Structured Security Group assigns their NAIC designation based upon modeling assumptions; although other structured securities still are FE. If an insurer has a material amount of Structured Notes, the analyst should, through discussion with the insurer, determine whether management has adequately reviewed the insurer’s structured note portfolio and understands the underlying yields, cash flows and their volatility. The analyst should consider the following risks related to Structured Notes: collateral type concentration, subordination in the overall structure of the transactions, and trend analysis of underlying assets to ensure appropriate valuation. The analyst should assess if the notes are valued appropriately so as to ensure the insurer is not undercapitalized. The analyst should also refer to any recent examination findings. The procedures also instruct the analyst to inquire of the insurer on such items as the structured note’s use, valuation, the insurer’s level of expertise with this type of security and controls the insurer has implemented to mitigate this risk.

Procedure #2e assists the analyst in determining whether concerns exist due to the level of investment in real estate and mortgage loans. These investments are less liquid than many other types of investments. The analyst may have concerns regarding the fair value of the real estate, whether it is the underlying investment or the collateral for a mortgage loan. Most states restrict mortgage loan investments to first liens on property, with some states allowing second liens in instances where the insurer also owns the first lien. Second liens are more risky because, in the event of default, the holder of the first lien would be repaid out of any proceeds from the sale of the underlying property prior to the holder of the second lien.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the level of investment in real estate and mortgage loans. If there are concerns regarding real estate owned, the analyst should consider reviewing Schedule A, Part 1—Real Estate Owned to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the book/adjusted carrying value, reported fair value, and the year of the last appraisal. In addition, for those properties with book/adjusted carrying values in excess of fair value; the analyst might consider whether the asset should be written down. The analyst should also consider investigating any instances where a property has a book/adjusted carrying value in excess of its cost and requesting information from the insurer regarding any increases in book/adjusted carrying value during the year. If there are concerns regarding mortgage loans, the analyst should consider reviewing Schedule B, Part 1—Mortgage Loans Owned to compare the book/adjusted carrying value of each loan to the value of the land and buildings mortgaged. The analyst should determine whether the mortgage loans are adequately collateralized and whether any of the mortgage loans are to officers, directors, or other affiliates of the insurer. For those loans that have had an
increase in book/adjusted carrying value during the year, the analyst might consider requesting information from the insurer regarding the increase to determine whether the increase should be considered an admitted asset.

*Procedure #2f* assists the analyst in determining whether concerns exist due to the level of investment in other invested assets (Schedule BA). Schedule BA includes, but is not limited to, investments in collateral loans, joint ventures and partnerships interests, oil and gas production, and mineral rights. Joint ventures and partnerships typically involve real estate. These types of assets tend to be fairly illiquid and may contain significant credit risk.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

Additional steps that the analyst may perform if there are concerns regarding the level of investment in other invested assets are available. The analyst should consider reviewing Schedule BA, Part 1—Other Long-Term Invested Assets to determine the amount and types of other invested assets owned, and to determine whether they are properly categorized as other invested assets. Information might be requested from the insurer to support any increases by adjustment in book/adjusted carrying value during the year. In addition, the analyst should consider requesting the current Annual Audited Financial Report and other documents (e.g., partnership agreements), necessary to support the book/adjusted carrying value of the insurer’s investment in partnerships and joint ventures and information to support the book/adjusted carrying value of significant other invested assets (other than partnerships and joint ventures). For investments in collateral loans, the analyst may want to compare the fair value of the collateral to the amount loaned to determine whether the loan is adequately collateralized.

In addition to the steps for the types of investments included in procedure #2, the analyst should review procedures #3 and #4 in Level 2—Affiliated Transactions.

*Procedure #3* assists the analyst in determining whether the purchase and sales of all investments are approved or authorized by the insurer’s board of directors and whether all securities are owned as of December 31 of the current year by the insurer are under the exclusive control of the insurer and are in the insurer’s possession. Most states require investment transactions to be approved by the insurer’s board of directors or a designated subordinate committee. General Interrogatories, Part 1, #16 indicates whether this has been done. General Interrogatories, Part 1, #24.01 and #24.02 indicate whether the stocks, bonds, or other securities of which the insurer has exclusive control (defined by the NAIC as the exclusive right by the insurer to dispose of an investment at will, without the necessity of making a substitution therefore) are in the actual possession of the insurer. If the insurer owns securities that are not in its possession, a custodian should hold them under a properly executed custodial agreement in order for them to be considered admitted assets. General Interrogatories, Part 1, #25.1 and #25.2 indicate whether any of the stocks, bonds, or other assets of the insurer are not exclusively under its control. Assets that are not under the insurer’s control might not meet the state’s requirements to be considered admitted assets.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

Additionally, the analyst may perform additional steps if there are concerns regarding investment approval or control and possession. If there are concerns regarding investment approval, the analyst should consider requesting a copy of the insurer’s formal adopted investment plan to determine who is authorized to purchase and sell investments as well as what approvals are required for investment transactions. If there are concerns regarding investments that are held by someone other than the insurer,
the analyst should review General Interrogatories, Part 1, #24 in more detail, to determine the reason the securities are not in the insurer’s possession and who holds the securities in order to evaluate whether they qualify as admitted assets of the insurer under the state insurance laws or whether there are concerns regarding the insurer’s ability to have access to the securities when needed. If there are concerns regarding investments that are not under the insurer’s exclusive control, the analyst should consider reviewing General Interrogatories, Part 1, #25 in more detail, to determine the reason the assets are not under the insurer’s exclusive control (e.g., loaned to others, subject to repurchase or reverse repurchase agreements, pledged as collateral, placed under option agreements) and who holds the assets in order to evaluate whether they qualify as admitted assets for the insurer under the state’s insurance laws or whether there are other concerns.

Procedure #4 assists the analyst in determining whether the securities owned by the insurer have been valued in accordance with the standards promulgated by the SVO. Beginning in 2004, the Provisional Exemption (PE) identifier in the Purposes and Procedures Manual of the NAIC Investment Analysis Office was changed to Filing Exempt (FE). This change expands the exemption to preferred stocks and all NAIC equivalent designations, and removes several of the optional requirements. In conjunction with this change, the SVO compliance certificate was changed to a general interrogatory in the investment section. According to NAIC requirements, all securities purchased that are not FE per the Investment Analysis Office P&P Manual should be submitted to the SVO for valuation within 120 days of the purchase. In accordance with the NAIC Annual Statement Instructions, if the SVO provides an NAIC designation or price, that designation or price should be utilized. Insurers are required to complete the general interrogatory on compliance filing requirements of the Investment Analysis Office P&P Manual and list exceptions as a component of the Annual Financial Statement. This interrogatory should indicate that: (1) all prices or NAIC designations for the securities owned by the insurer that appear in the Valuations of Securities (VOS) have been obtained directly from the SVO; (2) all securities previously valued by the insurer and identified with a “Z” suffix (which indicates that the security is not FE, does not appear in the VOS, or has not been reviewed and approved in writing by the SVO) have either been submitted to the SVO for a valuation or disposed of; and (3) all necessary information on securities that have previously been designated NR (not rated due to lack of current information) by the SVO have been submitted to the SVO for a valuation or that the insurer has disposed of the securities. In addition, the analyst should review Schedule D, Part 1—Bonds and Schedule D, Part 2—Preferred Stocks and Common Stocks, to determine whether it appears that the insurer is complying with the requirement to submit securities to the SVO for valuation. There should be no securities that were acquired prior to the current year that have a “Z” suffix after the NAIC designation.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding whether securities have been valued in accordance with the standards promulgated by the SVO. The analyst should consider reviewing Schedule D, Part 1—Bonds to determine whether all bonds with an NAIC designation of 3, 4, 5, or 6 (non-investment grade bonds) have been valued at their fair value, and all other bonds have been valued at their book/adjusted carrying value in accordance with the NAIC’s Accounting Practices and Procedures Manual (AP&P Manual). The analyst should also consider reviewing Schedule D, Part 2—Preferred Stocks and Common Stocks to determine whether sinking fund preferred stocks have been valued at cost and all other stocks have been valued at fair value in accordance with the AP&P Manual. For those securities listed in Schedule D, Part 1—Bonds or Schedule D, Part 2—Preferred Stocks and Common Stocks with a “Z” suffix after the NAIC designation, the analyst might request verification from the insurer that the securities are filing exempt or have been submitted to and subsequently valued by the SVO. The analyst should compare the price or designation subsequently received from the SVO to that
included in the Annual Financial Statement for significant securities. The analyst should also consider using the Examination Jumpstart investment analysis tool (available on I-SITE) to compare the CUSIP number, NAIC designation, and fair value for each of the securities listed in Schedule D, Part 1—Bonds, Schedule D, Part 2—Preferred Stocks and Common Stocks, and Schedule DA—Short-Term Investments to information on the SVO master file.

*Procedure #5* assists the analyst in determining whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value. General Interrogatories, Part 1, #30 shows the aggregate statement value and the aggregate fair value of bonds and preferred stocks owned, and requires the insurer to indicate how the fair values were determined. If the statement value of bonds and sinking fund preferred stocks is significantly greater than the fair value, the insurer could realize significant losses if it were forced to sell these investments to cover unexpected cash flow needs due to larger than anticipated losses.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the significance of any excess of the book/adjusted carrying value over the fair value of bonds and sinking fund preferred stocks. The analyst should consider reviewing Schedule D, Part 1—Bonds and Schedule D, Part 2—Preferred Stocks and Common Stocks, or request information from the insurer to determine which individual bonds and sinking fund preferred stocks have a book/adjusted carrying value significantly in excess of their fair value. The analyst should be aware that the fair value for those securities with an “AV” (amortized value) designation in the rate used to obtain the fair value column in Schedule D does not represent a true fair value for the securities. For those securities with a book/adjusted carrying value significantly in excess of their fair value, the analyst might consider verifying the NAIC designation assigned and determine whether it has recently been reviewed by the SVO. In addition, the analyst should review the current rating by a credit rating provider and evaluate whether there has been an other-than-temporary decline in fair value. For bonds and sinking fund preferred stocks with other-than-temporary declines, the analyst should also consider whether the investment should be written down to its fair value to properly reflect the value of the investment. If the insurer has experienced negative cash flows or has other liquidity problems, the analyst should consider requesting information from the insurer regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

*Procedure #6* assists the analyst in determining whether the fair value of common stock is significantly greater than or less than the actual cost. The analyst should review Schedule D, Part 2, Section 2—Common Stocks Owned December 31 of Current Year, to determine what the aggregate fair value position is in relation to aggregate actual cost of common stock. The analyst should also review individual stock issues to determine if the fair value is significantly above or below actual cost. If the fair value of a stock issue is significantly below cost (unrealized loss), the insurer may incur a loss upon disposition. If the fair value of an individual stock issue is significantly greater than actual cost (unrealized gain), the insurer may be reflecting an unrealized gain that will not be realized at disposition.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the significance of any excess of cost over fair values of common stocks owned. The analyst should consider reviewing Schedule D, Part 2,
Section 2—Common Stocks to determine which individual common stocks have a cost significantly in excess of their fair value. The analyst should also determine whether the stock is listed on a national exchange and verify the price per stock and the total fair value listed in the statement. If the NAIC designation of the stock is “A” (unit price of the share of common stock is determined analytically by the SVO), the analyst should determine when the price per share was last analyzed by the SVO. The analyst should also consider whether the common stock has had an other-than-temporary decline in its value. The analyst should consider requesting the Annual Audited Financial Report and other documents necessary to support the value of the common stock. The analyst should also consider requesting information from the insurer regarding investment strategies and short-term cash flow needs.

*Procedure #7* assists the analyst in determining whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year. The analyst can identify significant purchases or sales of securities by reviewing Schedule D, Part 3—Long-Term Bonds and Stocks Acquired During Current Year; Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year; and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Current Year. If significant purchases or sales of securities occurred near the beginning and/or end of the year, the insurer might have rented securities or engaged in window dressing of its investment portfolio (replacing lower quality investments near year-end and then re-acquiring the same or similar lower quality investments after year-end) in an attempt to avoid additional regulatory scrutiny that would have occurred with the insurer’s lower rated investment portfolio.

*Procedure #8* assists the analyst in determining whether concerns exist due to the level of investment turnover. The analyst can identify significant turnover by reviewing Schedule D, Part 3—Long-Term Bonds and Stocks Acquired During Current Year; Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year; and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Current Year. This information can assist the analyst in determining the types of securities sold and acquired, as well as the length of time each security was held and the quality of the security. The turnover ratio represents the degree of trading activity in long-term bonds and preferred and common stock investments that occurred during the year. Investment turnover is an indication of whether a “buy-and-hold” or “sell based on short-term fluctuation” strategy is utilized. A high turnover of investments generally leads to greater transaction costs, operating expenses, and the acceleration of realized capital gains. Sales result from securities reaching a price objective, anticipated changes in interest rates, changes in credit worthiness of issuers, or general financial or market developments. The analyst should also review realized capital gains from the sale of securities to determine any reliance on these gains. The analyst should also consider having a specialist review the insurer’s investment program.

*Procedure #9* assists the analyst in determining whether concerns exist due to the level of investment in derivative instruments. A derivative instrument is a financial market instrument that has a price, performance, value, or cash flow based primarily on the actual or expected price, performance, value, or cash flow of one or more underlying interests. Derivative instruments (which consist of options, caps, floors, collars, swaps, forwards, and futures) are used by some insurers to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to its assets, liabilities, or anticipated future cash flows. If an insurer invests in derivative instruments, it is important for the analyst to understand the impact that these derivative instruments have on the risk return profile of the insurer’s cash market investment portfolio under different scenarios. For insurers with significant investments in derivative instruments, this will probably require the analyst to obtain the assistance of an actuary.
Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the level of investment in derivative instruments. The analyst should consider obtaining a comprehensive description of the insurer’s hedge program in order to obtain an understanding of the insurer’s use of derivative instruments to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to the insurer’s assets, liabilities, or expected cash flows. The hedge program should be evaluated to determine whether it appears to result in hedges that are appropriate for the insurer based on its assets, liabilities, and cash flow risks and whether the insurer appears to be adhering to the hedge program. For significant derivative instruments that are open at year-end, the analyst should consider requesting and reviewing a description of the methodology used by the insurer to verify the continued effectiveness of the hedge provided, a description of the methodology to determine the fair value of the derivative instrument, and a description of the determination of the derivative instrument’s book/adjusted carrying value to determine whether the requirements of the NAIC AP&P Manual have been met. The analyst might also consider having the insurer’s derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.

**Discussion of Level 2 Quarterly Procedures**

The Level 2 Quarterly Procedures are designed to identify if: (1) the insurer’s investment portfolio is adequately diversified to avoid an undue concentration of investments by type or issue; (2) the insurer has a significant portion of its assets invested in or has significantly increased its holdings since the prior year-end in certain types of investments that tend to be riskier and/or less liquid than publicly traded bonds and stocks, and cash and short-term investments; (3) the insurer has significantly increased its holdings since the prior year-end in certain types of derivatives that tend to be riskier and/or less liquid than publicly traded bonds, stocks, cash and short-term investments; (4) all securities owned are under the control of the insurer and in the insurer’s possession; or (5) the insurer has complied with the requirements of the Investment Analysis Office P&P Manual, which requires all securities to be valued in accordance with standards promulgated by the SVO.
Primer on Derivatives

Derivative instruments are financial instruments whose value and cash flows are based on other financial instruments, indices, or statistics. Based on the current insurance regulatory framework, this definition is too broad. For example, some people call Collateralized Mortgage Obligations (CMOs) “mortgage-backed derivatives,” because the value and cash flows of a CMO are based on the value and cash flows of a pool of mortgages. For insurance regulatory purposes, only options, caps, floors, forwards, futures, swaps, collars, and similar instruments are considered derivative instruments. The definitions of these instruments are contained in the NAIC Accounting Practices and Procedures Manual (AP&P Manual).

This primer will concentrate on options, futures, and swaps. It will describe the instruments from an operational standpoint and from a use standpoint. It will also discuss how derivative instruments are reported in statutory financial statements. Accounting will be discussed only in general terms. A discussion of accounting details is provided in SSAP No. 86, Accounting for Derivative Instruments and Hedging Activities.

Derivative Instrument Basics

Options

An option is an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate, or effect a cash settlement based on the actual or expected price level, performance, or value of one or more underlying interests. Underlying interest is the asset(s), liability(ies), or other interest(s) underlying a derivative instrument including, but not limited to, any one or more securities, currencies, rates, indices, commodities, derivative instruments, or other financial market instruments.

An insurer can either purchase an option or write (sell) an option. When an insurer buys an option, the insurer pays a premium for a right, but not an obligation, to exercise the option at a strike. When an insurer writes (sells) an option, the insurer receives a premium from the other party to the transaction (counterparty). The counterparty has the right, but not the obligation, to exercise the option at the strike. An example will help to illustrate these concepts.

Consider an insurance company that sells equity indexed annuities. The equity indexed annuity provides a floor guarantee as to interest, with an additional guarantee that the policyholder will participate in the upside of an equity index if the growth in the equity index exceeds the guaranteed interest.

An insurer can purchase an option to hedge the equity risk in the annuity contract. The option purchased would be based on the same equity index as the annuity contract. The level of the strike in the option would be based on the amount determined by the guaranteed interest rate, the participation rate in the annuity contract, and any cap on index growth. If the index grew at a rate greater than the guaranteed interest rate in the annuity contract, the insurer would exercise the option to cover the equity index-based obligation in the annuity contract. If the holder of the option does not exercise the option, the holder’s downside is limited to the initial premium paid for the option.

Futures

A futures contract is an agreement traded on an exchange, board of trade, or contract market to make or take delivery of, or effect a cash settlement, based on the actual or expected price, level, performance, or value of one or more underlying interests.
Futures contracts are different from options in that an insurer entering a futures contract will participate in both gains and losses in the underlying financial instrument as measured from the date the futures contract is opened. For example, if an insurer takes a long position in U.S. Treasury futures, the insurer will experience any gains or losses in the U.S. Treasury futures (the underlying instrument) as measured from the date of opening the position. If interest rates increase after the futures contract is opened, the U.S. Treasuries will decrease in value, and the insurer will have to make a payment to the counterparty. On the other hand, if interest rates move down, the insurer will receive a payment from the counterparty. Since the insurer shares in both the upside and downside of the futures contract, the insurer does not pay a premium when entering a futures contract. If the futures contract is exchange traded, the insurer will typically put up a deposit in cash or securities. This deposit is to protect the counterparty in the event the insurer cannot make required payments.

Insurers exposed to interest rate risk can take short positions in U.S. Treasury futures contracts. In this case, the insurer receives payments if interest rates increase and makes payments if interest rates decrease. This is opposite of the situation when the insurer takes a long position. However, going short with U.S. Treasury futures can hedge the interest rate risk exposure on bonds that the insurer holds in its portfolio. This is especially important for GAAP accounting purposes when bonds are reported on a fair value basis.

In the discussion above, taking a “long” position has the same financial characteristics as buying the underlying instrument (in this case a bond). Taking a “short” position has the financial characteristics of short selling the underlying instrument (in this case a bond).

**Swaps**

A swap contract is an agreement to exchange or net payments at one or more times based on the actual or expected price, level, performance, or value of one or more underlying interests. A typical example is a fixed or floating swap. An insurer can make payments to a counterparty based on a fixed rate, for example 6 percent, semi-annually and receive a floating rate LIBOR (London Inter-Bank Offer Rate), for example, plus a spread. Each six months, the insurer would pay the counterparty 3 percent times the notional amount, $10,000,000 for example, and would receive an amount equal to $10,000,000 times the then current LIBOR rate plus a spread. Of course, the amounts are netted so that a single payment is made by one party to the other party. Depending on the LIBOR rate at any payment determination date, the insurer may be making or receiving a payment. In swap transactions, the rates and spread are set so that neither party pays an up-front premium to open the transaction. Also, the notional amount is never exchanged.

The floating rate of a swap transaction can be based on a multitude of different financial indices or rates. For example, in a credit swap transaction, the floating rate can be based on the total rate of return of a junk bond portfolio. In effect, the party that is paying the fixed rate can be exposed to junk bond market risk through a transaction of this type.

**Caps/Floors**

A cap is an agreement obligating the seller to make payments to the buyer. Each payment is based on the amount, if any, that a reference price, level, performance, or value of one or more underlying interests exceeds a predetermined value, sometimes called the strike/cap rate or price. A floor is an agreement obligating the seller to make payments to the buyer. Each payment is based on the amount, if any, that a predetermined number, sometimes called the strike/floor rate or price, exceeds a reference price, level, performance, or value of one or more underlying interests. Caps and floors are similar to options in that one party, the purchaser of the instrument, pays a premium and receives a payment from the other party if an index exceeds the “cap” or falls below the “floor” a specified value, or “strike.” An insurer might...
purchase a floor to protect itself against interest rates falling below the guarantees in the annuity contracts it has sold. An insurer can either buy or write (sell) caps or floors.

Collars
A collar is an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor. An insurer could buy a collar that includes the purchase of a cap and the sale of a floor. In effect, the insurer is protecting itself against an increase in interest rates and paying for the protection by selling the floor.

Forwards
A forward is an agreement (other than futures) to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests. It is an over-the-counter transaction as opposed to traded on an exchange, which makes it less liquid. It is customized to meet the needs of both parties whereas contracts traded on an exchange are standardized.

Warrants
A warrant is an agreement that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times according to a schedule or warrant agreement.

Uses of Derivative Instruments
Besides analyzing derivative instruments from an operational standpoint, they can be analyzed by their use. From an insurance regulatory perspective, derivative instruments can be used in four ways: hedging, income generation, replication of other assets, and speculation. Rules concerning hedging and income generation transactions are included in the NAIC Investment of Insurers Model Act (Defined Limits Version) (#280) and the NAIC AP&P Manual (SSAP No. 86).

Hedging
For a derivative instrument to qualify for hedge accounting, the item to be hedged must expose the company to a risk, and the designated derivative transaction must reduce that exposure. Examples include the risk of a change in the value, yield, price, cash flow, quantity of, or degree of exposure with respect to assets, liabilities, or future cash flows that an insurer has acquired or incurred or anticipates acquiring or incurring.

Some insurance companies that sell Guaranteed Investment Contracts (GICs) guarantee to the GIC holders an interest rate on future contributions for a specified period of time. The risk associated with this type of guarantee is that interest rates may drop before the GIC contract holder makes an additional contribution. The insurer can hedge this risk by using futures contracts.

Income Generation
Income generation transactions are defined as derivatives written or sold to generate additional income or return to the insurer. They include covered options, caps, and floors, (e.g., an insurer writes an equity call option on stock which it already owns).

Because these transactions require writing derivatives, they expose the insurer to potential future liabilities for which the insurer receives a premium up front. Because of this risk, dollar limitation and additional constraints are imposed, requiring that the transactions be “covered” (i.e., offsetting assets can be used to fulfill potential obligations). To this extent, the combination of the derivative and the covering...
asset works like a reverse hedge, where an asset owned by the insurer in essence hedges the derivative risk.

An example is the writing (selling) of call options that are covered. Covering the call option means that the insurer writing (selling) the options owns the financial instruments or the rights to the financial instrument that can be called by the option holder. The insurer writing (selling) the option earns a profit (the premium) if the option is not exercised by the other party. If the option is exercised, the financial instrument subject to call is paid to the holder of the option. From a risk/return standpoint, writing a covered call generates income in the same way a callable bond does as compared to a non-callable bond. As with derivatives in general, these instruments include a wide variety of terms regarding maturities, range of exercise periods and prices, counterparties, underlying instruments, etc.

Replication

The basic idea behind replication transactions is to combine the cash flows from a derivative instrument and another financial instrument to replicate the cash flows of a third financial instrument. The following is a typical example of a replication transaction: the insurer holds a high quality corporate bond that pays one 7 percent coupon per year. The insurer can enter into a swap transaction with another party in which the insurer receives 2 percent of the notional amount of the swap each year and, in turn, pays the counterparty the drop in fair value of a specific junk bond that would result if the junk bond would default. The insurer does not own the junk bond, but the combined cash flows of the high-grade corporate bond and the swap transaction replicate the cash flows of a junk bond.

Reporting of Derivative Instruments

Derivative instruments are reported in Schedule DB of the statutory financial statement. Options, caps, floors, collars, swaps, and forwards owned by the insurer are reported in Part A. Future contracts are reported in Part B, replications are reported in Part C, and counterparty exposure for derivative instruments are reported in Part D.

Schedule DB, Parts A and B, contains two sections: Section 1 identifies the contracts open as of the accounting date, and Section 2 identifies contracts terminated during the year.

Schedule DB – Part C – Section 1 contains the underlying detail of replicated assets owned at the end of the year. Schedule DB – Part C – Section 2 provides reconciliation between years of replicated assets. The assumption underlying the NAIC RBC formula that all derivative instruments are used for hedging purposes is one of the central issues that the NAIC is exploring in its revised disclosure in Schedule DB.

Schedule DB – Part D – Section 1 collects information necessary for Risk-Based Capital (RBC) purposes. Currently, the NAIC RBC formula assumes that all derivative instruments are used for hedging purposes, and the only risk exposure to the insurer is that the counterparty may not perform according to the terms of the contract. The concepts of Potential Exposure and Off-Balance Sheet Exposure have been defined to quantify the risk of non-performance by the counterparty. The definition of these concepts is contained in the Annual Statement Instructions.

On a quarterly basis, the insurer only reports derivative instruments that are open as of the current statement date. Schedule DB – Part A – Section 1 lists the insurer’s open options, caps, floors, collars, swaps and forwards. Open futures are reported in Schedule DB – Part B – Section 1, replications are reported in Schedule BD – Part C – Section 1, and counterparty exposure for derivatives instruments are reported in Schedule DB – Part D.
Accounting

Statutory accounting guidance for derivative instruments used for hedging and income generation transactions is contained in the NAIC AP&P Manual. Derivative transactions follow SSAP No. 86, *Accounting for Derivative Instruments and Hedging Activities*. The insurer is to disclose the transition approach that is being used. In order for a derivative instrument to qualify for hedge accounting treatment, the item to be hedged must expose the insurer to a risk, and the designated derivative transaction must reduce that exposure.

An insurer should set specific criteria at the inception of the hedge as to what will be considered “effective” in measuring the hedge and then apply those criteria in the ongoing assessment based on actual hedge results. The penalty for failure to meet the effectiveness criteria varies from state to state.

The NAIC accounting guidance includes a discussion of required documentation. One item that is not mentioned is the “term sheet.” The term sheet is a document signed by both parties to an over-the-counter derivative transaction such as a swap. The term sheet contains a detailed description of all of the terms and conditions of the swap transaction.

In many cases, an insurer will enter into several over-the-counter transactions with a single party. In this situation, the insurer should have entered into a master netting agreement. The existence of such an agreement has implications for RBC.

Comprehensive Description of a Hedging Program

When an insurer is actively engaged in derivative activity or when concerns exist regarding an insurer’s derivative activity, it may be necessary to obtain a comprehensive description of the insurer’s derivative program, a procedure included in the Level 2 Procedures.

States may have specific requirements for items to be included in a comprehensive description of an insurer’s derivative program. Items may include detailed information on the following:

- Authorization by the insurer’s board of directors or other similar body to engage in derivative activity.
- Management oversight standards including risk limits, controls, internal audit, and review and monitoring processes.
- The adequacy of professional personnel, technical expertise, and systems.
- The review and legal enforceability of derivative contracts between parties.
- Internal controls, documentation, and reporting requirements for each derivative transaction.
- The purpose and details of the transaction including the assets or liabilities to which the transaction relates, specific derivative instrument used, the name of the counterparty and counterparty exposure amount, or the name of the exchange and the name of the firm handling the trade.
- Management’s written guidelines for engaging in derivative transactions, for example:
  - Type, maturity, and diversification of derivative instruments
  - Limitations on counterparty exposures
  - Limitations based on credit ratings
  - Limitations on the use of derivatives
III. Analyst Reference Guide - B.1a. Level 2 Investments - Primer on Derivatives (Property/Casualty)

- Asset and liability management practices
- The liquidity and surplus needs of the insurer as it relates to derivative activity
- The relationship of the hedging strategies to the insurer’s operations and risks.
- Guidelines for the insurer’s determination of acceptable levels of basis risk, credit risk, foreign currency risk, interest rate risk, market risk, operational risk, and option risk.
- Guidelines that the board of directors and senior management comply with risk oversight functions and adhere to laws, rules, regulations, prescribed practices, or ethical standards.

III. Annual Procedures - B.2. Level 2 Unpaid Losses and LAE (Property/Casualty)

1. Determine whether an understatement of unpaid loss and loss adjustment expense (LAE) reserves would be significant.
   a. Is the loss and LAE reserves to surplus ratio greater than 250 percent?
   b. Is the net premiums written (long-tail lines) to net premiums written (total) ratio greater than 25 percent?
   c. Has the net premiums written (long-tail lines) to net premiums written (total) ratio increased by greater than 25 points from the prior year-end?

2. Determine whether unpaid losses and LAE appear to have been adequately reserved.
   a. Is the one-year reserve development to prior year-end surplus ratio (IRIS ratio #11) greater than 20 percent? If yes, provide an explanation.
   b. Is the two-year reserve development to the second prior year-end surplus ratio (IRIS ratio #12) greater than 20 percent? If yes, provide an explanation.
   c. Review the Five-Year Historical Data in the Annual Financial Statement. Has there been an adverse trend or unusual fluctuation in the one or two-year loss reserve development within the past five years?
   d. Is the estimated current reserve deficiency to surplus ratio (IRIS ratio #13) greater than 25 percent?
   e. Has there been a significant change in the loss ratio from the prior year (+/– 15 points) or over each of the past five years (+/– 20 points)?
   f. Has there been a shift in the mix of business from short-tail property lines to long-tail liability lines within the past five years?
   g. Were net premiums written from loss sensitive contracts more than 15 percent of total net premiums written?
   h. Were net unpaid losses and LAE from loss sensitive contracts more than 15 percent of total net unpaid losses and LAE?
   i. Review the Notes to Financial Statements, Note #33—Asbestos/Environmental Reserves.
      i. Is there exposure to asbestos and environmental liability?
      ii. Are net asbestos and environmental unpaid loss and LAE reserves greater than 15 percent of surplus?
      iii. If the change in net asbestos and environmental unpaid loss and LAE reserves is greater than 5 percent of surplus, have those reserves increased by more than 15 percent over the prior year?

Additional procedures and prospective risk considerations, if further concerns exist:

j. Review, by line of business, the one-year and two-year development in incurred net losses and defense and cost containment expenses by accident year reflected in Schedule P, Part 2, or review the loss reserve development section in the Financial Profile Report.
   i. Have any internal changes been initiated that may impact the reserve estimates (e.g. accelerating claim payments)?
k. Compare, by line of business, the one-year and two-year development in incurred losses and defense and cost containment expenses by accident year reflected in Schedule P, Part 2 to the industry average to determine any significant deviations.

l. If the insurer has experienced a shift in its mix of business from short-tail property lines to long-tail liability lines, calculate the ratio of estimated current reserve deficiency to surplus (IRIS ratio #13) separately for the major lines of business.

m. Review, by line of business, the incurred loss and LAE ratio by accident year in Schedule P, Part 1, and note any unusual fluctuations or trends between accident years.

n. Compare, by line of business, the incurred loss and LAE ratio in Schedule P, Part 1 to the industry average to determine any significant deviations.

o. Review, by line of business, the cumulative net paid losses and defense and cost containment expenses by accident year in Schedule P, Part 3 and comment on any unusual fluctuations or aberrations in loss and expense payment patterns between accident years.

p. Review Schedule P Interrogatories, #7.1 for any information provided regarding significant events, coverage, retention, or accounting changes that have occurred that should be considered when analyzing the data provided in Schedule P to estimate the adequacy of the current loss and LAE reserves.

q. Perform loss reserve analysis on the more volatile long-tail liability lines of business using Examination Jumpstart or other loss reserve analysis software to project loss reserves based on incurred claims data in Schedule P, Part 2 and paid claims data in Schedule P, Part 3. Compare the projected reserves to the reserves established by the insurer.

3. Determine whether unpaid losses and/or LAE reserves have been discounted (non-tabular) and, if so, whether concerns exist regarding the loss reserve discounting.

a. Review Schedule P, Part 1—Summary. Have unpaid losses and/or LAE been discounted for the time value of money? If “yes,” is the discount 5 percent or more of surplus?

b. Review the Notes to Financial Statements, Note #32—Discounting of Liabilities for Unpaid Losses and Unpaid LAE, and consider the following:
   i. The lines of business with discounted reserves.
   ii. The interest rates used to discount reserves, including the basis indicated for using those rates.
   iii. The amount of discount in relation to surplus.
   iv. If the interest rates used to discount the prior accident years’ reserves have changed from the previous Annual Financial Statement, document the change in discounted reserves due to the change in interest rate assumptions and the effect on surplus.

Additional procedures and prospective risk considerations, if further concerns exist:

c. Determine whether the interest rates used to discount reserves appear to be reasonable considering the insurer’s investment yield and the insurer’s comments in Note #32 regarding the basis for the interest rates used.
III. Annual Procedures - B.2. Level 2 Unpaid Losses and LAE (Property/Casualty)

4. Determine whether anticipated salvage and subrogation has been included as a reduction of unpaid losses and LAE and whether concerns exist regarding the use of anticipated salvage and subrogation in the development of unpaid losses and LAE.

   a. Review Schedule P, Part 1—Summary. Has anticipated salvage and subrogation been included as a reduction of unpaid losses and LAE?

   b. Is the anticipated salvage and subrogation to surplus ratio greater than 10 percent?

Additional procedures and prospective risk considerations, if further concerns exist:

   c. Review Schedule P, Part 1 to determine which lines of business have unpaid losses and LAE that have been reduced due to consideration of anticipated salvage and subrogation.

   d. For the more significant lines of business, review Schedule P, Part 1 and compare the anticipated salvage and subrogation to unpaid losses and LAE ratio (gross of anticipated salvage and subrogation) to the salvage and subrogation received to claims paid ratio (gross of salvage and subrogation received) to determine the reasonableness of anticipated salvage and subrogation.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding unpaid losses and LAE. In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating unpaid losses and LAE 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 examination section for targeted examination
- 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 ________
III. Quarterly Procedures – B.2. Level 2 Unpaid Losses and LAE (Property/Casualty)

1. Determine whether significant changes in unpaid losses or LAE have occurred since the prior year-end or whether significant changes in incurred losses or LAE have occurred since the prior year-to-date.
   a. Have loss reserves changed by greater than +/- 15 percent from the prior year-end?
   b. Have LAE reserves changed by greater than +/- 15 percent from the prior year-end?
   c. Have net losses incurred changed by greater than +/- 25 percent from the prior year-to-date?
   d. Has LAE incurred changed by greater than +/- 25 percent from the prior year-to-date?

2. Determine whether there has been significant adverse development in the liabilities for unpaid losses and LAE, which were established as of the end of the prior year.
   a. Is the loss and LAE reserves to surplus ratio greater than 250 percent?
   b. Has the loss and LAE reserves to surplus ratio changed by greater than +/- 25 percentage points from the prior year-end?
   c. Review, by line of business, the year-to-date incurred loss ratio on direct business for the current and prior year in Part 1 - Loss Experience. Has the incurred loss ratio on direct business for any line of business changed by greater than +/- 10 percentage points?
   d. Has there been a significant change in the overall net incurred loss ratio from the prior year-end by greater than +/- 15 points or from the prior quarter by greater than +/- 20 points?
   e. Review the year-to-date reserve development of the prior year-end’s loss and LAE reserves (case and IBNR components shown separately) in Part 3 - Loss and LAE Reserves Schedule.
      i. Is the year-to-date reserve development of the prior year-end case reserves greater than +/- 30 percent of prior year-end case reserves?
      ii. Is the year-to-date reserve development of the prior year-end IBNR reserves greater than +/- 30 percent of prior year-end IBNR reserves?
      iii. Is the year-to-date reserve development of the prior year-end total loss and LAE reserves (case and IBNR) greater than 20 percent of prior year-end surplus?

3. Determine whether there have been any significant changes pertaining to loss reserve discounting.
   a. Review General Interrogatories, Part 2, #4.1. Have unpaid losses and/or LAE been discounted at a rate of interest greater than zero?
   b. If 3a is “yes,” is the total discount on unpaid losses and LAE to surplus ratio greater than 20 percent?
   c. Have any lines of business been discounted for the first time this quarter?
   d. Is the interest rate used to discount reserves greater than 5 percent for any single line of business?
Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

The single largest liability reported by most property/casualty insurers is the liability for unpaid losses (commonly known as loss reserves). Loss reserves are based on estimates rather than payments thus cannot be precisely determined in advance. The underlying goal in estimating reserves is for unpaid losses to reflect the outstanding liability, net of reinsurance, for all losses that have occurred and not paid as of the financial statement date. Except for claims-made policies, losses are recognized as they occur, not as they are reported. Typically, claims-made policies only cover losses that are reported during the policy period or renewal term. Under these policies, a loss is recognized when it is reported to the insurer rather than when it occurs, and the report date is substituted for the incurred date for the loss.

Unpaid losses are categorized as either “reported” or “incurred but not reported” (IBNR). Because the dollar amount of IBNR losses are not known as of the financial statement date, the estimate is highly subjective. Even with respect to those claims that have been reported to the insurer, the actual amount that the insurer will pay will not be known until the claims are settled in full, which could be years after the insurer initially established the reserve. Generally, an insurer is required to estimate the value of what its claims will be when they are ultimately settled. Excluding certain types of losses that an insurer may be allowed to discount, statutory accounting practices require that for every dollar of unpaid losses, an insurer reserves a dollar for the future payment of those losses.

In addition to unpaid losses, an insurer must also reserve for the future costs of settling the unpaid losses, otherwise known as loss adjustment expenses (LAE). The reserve for LAE is an estimate of all expenses that will be incurred in connection with the settlement of unpaid losses, which includes claims adjustment expenses, legal fees, court costs, investigation fees, claims processing, and payment expenses. LAE is classified as either “defense and cost containment payments” or “adjusting and other payments.” Defense and cost containment payments are correlated with the loss amounts and include defense, litigation, and cost containment expenses, whether internal or external. Adjusting and other payments are correlated with claim, count, or are general loss adjusting expenses and include those expenses in the Underwriting and Investment Exhibit, Part 3—Expenses. The reserve for LAE should be the insurer’s best estimate of the loss adjustment expenses that will be incurred in order to settle both reported and IBNR unpaid losses. In addition to these expenses, the insurer must also establish a liability for incurred but unpaid loss adjustment expenses and for incurred and unpaid general expenses.

Due to the complexity of reserving for unpaid losses and LAE, most insurers rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some insurers do not use actuaries to actually set their reserves, they are required to obtain annually an opinion regarding the reasonableness of the established reserves by a qualified actuary.

Since these liabilities must be estimated, they are generally considered a high-risk area for property/casualty insurers. The accuracy of an insurer’s liabilities for unpaid losses and LAE must be closely monitored on an ongoing basis. A deficiency in these liabilities directly affects surplus, which affects the insurer’s overall financial solvency. Therefore, the primary concern of the analyst in the review of unpaid losses and LAE is whether the liabilities established by the insurer are sufficient to cover the future costs of settling all of the insurer’s covered losses that have occurred as of the financial statement date.

Discussion of Level 2 Annual Procedures

The Level 2 Annual Procedures are designed to identify potential areas of concern as to whether the insurer’s reserves are sufficient to cover the costs of settling all of its losses that have occurred as of the financial statement date.
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. The analyst should also consider the insurer’s corporate governance that includes the assessment of the risk environment facing the insurer, in order to identify current or prospective solvency risks, oversight provided by the board of directors, and the effectiveness of management, including the code of conduct established by the board of directors.

**Procedure #1** assists the analyst in determining whether an understatement in unpaid loss and LAE reserves would be significant to the insurer. The ratio of loss and LAE reserves to surplus is a leverage ratio that indicates the margin of error an insurer has in estimating its reserves. For an insurer with a reserve leverage ratio of 300 percent, a 33 percent understatement of its reserves would eliminate its entire surplus. In addition to the reserve leverage ratio, the analyst should consider the nature of the insurer’s business. An insurer that writes primarily short-tail property lines might not be a concern, even though its leverage ratio is greater than 300 percent. The risk of significant understatement of its reserves is less than that of an insurer that writes primarily long-tail liability lines, such as medical professional liability.

**Procedure #2** assists the analyst in determining whether unpaid losses and LAE appear to have been adequately reserved. The ratios of one-year reserve development to prior year-end surplus and two-year reserve development to second prior year-end surplus measure the adequacy of the loss reserves. Positive results for these ratios represent additional or adverse loss reserve development on the reserves originally established (the amount by which the reserves originally established have proved to be understated based on subsequent activity). If the insurer’s ratio results consistently show adverse development, and/or the two-year reserve development to second prior year-end surplus result is consistently worse than the one-year reserve development to prior year-end surplus, this could be an indication that the insurer is intentionally understating its reserves.

The ratio of estimated reserve deficiency to surplus compares the estimated reserves needed by the insurer (calculated by multiplying the current net earned premiums by the average ratio of developed reserves to earned premiums for the last two years and subtracting the actual reserves established by the insurer) to the actual reserves established by the insurer and expresses the resulting difference as a percentage of the insurer’s surplus. A positive ratio result reflects an estimated reserve deficiency. The results of this ratio can be affected by changes in product mix.

The loss ratio is also reviewed as a part of this procedure. Significant increases in this ratio might be indicative of reserve strengthening due to prior understatements, whereas significant decreases might be indicative of current reserve redundancies.

In addition, the mix of the insurer’s business is reviewed for changes from prior years. For example, a property insurer that begins writing significant liability business, for which it is more difficult to establish an accurate reserve and which the insurer does not have historical experience writing, might cause concern regarding the adequacy of the unpaid loss and LAE reserves.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the adequacy of unpaid loss and LAE reserves. The steps to consider include a review, by line of business, of some of the same items reviewed in the Level 1 Procedures, including: one-year and two-year development in incurred losses; defense and cost containment LAE per Schedule P, Part 2 to determine which lines of business are developing adversely; and incurred loss and LAE ratios per Schedule P, Part 1 to determine any unusual
fluctuations between years. If incurred loss and LAE reserve development or loss ratios appear unusual, they may be compared to industry averages to determine the reasonableness of the insurer’s reserve for incurred losses and LAE. If the insurer’s mix of business has shifted from property lines of business to liability lines of business, the ratio of estimated current reserve deficiency to surplus, which was reviewed as part of the annual process, may be calculated separately for the major lines of business to help evaluate the current adequacy of the unpaid loss and LAE reserves.

Other steps to consider include the review of cumulative paid net losses and LAE by line of business in Schedule P, Part 3 to determine whether there were any unusual fluctuations or aberrations in payment patterns between accident years. The review of Schedule P, Interrogatory #7 is used to determine if there are any other factors that the insurer indicated should be considered in the analysis of the adequacy of unpaid losses and LAE. If there are still concerns regarding the adequacy of unpaid losses and LAE as a result of other supplemental steps performed, the analyst should consider performing a loss reserve analysis on the more volatile long-tail liability lines of business using Loss Reserve Estimation Tool (or other loss reserve analysis software) to project loss reserves based on incurred and on paid claims per Schedule P. However, the analyst should be aware that this loss reserve analysis tool merely projects reserves based on historical experience without considering changes in product design, pricing, claims payment practices, etc. If unusual results are obtained as a result of the loss reserve analysis performed, the analyst should consider having an actuary review the analysis performed.

Procedure #3 assists the analyst in determining whether unpaid losses and/or LAE have been discounted 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 permit insurers to discount other long-tail liability lines of business on a non-tabular basis, such as medical professional liability. All discounting, other than tabular discounting, must be approved by the domiciliary state insurance department and must be disclosed in Schedule P Interrogatories of the Annual Financial Statement. Schedule P, Part 1 is required to be completed gross of non-tabular discounting, and Schedule P, Parts 2 through 6 are required to be completed gross of all discounting. If loss reserves are discounted, the Underwriting and Investment Exhibit, Part 2A—Unpaid Losses and Loss Adjustment Expenses is completed net of discount, and disclosure of discounting is required in the Notes to Financial Statements #32—Discounting of Liabilities for Unpaid Losses or Unpaid Loss Adjustment Expenses. This disclosure includes a discussion of the discount rates used and the basis for using those rates. In addition, if the rates used to discount prior accident years’ reserves have changed from the previous Annual Financial Statement, the insurer is required to disclose the amount of discounted current reserves (excluding the current accident year) at current interest rate assumptions, the amount of discounted current reserves (excluding the current accident year) at previous interest rate assumptions, and the change in discounted reserves due to the change in interest rate assumptions.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the discounting of unpaid losses and/or LAE. The analyst should consider reviewing the information in the Note, #32 in more detail and compare the interest rates used to discount reserves to the insurer’s investment yield and the appropriateness of the matching of the insurer’s investment portfolio maturities to the expected payout patterns of the insurer’s liabilities to determine the reasonableness of the reserve discount.

Procedure #4 assists the analyst in determining whether anticipated salvage and subrogation has been included as a reduction of unpaid losses and LAE and, if so, whether concerns exist regarding the
consideration of estimated salvage and subrogation in establishing unpaid losses and LAE. Salvage is the proceeds received by an insurer from the sale of property on which the insurer has paid a total loss to the insured. For example, when an insurer pays the insured the full value of a wrecked automobile, the insurer takes title of the automobile. The damaged automobile is then sold, and the proceeds represent salvage, which is applied by the insurer to reduce the amount of losses paid. Subrogation is the statutory or legal right of an insurer to recover from a third party who is wholly or partially responsible for a loss paid by the insurer under the terms of a policy. For example, when an insurer has paid the insured for a loss sustained to his or her automobile as a result of a collision, the insurer may collect the amount paid, or portion thereof, through the process of subrogation from the third party responsible for the accident. Subrogation recoverables are treated as a reduction of losses paid. Because of the difficulty in determining an estimate of anticipated salvage and subrogation on unpaid losses, it is generally recognized in the Annual Financial Statement only after it has been reduced to cash or its equivalent. However, if anticipated salvage and subrogation is included as a reduction of loss reserves and LAE reserves as reported in the Annual Financial Statement, whether explicitly or implicitly, the amount of such anticipated salvage and subrogation must be disclosed in Schedule P.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the use of anticipated salvage and subrogation as a reduction in unpaid losses and LAE. The analyst should consider reviewing Schedule P, Part 1 to determine which lines of business have reserves that have been reduced due to anticipated salvage and subrogation. For the more significant lines of business, the analyst might compare the ratio of anticipated salvage and subrogation to unpaid losses and LAE to the ratio of salvage and subrogation received to claims paid to help determine the reasonableness of the anticipated salvage and subrogation.

**Discussion of Level 2 Quarterly Procedures**

The Level 2 Quarterly Procedures are intended to identify significant changes in unpaid losses and LAE and in incurred losses and LAE that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement, significant adverse development on the liabilities for unpaid losses and LAE that were established as of prior year-end, and any significant changes pertaining to loss reserve discounting.
III. Annual Procedures – B.3. Level 2 Income Statement and Surplus (Property/Casualty)

1. Determine whether concerns exist regarding the insurer’s Statement of Income or operating performance.
   a. Is the combined ratio greater than 105 percent or less than 80 percent?
   b. Has the combined ratio increased more than 10 points or decreased more than 25 points from the prior year?
   c. Review the combined ratio for the past five years and note any unusual fluctuations or trends between years.
   d. Is the return on surplus ratio greater than 20 percent or less than 5 percent? Display the surplus ratio for each of the past five years.
   e. Is the two-year operating ratio (IRIS ratio #5) greater than 100 percent? Display the two-year operating ratio for each of the past five years.
   f. Has there been a +/- 25 percent change in net earned premiums from the prior year?
   g. Has there been a + 20 or – 35 percent change in net incurred losses and LAE from the prior year?
   h. Has there been a +/- 20 point change in the loss ratio from the prior year? Display the loss ratio for each of the past five years.
   i. Is the gross expenses and commissions to gross premiums written ratio greater than 40 percent or less than 10 percent?
   j. Is the change in gross expenses and commissions ratio more than +/- 30 percent?
   k. Is the investment yield ratio (IRIS ratio #6) greater than 6.5 percent or less than 3 percent? Display the investment yield ratio for each of the past five years.
   l. If the absolute value of net realized capital gains or losses exceeds 3% of surplus, is the ratio of net realized capital gains or losses to net income greater than +/- 25 percent?
   m. If the absolute value of other income exceeds 3% of surplus, is the ratio of other income to net income greater than +/- 25 percent?

Additional procedures and prospective risk considerations, if further concerns exist:

   n. Review, by line of business, earned premiums by year in the Financial Profile Report for shifts in the mix of business between years.
   o. Review, by line of business, the incurred loss and LAE ratios in the Financial Profile Report and note any unusual fluctuations or trends between accident years.
   p. Compare, by line of business, the incurred loss and LAE ratio in Schedule P, Part 1 to the industry average to determine any significant deviations.
   q. Review the expense ratio and note any unusual fluctuations or trends between years.
   r. If there are concerns regarding the insurer’s operating performance as it relates to expenses overall or by line of business, review General Interrogatories, Part 1, #33-35 or the Insurance Expense Exhibit (IEE):
III. Annual Procedures – B.3. Level 2 Income Statement and Surplus (Property/Casualty)

i. Review the IEE.
   A. Investigate unusual items, especially situations where expenses were allocated to lines of business using methods not defined in the *Annual Statement Instructions*. The *Annual Statement Instructions* are included in the Supplements section and additional guidance in this regard is included in the *Financial Condition Examiners Handbook*.

ii. Review the IEE, Part I—Allocation to Expense Groups.
   A. Investigate significant fluctuations in expenses by expense groups between years.
   B. Compare expenses by expense group for the insurer with industry averages.

   A. Investigate significant fluctuations in expenses by lines of business between years.
   B. Compare expenses by lines of business with industry averages.
   C. Determine whether the totals agree with financial statement line items included in the Annual Financial Statement.

iv. Review General Interrogatories, Part 1, #34.1 and #34.2, concerning legal expenses paid during the year. Note any changes.
   A. Investigate significant increases in legal expenses over the prior years.
   B. Compare legal expenses with industry averages.

v. Compare the expense ratio to the industry average to determine any significant deviation.

vi. Review the loss ratios for direct, assumed, and ceded business, as well as contingent commissions per the Commissions and Brokerage Ratios in the Financial Profile Report and note any unusual fluctuations or trends between years.

vii. Compare the commission ratios per the Commissions and Brokerage Ratios in the Financial Profile Report to the industry average to determine any significant deviations.

viii. Review the write-ins for underwriting deductions in the Statement of Income for reasonableness. Also review aggregate write-ins for underwriting deductions in the Financial Profile Report and note any unusual fluctuations or trends between years.

ix. Review the detail of investment income in the Exhibit of Net Investment Income and the detail of realized gains (losses) in the Exhibit of Capital Gains (Losses) for reasonableness.

x. Review the yield on invested assets in the Financial Profile Report and note any unusual fluctuations or trends between years.

xi. Compare the yield on invested assets in the Financial Profile Report to the industry average to determine significant deviation.
III. Annual Procedures – B.3. Level 2 Income Statement and Surplus (Property/Casualty)

y. Review the components of other income in the Statement of Income, including write-ins for miscellaneous income, for reasonableness.

z. Compare the return on surplus ratio to the industry average to determine any significant deviation.

2. Describe any known trends that have had or that the insurer reasonably expects will have a material favorable or unfavorable impact on net revenues or net income. If the insurer knows of events that will cause a material change in the relationship between benefits, losses and expenses, the change in the relationship should be disclosed.

3. Determine whether concerns exist regarding changes in the volume of premiums written or changes in the insurer’s mix of business (lines of business written and/or geographic location of premiums written).
   a. Is the change in gross premiums written greater than +/- 25 percent?
   b. Is the change in net premiums written greater than +/- 25 percent?
   c. Review the Five-Year Historical Data of the Annual Financial Statement. Has there been a shift in the mix of gross premiums written or net premiums written from property lines to liability lines within the past five years? If “yes,” provide an explanation.
   d. Have direct premiums written for any line of business changed by greater than +/- 33 percent?
   e. If premiums are being written within any new lines, do they account for more than 5 percent of the total direct premiums written?
   f. Review the direct premiums written by state section in the Financial Profile Report on I-SITE.
      i. Has there been a significant change (+/- 50 percent) in direct premiums written in any one state where direct premiums written exceed 10 percent of total direct premiums in either the current or prior year? If “yes,” provide an explanation.
      ii. If premiums are being written in any new states, does any one new state account for more than 5 percent of total direct premiums written? If “yes,” provide an explanation.
   g. Review the Annual Financial Statement, Schedule T—Exhibit of Premiums Written for new direct business written in any state where the insurer is not licensed.

 Additional procedures and prospective risk considerations, if further concerns exist:
   h. Does the analyst consider the company to be diversified in terms of product lines and geographical exposure?
   i. Review the insurer’s mix of business by line and by state in order to identify concerns relating to involuntary pools and assigned risk plans, such as:
      i. Plans with known significant timing delays in reporting results to the insurers.
      ii. Plans with known adverse development trends.
   j. Verify that the insurer is authorized to write all lines of business written.
k. Determine whether the insurer has expertise (e.g., distribution network, underwriting, claims, and reserving) in the lines of business written. Consider reviewing the insurer’s MD&A and/or seeking additional information from the insurer to determine the insurer’s expertise in the lines of business written.

l. Review the writings section in the Financial Profile Report that shows the top ten states in terms of direct premiums and the percentage of total direct premiums written in those states. Based on the lines of business written, determine whether there appears to be large concentrations of premiums in areas especially prone to catastrophic events. If so, provide an explanation.

4. If there are concerns regarding the insurer’s participation in involuntary pools and assigned risk plans resulting from specific lines of business and geographic concentrations of business, consider performing one or more of the following procedures:

a. Verify that the insurer is participating in and properly accounting for its participation in involuntary pools and assigned risk plans in the various states.
   ii. Determine whether the insurer’s method of accounting for involuntary pools is consistent with prior years.
   iii. Review the insurer’s prior examination reports to determine whether the insurer properly participated in the various involuntary pools and assigned risk plans and properly accounted for such participation.

5. Determine whether the insurer is excessively leveraged due to the volume of premiums written.

a. Is the gross premiums written to surplus ratio (IRIS ratio #1) greater than 900 percent?

b. Is the net premiums written to surplus ratio (IRIS ratio #2) greater than 300 percent?

c. Is the net premiums written (long-tail lines) to total net premiums written ratio greater than 25 percent?

d. Has the net premiums written (long-tail lines) to total net premiums written ratio increased by greater than 25 points from the prior year-end?

Additional procedures and prospective risk considerations, if further concerns exist:

e. Review the net premium written by line of business in the Financial Profile Report to determine which lines of business are being written.

f. Compare the gross premium written to surplus ratio and the net premium written to surplus ratio to the industry averages to determine any significant deviations from the industry averages.

g. If the insurer is a member of an affiliated group of insurers, compute the gross premium written to surplus ratio and the net premium written to surplus ratio on a consolidated basis to determine if the affiliated group of insurers appears to be excessively leveraged.

h. Determine whether the insurer has adequate reinsurance protection against large losses and catastrophes and that the reinsurers are of high quality (review Level 2 Annual Procedures—Reinsurance, #1 and 4).
i. Obtain an explanation from the insurer for unusual results for IRIS ratios #1 and #2.

   a. Does any reinsurance contract considered in the calculation of this amount include an aggregate limit of recovery without also including a reinstatement provision?

7. Determine whether concerns exist regarding the amount of the insurer’s surplus.
   a. Review the Five-Year Historical Data of the Annual Financial Statement. Is the RBC ratio (total adjusted capital divided by authorized control level risk-based capital) less than or equal to 250 percent? Display the RBC ratio for each of the past five years.
   b. Is the surplus to assets ratio less than 20 percent?
   c. Is the gross change in surplus ratio (IRIS ratio #7) greater than 50 percent or less than – 10 percent?
   d. Review the Five-Year Historical Data of the Annual Financial Statement. Has the insurer’s surplus decreased by more than 10 percent from the ending balance for any of the prior four years?
   e. Did the insurer declare dividends to stockholders during the year?
      i. If the answer to 7e is “yes,” was the amount of the stockholder dividend at a level that required prior regulatory approval or notification?
      ii. If the answer to 7e(i) is “yes,” did the insurer fail to obtain proper regulatory approvals?
   f. Is there a parental/affiliated guaranty, of any form, in place between the company and any member within its holding company system? If so, provide details?
   g. Is the ratio of capital and/or surplus notes to policyholders’ surplus greater than 10 percent?
   h. Are write-ins for special surplus funds and/or write-ins for other than surplus funds greater than 10 percent of surplus?
   i. Are unassigned funds negative?
   j. Does the absolute value of the current year change exceed 3 percent of current year surplus for any of the following items: (1) net unrealized capital gains/losses, (2) net unrealized foreign exchange capital gains/losses, (3) net deferred taxes, (4) nonadmitted assets, (5) provision for reinsurance, (6) surplus notes, or (7) change in accounting principle?
   k. Review footnote (h) in the Exhibit of Net Investment Income. Did the insurer report interest expense on capital or surplus notes during the year?

Additional procedures and prospective risk considerations, if further concerns exist:
   l. Review the procedures in Level 2 Annual Procedures—Risk-Based Capital.
   m. Compare the surplus to assets ratio to the industry average to determine any significant deviation.
n. If the insurer has outstanding surplus notes or capital notes issued, review the Notes to Financial Statements, Note #13—Capital and Surplus, Dividend Restrictions, and Quasi-Reorganizations, and Note #11—Debt to determine the following information:

- Date issued
- Interest rate
- Amount of note and current value
- Interest paid—current year-end total
- Accrued interest
- Date of maturity
- Name of holder (and indication of whether the holder is an affiliated entity)
- Description of assets received
- Repayment conditions or restrictions

o. If capital or surplus notes were issued during the year, determine whether they were approved by the domiciliary state insurance department.

p. If principal was repaid and/or interest was paid on surplus notes during the year, determine whether the principal repayments and/or the interest payments were approved by the domiciliary state insurance department.

q. If surplus notes represent a significant portion of surplus, recalculate important ratios, excluding the amount of surplus notes, to determine the effect of surplus notes on the ratio results.

r. Review the write-ins for special surplus funds and for other than special surplus funds for reasonableness.

s. Review the Capital and Surplus section in the Financial Profile Report for unusual fluctuations or trends in the changes in surplus between years.

t. Review the detail of unrealized gains (losses) in the Exhibit of Capital Gains (Losses) for reasonableness.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer’s Statement of Income and surplus. 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 insurer’s Statement of Income and surplus 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 examination section for targeted examination
- Meet with the insurer’s management
- Obtain a corrective plan from the insurer
- Other (explain)
Comments as a result of supervisory review.

Reviewer _______________ Date ________
III. Quarterly Procedures – B.3. Level 2 Income Statement and Surplus (Property/Casualty)

1. Determine whether concerns exist regarding the insurer’s income statement or operating performance.
   a. Is the combined ratio greater than 105 percent or less than 80 percent?
   b. Is the change in the combined ratio greater than a 10-percentage-point increase or more than a 20-percentage-point decline from the prior year-to-date?
   c. Have net premiums earned changed by greater than +/- 20 percent from the prior year-to-date?
   d. Have net losses incurred changed by greater than +/- 25 percent from the prior year-to-date?
   e. Review Part 1 - Loss Experience. Has the incurred loss ratio on direct business for any line of business changed by greater than +/- 10 percentage points from the prior year-to-date?
   f. If the absolute value of net realized capital gains or losses exceeds 3 percent of surplus, is the ratio of net realized capital gains or losses to net income greater than +/- 25 percent?
   g. If the absolute value of other income exceeds 3 percent of surplus, is the ratio of other income to net income greater than +/-25 percent?

2. Determine whether concerns exist regarding changes in the volume of premiums written or changes in business mix (lines of business and/or geographic location).
   a. Review, by line of business, the current and prior year-to-date direct premiums written in Part 2 - Direct Premiums Written.
      i. Have direct premiums written for any line of business changed by greater than +/- 33 percent?
      ii. If direct premiums are being written in any new lines, do they account for more than 5 percent of the total direct premiums written?
   b. Review, by state, the current and prior year-to-date direct premiums written in Schedule T -Exhibit of Premiums Written.
      i. Has there been a significant change ( +/- 50 percent) in premiums written in any one state where direct premiums written exceed 10 percent of total direct premiums in either the current or prior year?
      ii. If premiums are being written in any new states, do they account for more than 5 percent of the total direct premiums?
   c. Have total net premiums written changed by greater than +/- 50 percent from the prior year-to-date?

3. Determine whether the insurer is excessively leveraged due to the volume of premiums written.
   a. Is the gross premiums written (rolling year) to surplus ratio greater than 900 percent?
   b. Is the net premiums written (rolling year) to surplus ratio greater than 300 percent?
III. Quarterly Procedures – B.3. Level 2 Income Statement and Surplus (Property/Casualty)

4. Determine whether concerns exist regarding the amount of the insurer’s surplus or changes in surplus notes from the prior quarter.
   a. Has surplus increased by more than 25 percent or decreased by more than 10 percent from the prior year-end?
   b. Is the surplus to assets ratio less than 20 percent?
   c. Has the insurer issued any surplus notes or capital notes during the quarter, which in the aggregate are greater than 10 percent of surplus?
   d. Has the insurer repaid any principal and/or paid any interest on surplus or capital notes during the quarter?
   e. Are write-ins for special surplus funds and/or write-ins for other than surplus funds greater than 10 percent of surplus?
   f. Are unassigned funds negative?

5. If there are concerns (e.g. changes in: surplus, writings, reserves, investments) about the current level of RBC, has the analyst considered completing and/or requesting an interim RBC projection?

6. Determine whether concerns exist regarding the declaration or payment of dividends. Review the Dividends to Stockholders line under the Capital and Surplus Account section of the Statement of Income.
   a. Has the insurer declared any dividends to stockholders during the quarter?
      i. If the answer to 5a is “yes,” is the amount at a level that required prior regulatory approval or notification?
      ii. If the answer to 5ai is “yes,” did the insurer fail to obtain proper prior regulatory approvals?

**Summary and Conclusion**

Develop and document an overall summary and conclusion regarding the insurer’s statement of income and surplus. 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 insurer’s income statement and surplus under the specific circumstances involved.

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

Statutory accounting principles emphasize the balance sheet because statutory accounting is primarily directed toward the determination of an insurer’s financial condition on a specific date. However, the income statement is also important and should be reviewed as a part of the financial analysis process. Income statement analysis primarily focuses on the operating performance of an insurer. The most common measure of an insurer’s underwriting profitability for a property/casualty insurer is the combined ratio, which is a combination of the loss ratio, expense ratio, and the policyholder dividend ratio. The combined ratio is sometimes thought of as the amount of each dollar an insurer pays out for every dollar of premium received. For example, if an insurer has a combined ratio of 105 percent, it pays out roughly $1.05 in claims, expenses, and policyholder dividends for every dollar of premiums received. However, such an insurer may still be profitable because it will be earning investment income on the premium dollars held until claims and expenses are paid. The two-year overall operating ratio (IRIS ratio #5) and the return on surplus are two measures of overall operating performance that include investment income.

Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums written may be an indication of an insurer’s entrance into new lines of business or sales territories that might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses. Significant increases in incurred loss ratios may indicate premium pricing errors or reserve strengthening due to prior reserve understatements, whereas significant decreases in incurred loss ratios may be indicative of current reserve redundancies.

In assessing the financial condition, considerable emphasis is placed on the adequacy of an insurer’s surplus (see section B4 of the Analyst Reference Guide for a detailed discussion of RBC). Surplus provides a cushion for policyholders against adverse underwriting results, catastrophe, deficiency in loss reserves, insolvency of reinsurers, and fluctuations in the value of investments. In addition, surplus provides underwriting capacity and allows an insurer to expand its premium writings. The gross and net premiums written to policyholders’ surplus ratios measure the extent to which an insurer utilizes its underwriting capacity. High ratio results may indicate that an insurer is excessively leveraged and lacks sufficient surplus to finance the business currently being written. Other surplus leverage ratios, which consider loss reserves and reinsurance, are discussed in sections B2—Unpaid Losses and LAE and B6—Reinsurance of the Analyst Reference Guide.

The components of surplus can include common capital stock, preferred capital stock, gross paid-in and contributed surplus, surplus notes, unassigned funds (or retained earnings), and special surplus funds (usually established through an appropriation of unassigned funds). Each state has, by statute, established a minimum required amount of surplus for insurers. In some states, these minimum amounts are based on the lines of business written, while in other states the minimum amounts are based on the type of insurer. In addition, the RBC requirements must also be met.

Insurers may issue capital or surplus notes as a source of financing growth opportunities or to support current operations. Surplus notes (sometimes referred to as “surplus debentures” or “contribution certificates”) have the characteristics of both debt and equity. Surplus notes resemble debt in that they are repayable with interest and sometimes, depending on the requirements of the domiciliary state insurance department, include maturity dates and/or repayment schedules. However, key provisions of the surplus notes make them tantamount to equity. These provisions include approval requirements as to form and content and the requirement that interest may be paid and principal may be repaid only with the prior approval of the domiciliary state insurance department. SSAP No. 41 — Surplus Notes, requires that
interest on surplus notes is to be reported as an expense and a liability only after payment has been approved. Accrued interest that has not been approved for payment should be reflected in the Notes to Financial Statements. Provided that the domiciliary state insurance department has approved the form and content of the surplus notes and has approval authority over the payment of interest and repayment of principal, surplus notes are considered to be surplus and not debt. The proceeds from the issuance of surplus notes must be in the form of cash, cash equivalents, or other assets having a readily determinable value satisfactory to the domiciliary state insurance department. Information regarding surplus notes must be reported in the Notes to Financial Statements #13 — Capital and Surplus, Dividend Restrictions and Quasi-Reorganizations.

Insurers may also issue capital notes, which are reported as a liability by the insurer, and are therefore treated as debt instruments (although in liquidation rank with surplus notes) and are subordinate to the claims of policyholders, claimants, and general creditors. Capital notes are included in the insurer’s total adjusted capital for RBC calculations. Like surplus notes, capital notes are repayable with interest and include maturity dates and/or repayment schedules. However, payment of interest and repayment of principal generally do not require regulatory approval. When total adjusted capital falls below certain levels or if other adverse conditions exist, capital note payments may be required to be deferred. While deferred, any interest on the capital note should not be reported as an expense or the accrual as a liability, but instead should be reflected in the Notes to Financial Statements #11 — Debt, similar to surplus note interest payments that have not been approved.

Capital and surplus notes may have the effect of enhancing surplus or providing funds only on a temporary basis. The person or entity that holds the capital or surplus note may expect repayment on a scheduled basis and may exert pressure on the insurer to generate cash in order to be able to make the payments. As a result, the analyst should be cautious when reviewing insurers that rely heavily on these notes. Capital and surplus notes are not inherently bad. They have provided regulators with flexibility in dealing with problem situations to attract capital to insurers whose surplus levels are deemed inadequate to support current operations. They provide a source of capital to mutual and other types of non-stock entities who do not have access to traditional equity markets and provide an alternative source of capital to stock reporting entities.

**Discussion of Level 2 Annual Procedures**

The purpose of this section is primarily to assist the analyst in reviewing and analyzing the insurer’s operating performance with emphasis on the level and change in the insurer’s premium writings, underwriting income, investment income, and net income, along with changes in other components of the income statement and in surplus. In addition, significant amounts of activity related to capital and surplus notes are identified. Separate sections of the Level 2 Annual Procedures provide specific guidance with respect to RBC, loss reserves, and reinsurance.

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 is crucial during the consideration of these procedures. The analyst should also consider the insurer’s corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors, and the effectiveness of management; including the code of conduct established by the board of directors.

*Procedures #1 and 2* assist the analyst in determining whether concerns exist regarding the insurer’s income statement or operating performance. In evaluating the insurer’s operating performance, the analyst...

should review the combined ratio to measure underwriting profitability in conjunction with the two-year overall operating ratio (IRIS ratio #5). Another measure of the insurer’s operating performance is the return on surplus, which considers net income and unrealized gains (losses) as a percentage of two-year average surplus. Other steps are designed to assist the analyst in identifying unusual trends and fluctuations in the insurer’s income statement that could have an impact on operating performance.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the insurer’s income statement or operating performance. The results of the combined ratio could be reviewed for the past five years to identify unusual fluctuations or trends, and the results could be compared to the industry average. Earned premiums and incurred losses by line of business per Schedule P, Part 1 may be reviewed for unusual fluctuations or trends if concerns exist regarding changes in these amounts in total. Loss ratios by line of business, the expense ratio, commission ratios, and investment yield ratios could also be compared to industry averages. If write-ins for underwriting deductions or other income are significant, the analyst should consider reviewing the individual components of these amounts for reasonableness. In addition, the detail of investment income may be reviewed if there are concerns regarding the investment yield to determine if there are significant invested assets that are not producing an adequate return.

The analyst may also perform a review of the insurer’s operating performance as it relates to expenses overall or by line of business if there are concerns. It focuses on the Insurance Expense Exhibit (IEE), a supplemental property/casualty schedule filed by April 1. The IEE includes an interrogatories section and three major parts. Part I—Allocation to Expense Groups shows, for each expense line item included in the Annual Financial Statement, the allocation to five expense groups: (1) loss adjustment expense; (2) acquisition, field supervision, and collection expenses; (3) general expenses; (4) taxes, licenses, and fees; and (5) investment expenses. Part II—Allocation to Lines of Business Net of Reinsurance shows major categories of expenses and the allocation to each line of business. Part III—Allocation to Lines of Direct Business Written is similar to Part II except that premiums are reflected on a direct basis. While the IEE is not a primary source of information for solvency analysis, it does provide meaningful information for evaluating an insurer’s operations and overall profitability. In addition, the IEE may be used in the rate-making process or for evaluating an insurer’s performance by line of business.

Procedure #3 assists the analyst in determining whether concerns exist regarding changes in the volume of premiums written or changes in the insurer’s mix of business. Significant increases or decreases in premiums written may indicate a lack of stability in the insurer’s operations. In addition, a significant increase in premiums written may be an indication of the insurer’s entrance into new lines of business or sales territories, which might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums written might also be an indication that the insurer is engaging in cash flow underwriting. Cash flow underwriting is the practice of writing a significant amount of business in order to invest and earn a greater investment return than the costs associated with potentially underpriced business. Cash flow underwriting can be a serious concern if it is accompanied by a shift in business written from short-tail property lines of business to long-tail liability lines.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding changes in the volume of premiums written or changes in the insurer’s mix of business. The analyst should consider reviewing
premiums written by line of business to determine which lines increased or decreased significantly and whether any new lines of business are being written. The analyst should also consider verifying that the insurer is authorized to write all lines of business being written. If new lines of business are being written, or if premiums are being written in new states, the analyst should consider determining whether the insurer has expertise in the new lines of business or new sales territories. This would include expertise in distribution, underwriting, claims, and reserving. There is no information in the Annual Financial Statement to assist the analyst in making this determination. However, there may be helpful information in the insurer’s MD&A. Otherwise, information may be requested from the insurer. The analyst should also consider determining if, as a result of changes in the mix of business, the insurer’s business is concentrated in specific geographic areas, which could result in the insurer being potentially exposed to catastrophic losses.

Procedure #4 suggests steps if there are concerns relating to the insurer’s participation in involuntary pools and assigned risk plans. In general, involuntary pools and assigned risk plans are administered by each state and are facilities established to provide access to insurance coverage for those that are considered high risk and, therefore, do not meet normal underwriting criteria. One such program is referred to as the Fair Access to Insurance Requirements (FAIR) plan. FAIR plans are state administered plans that underwrite property coverage’s (normally homeowners) that the standard insurance market avoids because of excessive risk. The plans are funded by assessments made on insurers based on the amount of premium volume written in the state. In addition to FAIR plans, other types of involuntary markets exist for the primary purpose of providing everyone, even the high-risk individuals and businesses, with access to insurance. Many states have also established pools for high-risk automobile coverage’s. These types of mechanisms either assign the risk to the insurers writing business in the state (e.g., require them to write the business), or assess each insurer a pro-rata portion of the state’s cost of operating the plan. While the type of involuntary mechanism may vary widely from state to state in terms of complexity, legal requirements, and financial impact, the overall concern to the analyst in this area is that the financial impact of involuntary pools and assigned risk plans, which is normally negative, is properly recorded on a timely basis on the insurer’s financial statements.

Procedure #5 assists the analyst in determining whether the insurer is excessively leveraged due to the volume of premiums written. Surplus can be considered as underwriting capacity, and the ratios of gross premiums written to policyholders’ surplus and net premiums written to surplus measure the extent to which that capacity is being utilized and the adequacy of the insurer’s surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross premiums written to surplus ratio result greater than 900 percent may indicate that the insurer is excessively leveraged, and special attention should be given to the adequacy of the insurer’s reinsurance protection and the quality of the reinsurers. A net premiums written to surplus ratio result greater than 300 percent may also indicate that the insurer is excessively leveraged and lacks sufficient surplus to finance the business currently being written. In evaluating these ratios, the analyst should also consider the nature of the insurer’s business. For example, an insurer that has historically written primarily short-tail property lines of business might not be considered excessively leveraged even though it has higher ratio results, because the risk of significant underpricing or adverse underwriting results is less than that of an insurer that writes primarily volatile long-tail liability lines of business such as medical professional liability.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding whether the insurer may be excessively leveraged due to the volume of premiums written. The analyst should consider reviewing the net premiums written by line to determine which lines of business are being written. An insurer that
writes primarily short-tail property lines may be able to write at higher levels of premiums to surplus than an insurer that writes primarily long-tail liability lines, because the risk of underpricing and significant adverse underwriting results is less with the short-tail property lines of business. The analyst should also consider comparing the ratios of gross premiums written to surplus and net premiums written to surplus to industry averages to help evaluate the insurer’s leverage. If the insurer is a member of an affiliated group of insurers, the analyst might want to compute the net and gross premiums written to surplus ratios on a consolidated basis to help evaluate whether the affiliated group of insurers is excessively leveraged. If the net and gross premiums written to surplus ratios results are high, the analyst should consider determining whether the insurer has adequate reinsurance protection against large losses and catastrophes and that the reinsurers are of high quality.

Procedure #6 assists the analyst in determining if the largest risks written by the insurer are properly reinsured. The concern is that the amount reported as a net risk could be larger if the underlying reinsurance contracts have treaty limits that restrict loss recoveries. If there are limitations, these recoveries may possibly be recouped if there is a reinstatement provision in the agreement that states that, for an additional premium, the insurer can have additional loss recoveries.

Procedure #7 assists the analyst in determining whether concerns exist regarding the amount of the insurer’s surplus. The RBC ratio is designed to calculate a minimum threshold of capital and surplus based on each insurer’s unique mix of asset risk, credit risk, off-balance sheet risk, business risk, and underwriting (premium and loss) risk. Leverage ratios pertaining to premiums written (procedure #3), loss reserves (section B2 of the Analyst Reference Guide), and reinsurance (section B6 of the Analyst Reference Guide) must also be considered in evaluating the amount of an insurer’s surplus. A measure of surplus adequacy that is commonly considered is the ratio of surplus to assets. The gross change in surplus (IRIS ratio #7) measures the improvement or deterioration in the insurer’s financial condition from the prior year. Even insignificant increases in the change in surplus ratio may indicate instability or mask financial problems attributable to fundamental changes in the insurer.

Another step is designed to assist the analyst in identifying dividend payments or declarations to determine if any necessary approvals were obtained. Other steps in this procedure are designed to assist the analyst in identifying significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds. The final step in this procedure is designed to assist the analyst in identifying other activity during the year related to capital and surplus notes.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the amount of the insurer’s surplus. In addition, the ratio of surplus to assets may be compared to the industry average to determine any significant deviation. If the insurer issued surplus or capital notes, the analyst should consider reviewing the information in the Note #11-Debt and Note #13-Capital and Surplus, Shareholders’ Dividend Restrictions and Quasi-Reorganizations. If either were issued or repaid, or if interest was paid during the year, the analyst should consider determining that these transactions were approved by the domiciliary state insurance department. In addition, if surplus notes represent a significant portion of surplus, the analyst should consider recalculating important ratios, excluding the surplus notes, to determine their effect on the ratio results. Other steps to consider include the review of the detail of unrealized gains (losses) and the review of other components of surplus.
Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are designed to identify whether concerns exist regarding the insurer’s income statement or operating performance, concerns exist regarding changes in the volume of premiums written or the insurer’s mix of business, the insurer is excessively leveraged due to the volume of premiums written, concerns exist regarding the amount of the insurer’s surplus or changes in surplus notes from the prior quarter, or concerns exist regarding the declaration or payment of dividends.
III. Annual Procedures - B.4. Level 2 Risk-Based Capital (Property/Casualty)

1. Determine whether concerns exist regarding the insurer’s Risk-Based Capital (RBC) position.
   a. Review the Annual Financial Statement, Five-Year Historical Data, RBC analysis and/or the RBC filing, and consider the following:
      i. Is the ratio of Total Adjusted Capital divided by Authorized Control Level less than or equal to 250 percent?
      ii. If the current RBC ratio is less than or equal to 300 percent, has there been a significant change, +/-30 points, in the RBC ratio from the prior year?
      iii. Has the RBC ratio declined each of the past two years? If “yes,” show the percentage-point decline over the two years and the current year RBC ratio.
      iv. Has Total Adjusted Capital declined by 15 percent or greater from the prior year?
      v. Has Authorized Control Level increased by 15 percent or greater from the prior year? If “yes,” review the five RBC risk factors for material changes from the prior year and document the leading underlying causes for the changes.

2. Did the insurer fail the RBC Trend Test? If “yes,” discuss the plans to address the RBC Trend Test failure.

3. If the insurer has triggered an action level RBC event and if authorized by statute:
   a. Obtain and review a copy of the insurer’s RBC plan and monitor the plan and overall progress in implementing plan initiatives and improving the RBC level.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding RBC. In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating RBC. The summary and conclusion should include details regarding strengths and weaknesses.

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 examination section for targeted examination.
- Meet with the insurer’s management.
- Request a statutory remedy, such as discontinue writing new business, rehabilitation, liquidation, etc.
- Other (explain).

Analyst ______________ Date ________

Comments as a result of supervisory review.

Reviewer ______________ Date ________
Overview

Beginning with the 1994 annual reporting year, property/casualty insurers became subject to an Annual Financial Statement requirement that they calculate and report an estimated level of capital that is dependent upon the insurer’s risk profile. An insurer’s Risk-Based Capital (RBC) requirement is calculated by applying risk factors to various assets, credits, premiums, reserves, and off-balance sheet items, where the factor is higher for those items with greater underlying risk and lower for those items with lower underlying risk. The RBC ratio is defined as the ratio of Total Adjusted Capital divided by Authorized Control Level RBC. States that enact the Risk-Based Capital for Insurers Model Act (#312) can take regulatory action based upon this ratio. Historically, minimal capital requirements were imposed on insurers by various state laws. Those minimums frequently were arbitrary, generally low, varied widely from state to state, and typically did not consider the risk profile of the insurer. The RBC Model Act supplements the system of absolute minimums and considers the risk profile of each individual insurer.

The RBC formula and Model Act were the result of several years of work by insurance regulators, actuaries, and other industry representatives. The formula is detailed and lengthy, but in concept is quite simple. There are five major categories of risk requirements: 1) Asset Risk - Subsidiary Insurance Companies; 2) Asset Risk - Fixed Income; 3) Asset Risk - Equity; 4) Asset Risk - Credit; and 5) Underwriting Risk - Reserves and Premiums. Each is discussed in more detail below.

1. Asset Risk - Subsidiary Insurance Companies

This risk focuses on the default of certain affiliated investments. This represents the RBC requirement of the downstream insurance subsidiaries owned by the insurer. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the carrying value. There are several categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items are included in this risk component, such as non-controlled assets, guarantees for affiliates, contingent liabilities, etc.

2. Asset Risk - Fixed Income

This risk focuses on the default of debt assets. Fixed income assets include bonds, mortgages, short-term investments, etc. For property/casualty insurers, the risk associated with fixed income assets and equity assets is not correlated, so there are two separate components of risk. Each category of assets is assigned a risk factor that increases with the perceived risk (quality) of the asset. For example, high quality bond investments are assigned a low factor, and non-investment grade bonds are assigned a high factor. An asset concentration factor also exists to reflect the additional risk of high concentrations in single exposures represented, for example, by an issuer of a bond or a holder of a mortgage.

3. Asset Risk - Equity

This risk focuses on the loss in fair value for equity assets. Equity assets include common and preferred stock, real estate, long-term assets, etc. Each category of assets is assigned a risk factor that increases with the perceived risk (quality) of the asset.

4. Asset Risk - Credit Risk

Credit risk attempts to measure the risk of defaults by agents, reinsurers, and other creditors. Ceded reinsurance balances, including recoverable from paid losses, case and incurred but not reported losses, and unearned premiums, are all assigned a risk factor. Some ceded reinsurance

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balances, such as recoverable from affiliates and from mandatory pools and associations, are exempt.

5. **Underwriting Risk - Reserves and Premiums**

There are two components to underwriting risk, reserve risk and premium risk.

Reserve risk attempts to measure the risk of adverse development in excess of expected investment income from loss reserves. Since reserves for the various types of business possess different frequency and severity characteristics, there are separate factors for each major line of business. The loss reserve calculation depends significantly on the development of overall industry loss reserves modified for the insurer’s actual experience. The resulting insurer’s loss reserve factor is adjusted for expected investment income and applied to its unpaid loss and LAE reserves.

Premium or pricing risk attempts to measure the risk of inadequate rates on business to be written over the coming year (premiums charged are not sufficient to pay future losses). Medium to long-tail lines of coverage are generally more volatile and, therefore, carry higher risk factors than short-tail lines. Similar to the loss reserve component, the pricing risk calculation depends significantly on the industry’s loss experience as modified for an insurer’s experience. The resulting company loss ratio is then adjusted for expected investment income and the insurer’s overall expense ratio on a line of business basis. The factor is applied to the previous year’s written premium. Thus, the formula establishes a minimum capital standard that requires for the industry as a whole to have sufficient capital to survive a repeat of historically poor underwriting experience. The factors for reserves and premiums are modified to increase the RBC required for lines with relatively favorable historical experience and lower the RBC required for lines with relatively adverse historical experience. This recognizes that particularly favorable or unfavorable historical experience will not necessarily repeat itself in the future.

The Model Act requires a comparison between Total Adjusted Capital and Authorized Control Level RBC. The Model Act then defines several levels of RBC. The description of each level includes a brief summary of what happens if an insurer’s Total Adjusted Capital is below that level. The various levels are related to one another by fixed percentages as follows:

- **> 200%**  
  No Action Level
- **> 200 to < 300% and a Combined Ratio of > 120%**  
  Trend Test
- **≥ 150 to ≤ 200%**  
  Company Action Level
- **≥ 100 to < 150%**  
  Regulatory Action Level
- **≥ 70 to < 100%**  
  Authorized Control Level
- **< 70%**  
  Mandatory Control Level

Most insurers are required to file an RBC report. The report shows the calculation of the Total Adjusted Capital and the calculation of the RBC levels. An insurer whose Total Adjusted Capital is greater than 200 percent of the Authorized Control Level is not within an action level. Other than filing the RBC report, no further action is required by the insurer. An insurer may trigger a Company Action Level event if the RBC Trend Test is triggered and the domiciliary state has adopted the trend test. An insurer that falls within or below the Company Action Level is required to file an RBC plan with the domiciliary state. The plan must include proposals for corrective steps by the insurer. The RBC Model Act provides that the plan is confidential. If an insurer’s Total Adjusted Capital is within the Regulatory Action Level, the insurance commissioner must perform an examination, as deemed necessary, of the company and
issue an order specifying the corrective steps to be taken by the insurer. If an insurer’s Total Adjusted Capital is within the Authorized Control Level, the commissioner may seize the company if deemed to be in the best interests of the policyholders and creditors of the insurer and of the public. If an insurer’s Total Adjusted Capital is within the Mandatory Control Level, the commissioner must seize the company. However, that step may be forgone if there is a reasonable expectation that the circumstances causing the company to be within that level will be eliminated within 90 days.

Discussion of Level 2 Annual Procedures

The Level 2 Annual Procedures are designed to identify potential areas of concern regarding RBC.

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. The analyst should also consider the insurer’s corporate governance that includes the assessment of the risk environment facing the insurer, in order to identify current or prospective solvency risks, oversight provided by the board of directors, and the effectiveness of management, including the code of conduct established by the board of directors.

Procedure #1 assists the analyst in understanding the insurer’s RBC position. Some examples that may cause the RBC Ratio to fall into an RBC Action Level include, but are not limited to, increased writings, heightened investment risk, catastrophic loss events, or an unexpected surplus decline. The procedure also identifies insurers with an RBC Ratio below 300 percent that have recorded significant increases or decreases from the prior year. Additionally, the procedure identifies insurers that have recorded RBC Ratio declines over two successive years. The procedure also identifies significant changes in the RBC Ratio components compared to the prior year. The analyst should document the leading underlying causes for changes in the Authorized Control Level and Total Adjusted Capital.

Procedure #2 determines for the analyst whether the insurer failed the RBC Trend Test. The RBC Trend test is triggered when an insurer has an RBC ratio between 200 and 300 percent and a combined ratio greater than 120 percent. An RBC Trend Test failure could potentially place the insurer in Company Action Level if the domiciliary state has adopted the trend test.

Procedure #3 directs the analyst to obtain a copy of the insurer’s RBC plan if the insurer has triggered an RBC action event. If applicable in your state, the analyst may participate in the review and approval process of the RBC plan. The RBC plan is a comprehensive financial plan that: 1) identifies the conditions in the insurer that contribute to the Company Action Level event; 2) contains proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the Company Action Level event; 3) provides projections of the insurer’s financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and/or surplus (the projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component); 4) identifies the key assumptions impacting the insurer’s projections and the sensitivity of the projections to the assumptions; and 5) identifies the quality of and problems associated with the insurer’s business including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance in each case, if any.
The analyst should also monitor, on a periodic basis, the insurer’s progress in achieving the initiatives included in the RBC plan and the impact of those initiatives on Total Adjusted Capital and the risk factors in the Authorized Control Level RBC. The goal of any RBC plan is the improvement of the underlying causes that led to an RBC Action Level, and an improvement in subsequent RBC ratio results that will remove the insurer from Action Level status.
1. Determine whether concerns exist regarding the insurer’s cash flow. Review the Annual Financial Statement, Cash Flow.
   a. If net cash from operations is negative, determine and note the underlying reasons and calculate the net cash from operations to surplus ratio.
   b. Review the trend in net cash from operations for the past five years and note any unusual fluctuations or negative trends between years.

2. Describe the insurer’s material commitments for capital expenditures as of the end of the latest fiscal period.
   a. For each commitment, indicate the general purpose and the anticipated source of funds needed.
   b. Are there any material changes between equity, debt, and any off-balance sheet financing arrangements?

3. Review Schedule E, Part 3 - Special Deposits and determine whether concerns exist regarding the insurer’s special deposits.
   a. Is the book/adjusted carrying value of all other special deposits (not for the benefit of all policyholders) greater than 50 percent of total special deposits?
   b. Is the percentage difference between the book/adjusted carrying value of total special deposits and the fair value of total special deposits greater than 5 percent?

Additional procedures and prospective risk considerations, if further concerns exist:
   c. If there are concerns regarding the amount of special deposits held by the insurer not for the benefit of all policyholders, and there is overall liquidity risk regarding the insurer, consider performing one or more of the following:
      i. Review all other special deposits held by the insurer and consider the number of states in which the insurer has these types of deposits (the greater the number, the more difficult it may be for the domiciliary state to call on these deposits in a rehabilitation) and the amount of concentration in any one particular state.
      ii. Contact the domiciliary state or perform research to determine if any of the states have restrictions on the ability of those deposits to be called by the domiciliary state during rehabilitation.

4. Determine whether concerns exist regarding the insurer’s overall level of liquidity.
   a. Review the five-year trend for the liquidity ratio within the Financial Profile Report and document any unusual fluctuations.
   b. Have liquid assets increased greater than 50 percent or decreased by more than 15 percent?
   c. Is the adjusted liabilities to liquid assets ratio (IRIS ratio #9) greater than 100 percent?

Additional procedures and prospective risk considerations, if further concerns exist:
   d. Compare the insurer’s adjusted liabilities to liquid assets ratio with industry and peer group averages in order to identify significant deviations.
Summary and Conclusion

Develop and document an overall summary and conclusion regarding cash flow and liquidity. In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating cash flow and liquidity 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 examination section for targeted 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 ________
III. Quarterly Procedures – B.5. Level 2 Cash Flow and Liquidity (Property/Casualty)

1. Determine whether concerns exist regarding the insurer’s cash flow. Review the Cash Flow for the current quarter and prior year quarter.
   a. Is net cash from operations negative?
   b. Has net cash from operations changed from the prior year-to-date by greater than +/- 5 percent of surplus?

2. Determine whether concerns exist regarding the insurer’s overall level of liquidity.
   a. Is the ratio of adjusted liabilities to liquid assets greater than 100 percent?
   b. Has the liquidity ratio changed by greater than +/- 10 percentage points from the prior quarter or +/- 20 percentage points from the prior year-end?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

   Analyst ________________ Date ________

Comments as a result of supervisory review.

   Reviewer ________________ Date ________

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Overview
Cash Flow is one of several core financial statements presented in the Annual Financial Statement of property/casualty insurers. It provides information about the primary sources of cash (inflow) and applications of cash (outflow). Cash Flow is organized to readily identify the net cash flow from operations separately from the net cash flow from investments. Other important sources and applications of cash are also shown, such as dividends to stockholders. The net change in cash and short-term investments, as reflected on Cash Flow, reconciles to the change in the balance sheet accounts of cash and short-term investments for the year.

While Cash Flow provides information about historical sources and applications of cash, the analyst should analyze the liquidity of the balance sheet in order to evaluate the insurer’s ability to fund loss reserves and other demands for cash in the future. One common way of accomplishing this is to compare the total adjusted liabilities of the insurer in relation to its liquid assets.

Discussion of Level 2 Annual Procedures
The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. One concern relates to identifying situations where negative cash flow is being generated in the current year or prior year. Another concern focuses on the amount of special deposits not for the benefit of all policyholders. The final concern relates to evaluating the liquidity of the insurer’s balance sheet in terms of its ability to fund future liabilities.

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. The analyst should also consider the insurer’s corporate governance that includes the assessment of the risk environment facing the insurer, in order to identify current or prospective solvency risks, oversight provided by the board of directors, and the effectiveness of management, including the code of conduct established by the board of directors.

Procedures #1 and 2 assist the analyst in identifying situations where the insurer’s operations are generating negative cash flow. By analyzing the components of net cash from operations, the analyst will determine whether a fluctuation in cash inflow or cash outflow or both are resulting in a negative value. Material changes in cash inflows may be impacted by shifts in premiums collected as a result of changes in reinsurance, unearned premiums, or agents’ balances, or other issues that require additional investigation. Shifts in cash outflows may be impacted by changes in loss reserves or reinsurance recoverable, or the insurer’s overall expenses, etc. In conjunction with the review of net cash from operations, it is also important for the analyst to review net cash from investments, or financing and miscellaneous sources to identify any potential impact to cash and short-term investments. Negative cash flow from operations should be evaluated closely for persistent negative trends by reviewing the five-year trend within the Financial Profile Report.

Procedure #3 assists the analyst in determining if the insurer is exposed to greater-than-normal liquidity risk with respect to special deposits. Special deposits are segregated into two sections: 1) for the benefit of all policyholders, and 2) all other special deposits. Both categories reflect amounts aggregated by state. Deposits for the benefit of all policyholders are held by individual states. The assets composing these deposits are held on the various investment schedules in the financial statement. However, the assets are not held in custody of the insurer, and restrictions are placed on the assets disposal. In a situation of a rehabilitating or troubled insurer, these restrictions on assets may cause concerns, particularly those not held for the benefit of all policyholders.
This procedure also assists the analyst in determining if the domiciliary state may be having difficulty in calling deposits that are deemed “all other special deposits.” This procedure specifically applies when the level of deposits that are not for the benefit of all policyholders as a percentage of total assets is high, or in cases when the insurer has been determined to be troubled. The analyst may consider this assessment necessary in either of those cases because, once the insurer has moved into rehabilitation, the cash flow position of the insurer may deteriorate rapidly.

Procedure #4 assists the analyst in evaluating the insurer’s overall liquidity. The calculation of liquidity compares the insurer’s adjusted liabilities with its liquid assets available to fund such liabilities in the future. Affiliated holdings are removed from liquid assets because these investments are considered less liquid and may not be readily converted to cash for paying claims. The analyst should also consider reviewing the five-year trend of liquidity within the Financial Profile Report and identifying any significant fluctuations and the underlying cause(s).

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are intended to identify significant changes in cash flow and liquidity that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.
III. Annual Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

1. Determine whether the insurer has a reinsurance program in place that adequately supports its risk profile.
   a. Is the gross premiums written to surplus ratio (IRIS ratio #1) greater than 900 percent?
   b. Is the net premiums written to surplus ratio (IRIS ratio #2) greater than 300 percent?
   c. Are gross premiums written (from liability lines of business) to surplus greater than 300 percent?
   d. Are net premiums written (from liability lines of business) to surplus greater than 150 percent?
   e. Review General Interrogatories, Part 2, #6.1. Do any concerns exist regarding the provision the company has made to protect itself from any excessive loss in the event of a catastrophe under a workers’ compensation contract issued without limit of loss?
   f. Review General Interrogatories, Part 2, #13.1. Is the largest net amount insured in any one risk (excluding workers’ compensation) greater than 10 percent of surplus?

Additional procedures and prospective risk considerations, if further concerns exist:

   g. Review General Interrogatories, Part 2, #6.3. Do any concerns exist regarding the provision the company has made to protect itself from an excessive loss arising from the types and concentrations of insured exposures composing its probable maximum property insurance loss?
   h. Review General Interrogatories, Part 2, #13.2. Does any reinsurance contract considered in the calculation of the largest net aggregate risk amount include an aggregate limit of recovery without also including a reinstatement provision?
   i. Review General Interrogatories, Part 2, #13.3. Are the number of reinsurance contracts considered in the calculation of the largest net aggregate risk amount cause for concern?
   j. Review, for each line of business included in Schedule P, the trends in accident year loss ratios, on both a gross and net basis, for indications of deteriorating underwriting results.
   k. Review Schedule T - Exhibit of Premiums Written and determine whether there appears to be large geographic concentrations of premiums in areas especially prone to catastrophic events.
   l. Obtain a copy of the insurer’s A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section.
   m. Briefly scan the individual reinsurers listed on Schedule F, Parts 5 - Provision for Unauthorized Reinsurance, Part 6 Section 1 - Provision for Reinsurance Ceded to Certified Reinsurers, and Part 6 Section 2 - Provision for Overdue Reinsurance Ceded to Certified Reinsurers.
      i. Determine if there are any significant new reinsurers known to engage in financial reinsurance transactions that may trigger concerns as to transfer of risk with respect to this specific insurer.
      ii. Determine if there are specific situations noted or overall trends that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies.
2. Determine whether the insurer’s accounting for reinsurance ceded is proper and in accordance with the *Annual Statement Instructions - Property/Casualty*.

   a. Briefly scan the individual reinsurers listed in Schedule F, Part 3 - Ceded Reinsurance. Determine whether any of the reinsurers listed as authorized or certified appear to be improperly classified.
      
      i. Select the five largest individual reinsurers based on the total reinsurance recoverables and determine whether they are authorized.
      
      ii. On a test basis, select a sample from among the remaining reinsurers and determine whether they are authorized, as necessary.
   
   b. Review Schedule F, Parts 3 - Ceded Reinsurance, 5 - Provision for Unauthorized Reinsurance, and 6 – Provision for Certified Reinsurers to determine whether the total provision for unauthorized reinsurance (unauthorized and certified) was calculated properly.

Additional procedures and prospective risk considerations, if further concerns exist:

   c. Review Schedule F, Part 7 - Provision for Overdue Authorized Reinsurance and determine whether the provision for overdue authorized reinsurance was calculated properly.
   
   d. Review Schedule F, Part 8 - Provision for Overdue Reinsurance and determine whether the provision for overdue reinsurance was calculated properly, and reconcile the amount to Liabilities, Surplus and Other Funds.
   
   e. Run the I-SITE Examination Jumpstart analysis to determine whether ceding company credits are appropriately “mirrored” by the reinsurer after considering the possibility of normal timing delays.

3. Determine whether amounts recoverable from reinsurers are significant.

   a. Are non-affiliated reinsurance recoverables on paid losses greater than 10 percent of surplus?
   
   b. Are non-affiliated reinsurance recoverables on unpaid losses greater than 50 percent of surplus?
   
   c. Review Schedule F, Parts 5 - Provision for Unauthorized Reinsurance, 6 Section 1 - Provision for Reinsurance Ceded to Certified Reinsurers, and 6 Section 2 - Provision for Overdue Reinsurance Ceded to Certified Reinsurers. Is the provision for unauthorized and/or certified reinsurance as a percentage of reinsurance recoverables from unauthorized and/or certified reinsurers greater than 30 percent?

4. Determine whether amounts recoverable from reinsurers are collectable.

   a. Are overdue paid losses and LAE reinsurance recoverables (91 days or more) greater than 10 percent of surplus?
   
   b. Are reinsurance recoverables from unauthorized reinsurers greater than 25 percent of surplus?
   
   c. Are reinsurance recoverables from alien reinsurers greater than 10 percent of surplus?
d. Review, by individual reinsurer, the amounts shown as security. Identify any unusual trends and determine the need to examine the underlying security in more detail to ensure its validity.

e. If the insurer holds a material letter of credit (LOC) securing unauthorized and/or certified reinsurance recoverables, identify the amount of the LOC and the issuing bank.

f. If the answer to 4e is “Yes,” then provide the rating of the bank and summarize any concerns.

g. Review General Interrogatories Part 1, # 15.1 and 15.2.
   i. Is the reporting entity the beneficiary of the LOC that is unrelated to reinsurance where the issuing or confirming bank is not on the NAIC SVO Bank List?
   ii. If the answer to 4g(i) is “Yes,” list the name of the issuing or confirming bank, the circumstances that can trigger the LOC and the amount.

h. Review Schedule F, Part 7 - Provision for Overdue Authorized Reinsurance. Is the provision for overdue authorized reinsurance as a percentage of reinsurance recoverables in dispute less than 20 percent?

i. Review the Notes to Financial Statements, Note #23 - Reinsurance.
   i. Are unsecured reinsurance recoverables greater than 25 percent of surplus?
   ii. Are reinsurance recoverables from any unauthorized or certified reinsurer greater than 10 percent of surplus?
   iii. Are reinsurance recoverables from any alien reinsurer greater than 5 percent of surplus?
   iv. Are reinsurance recoverables in dispute greater than 5 percent of surplus?
   v. Is the maximum amount of net return commissions due reinsurers in the event of cancellation of all reinsurance greater than 15 percent of surplus?
   vi. Is uncollectable reinsurance greater than 5 percent of surplus?

j. Review the results of the Statement of Actuarial Opinion. Were any concerns noted regarding the collectability of reinsurance recoverables?

Additional procedures and prospective risk considerations, if further concerns exist:

k. Determine the current ratings of the reinsurer from the major rating agencies, and investigate significant changes during the past 12 months.

l. Review the reinsurer’s current and prior year Analyst Team priority designations. For any reinsurer that has received a Validated Level “A” or “B,” request a copy of the reinsurance agreement(s) and confirm amounts included on Schedule F, Part 5.

m. Review information about the reinsurer that is available from industry analysts and benchmark capital adequacy with top performers and peer groups.

n. Request a copy of the insurer’s A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section for unusual items.

o. Obtain and review the Audited Financial Report and Annual Financial Statement of the reinsurer for additional insight regarding collectability.
III. Annual Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

p. Review SEC filings of the reinsurer, if applicable, for insight regarding collectability.
q. Obtain and review the Statement of Actuarial Opinion of the reinsurer for additional insight regarding collectability.
r. Determine whether adequate levels of acceptable collateral (LOCs, trust funds, etc.) are being maintained to secure outstanding losses.
s. Contact the domiciliary state to determine whether any regulatory actions are pending against the reinsurer.
t. Review the reinsurer’s historical payment patterns of recoverables and comment on findings.
u. Using the Global Receivership Information Database (GRID) within I-SITE, review the status of any relevant multi-state, single state, or alien reinsurance company departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).
v. Review analysis and supporting documentation that is already available within the insurance department (e.g., examination reports, recent analysis, current financial statements, etc.).

5. Determine whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another.

a. Review the Underwriting and Investment Exhibit Part 1B – Premiums Written.
   i. Are assumed premiums written from affiliates greater than 50 percent of gross premiums written?
   ii. Are affiliated ceded premiums written greater than 50 percent of gross premiums written?
   iii. Has there been a significant change in either of the above two ratios within the past five years? Compare the current year to the prior year (+/- 25 points) and the current year to the remaining years (+/- 50 points).

b. Review Schedule F, Part 3 - Ceded Reinsurance. Are reinsurance recoverables from affiliates greater than 20 percent of surplus?
c. Review the Notes to Financial Statements, Note #10 - Information Concerning Parent, Subsidiaries, and Affiliates, and Note #26 - Intercompany Pooling Arrangements. Were there any changes in intercompany pooling agreements during the year?
d. Review Schedule F, Part 2 - Premium Portfolio Reinsurance Effected or (Canceled) during Current Year. Were there any premium portfolio transfers involving affiliates?

Additional procedures and prospective risk considerations, if further concerns exist:
e. Obtain and review the underlying agreements that support the transaction(s) in question.

III. Annual Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

f. Critically assess the substance of the transaction in terms of the following criteria:
   i. The transaction must be economic-based and at arm’s length.
   ii. The transaction must result in the transfer of risk and represent a consummated or permanent act.
   iii. Any assets transferred to an affiliate must be transferred at fair value in an economic-based transaction.
   iv. In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approvals.

6. Determine whether pyramiding may be occurring that could cause significant collectability risk to the insurer.
   a. Review the individual authorized reinsurers listed in Schedule F, Part 3 – Ceded Reinsurance. Are any of the reinsurers generally known to enter into significant retrocession agreements?
   b. For the five largest individual unauthorized reinsurers and the five largest individual certified reinsurers listed in Schedule F, Part 3 - Ceded Reinsurance, consider the need to obtain the reinsurer’s Annual Financial Statement and determine the extent to which the reinsurer has engaged in retrocession agreements. If considered necessary, was it determined that any of these unauthorized and/or certified reinsurers have ceded reserves greater than 50 percent of total gross reserves?
   c. If there are concerns that pyramiding exists, consider completing one or more of the following procedures:
      i. Obtain the Annual Financial Statement of selected large reinsurers and determine the extent to which the reinsurer cedes business to other reinsurers.
      ii. On a test basis, as considered necessary, obtain the Annual Financial Statement of the retrocessionaire and determine the extent to which that reinsurer cedes business to other reinsurers.

Proceed with this process as long as concerns regarding pyramiding continue to exist. Throughout this process, be alert to declines in the overall quality level of reinsurers throughout the chain of reinsurance. If significant collectability concerns surface as a result of these procedures, perform the appropriate procedures to evaluate collectability (also procedures #3 and #4 within this chapter).

7. Determine whether reinsurance is being used for fronting purposes and if so, whether any potential abuses exist.
   a. Are ceded premiums written greater than 75 percent of gross premiums written?
   b. Are ceded premiums written for any significant line of business (defined as a line of business where gross premium written is greater than 20 percent of total gross premiums) greater than 90 percent of gross premiums written?
   c. Are ceded commissions to ceded premiums written more than 30 percent of the insurer’s expense ratio?
III. Annual Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

d. Evaluate the collectability of reinsurance recoverables (see procedures #3 and #4 within this chapter), summarize any concerns.

8. Determine whether any unusual reinsurance intermediary agreements or reinsurance assumed agreements exist.
   a. Are assumed premiums written from non-affiliates greater than 50 percent of gross premiums written?
   b. Is the total amount of funds withheld for payment of losses by ceding companies greater than 10 percent of surplus?
   c. Verify by direct contact or confirmation that funds withheld for payment are valid and adequately segregated for payment of losses.
   d. If assumed premiums written exceed 20 percent of gross premiums written, is the assumed loss ratio significantly higher or lower (+/- 25 points) than the gross loss ratio?

Additional procedures and prospective risk considerations, if further concerns exist:
   e. Obtain and review underlying documents relating to the use of the reinsurance intermediary.
   f. Determine whether the agreement is at arm’s length and has economic substance.
   g. Determine whether the requirements of the NAIC Reinsurance Intermediary Model Act (#790) have been met. If not, list the requirements that the insurer has not met.
   h. Determine whether the requirements of the NAIC Managing General Agents Model Act (#225) have been met. If not, list the requirements that the insurer has not met.

9. Determine whether any unusual reinsurance transactions were completed during the year.
   a. Were any portfolio transfer transactions consummated that, individually or in the aggregate, resulted in an increase in surplus greater than 5 percent?
   b. Review the Notes to Financial Statements, Note #23E - Commutation of Ceded Reinsurance. Were any commutation agreements consummated that, individually or in the aggregate, resulted in a significant change in surplus (+/- 5 percent)? If so, list the agreements.
   c. Review Schedule F, Part 3 - Ceded Reinsurance, Note A (footnote disclosure of the five highest commission rates relating to reinsurance treaties). Are any of the commission rates greater than 40 percent?
   d. Is the surplus aid to surplus ratio (IRIS ratio #4) greater than 15 percent?
   e. Review General Interrogatories, Part 2, #7.1. Has the company reinsured any risk under a quota share reinsurance contract that would limit the reinsurers’ losses below the stated quota share percentage?
   f. Review General Interrogatories, Part 2, #9.1. Has the reporting entity ceded any risk under any reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which, during the period covered by the statement: (1) it recorded a positive or negative underwriting result greater than 5 percent of current year-end surplus as
III. Annual Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

regards to policyholders, or it reported calendar-year written premium ceded or year-end loss and loss expense reserves ceded greater than 5 percent of current year-end surplus as regards policyholders, (2) it accounted for the contract as reinsurance and not as a deposit, and (3) the contract(s) contain(s) one or more of the following:

- A contract term longer than two years, and the contract is non-cancelable by the reporting entity during the contract term;
- A limited or conditional cancellation provision under which cancellation triggers an obligation by the reporting entity, or an affiliate of the reporting entity, to enter into a new reinsurance contract with the reinsurer, or an affiliate of the reinsurer;
- Aggregate stop loss reinsurance coverage;
- An unconditional or unilateral right by either party (or both parties) to commute the reinsurance contract, whether conditional or not, except for such provisions which are only triggered by a decline in the credit status of the other party;
- A provision permitting reporting of losses, or payment of losses, less frequently than on a quarterly basis (unless there is no activity during the period); or
- Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.

g. Review General Interrogatories, Part 2, #9.2. Has the reporting entity, during the period covered by the statement, ceded any risk under a reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which it recorded a positive or negative underwriting result greater than 5 percent of prior year-end surplus as regards policyholders, or for which it reported calendar-year written premium ceded or year-end loss and loss expense reserves ceded greater than 5 percent of prior year-end surplus as regards policyholders, excluding cessions to approved pooling arrangements or to captive insurance companies that are directly or indirectly controlling, controlled by, or under common control with (1) one or more unaffiliated policyholders of the reporting entity, or (2) an association of which one or more unaffiliated policyholders of the reporting entity is a member where:

- The written premium ceded to the reinsurer by the reporting entity or its affiliates represents 50 percent or more of the entire direct and assumed premium written by the reinsurer based on its most recently available financial statement; or
- Twenty-five percent or more of the written premium ceded to the reinsurer has been retroceded back to the reporting entity or its affiliates in a separate reinsurance contract.

h. Review General Interrogatories, Part 2, #9.4. Except for transactions meeting the requirements of paragraph 32 of SSAP No. 62R, *Property and Casualty Reinsurance*, has the reporting entity ceded any risk under a reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement and either accounted for that contract as reinsurance (either prospective or retroactive) under statutory accounting principles (SAP) and as a deposit under generally accepted accounting principles (GAAP), or accounted for that contract as reinsurance under GAAP and as a deposit under SAP?
i. Review General Interrogatories, Part 2, #8.1. Were there any agreements to release reinsurers from liability during the year? If yes, explain.

j. Review General Interrogatories, Part 2, #10. If the insurer has assumed risks from another company, did the company fail to establish a reserve equal to that which the original company would have been required to establish had it retained the risks? If yes, explain.

k. Review General Interrogatories, Part 2, #11.1. Has the insurer guaranteed any policies issued by another company and now in force? If yes, explain.

l. Review the results of the Statement of Actuarial Opinion. Were any concerns expressed relating to loss portfolio transfers or financial reinsurance? If yes, explain.

m. In accordance with the Disclosure of Material Transaction Model Act, did the insurer report any material non-renewals, cancellations, or revisions of ceded reinsurance agreements?
   i. Obtain and review supporting documentation of such material transactions.
   ii. Determine whether, in the judgment of the analyst, any additional procedures are considered necessary.

Additional procedures and prospective risk considerations, if further concerns exist:

n. Obtain and review significant commutation agreements.
   i. Determine whether transfer of risk criteria have been met.
   ii. Obtain the Annual Financial Statement of the other insurer that is party to the commutation agreement, and determine whether the transaction has been properly mirrored.

o. Obtain and review significant portfolio transfer agreements.
   i. Determine that transfer-of-risk criteria has been met.
   ii. Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement, and determine whether the transaction has been properly mirrored.

p. If the insurer utilizes financial reinsurance:
   i. Review a summary of the reinsurance contract terms.
   ii. Review the discussion of management’s principal objectives for entering into the reinsurance contract, as well as the economic purpose achieved.
   iii. Review the aggregate financial impact gross of all ceded reinsurance contracts on the balance sheet and statement of income.
   iv. Determine whether the reinsurance contract has been accounted for properly, and note any special accounting treatment, including any difference in treatment between GAAP and SAP.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding reinsurance. In developing a conclusion, consider the above procedures as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating reinsurance under the specific circumstances involved.
III. Annual Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

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 examination section for targeted examination
- Engage an independent actuary or reinsurance expert to review 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 ________
III. Quarterly Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

1. Determine whether reinsurance recoverables are significant.
   a. Are reinsurance recoverables on paid losses greater than 10 percent of surplus?
   b. If the answer to 1a is “yes,” have reinsurance recoverables on paid losses changed by greater than +/- 10 percent from the prior quarter or +/- 35 percent from the prior year-end?

2. Determine whether amounts recoverable from reinsurers are collectable.
   a. Is the provision for reinsurance greater than 10 percent of surplus?
   b. If the current or prior period provision for reinsurance is/was greater than 5 percent of surplus, has it changed by greater than +/- 10 percent from the prior quarter or +/- 20 percent from the prior year-end?

3. Determine whether any significant changes may have been made to the insurer’s reinsurance program.
   a. Have ceded premiums earned changed by greater than +/- 20 percent from the prior year-to-date?
   b. Has the ceded premiums to gross premiums written ratio changed by greater than +/- 10 percentage points from the prior quarter or from the prior year-end?
   c. Have assumed premiums earned changed by greater than +/- 20 percent from the prior year-to-date?
   d. Has the assumed premiums to gross premiums written ratio changed by greater than +/- 10 percentage points from the prior quarter or from the prior year-end?
   e. Review Schedule F - Ceded Reinsurance. Were any new reinsurers added since the prior quarter?
      i. If “yes,” were any unauthorized?
      ii. Does the provision for reinsurance equal the amount reported at the prior year-end?
   f. Review General Interrogatories, Part 2, #1. If the Company is a member of a pooling arrangement, did the agreement or the Company’s participation change?

4. Determine whether any unusual reinsurance transactions were completed during the quarter.
   a. Review General Interrogatories, Part 2, #2. Were there any agreements to release reinsurers from liability during the quarter?
   b. Review General Interrogatories, Part 2, #3.1. Were there any cancellations of primary reinsurance contracts during the quarter?
   c. Review General Interrogatories, Part 1, #1.1. Did the insurer experience any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile as required by the Model Act?
      i. If the answer to 4c is “yes,” did the insurer fail to make the appropriate filing of a Disclosure of Material Transactions with the state of domicile?
III. Quarterly Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

d. Was the change in the ceded pure loss ratio from the prior year-end significantly greater (+/- 30 percentage points) than the change in the gross pure loss ratio?

e. Was the change in the assumed pure loss ratio from the prior year-end significantly greater (+/- 30 percentage points) than the change in the gross pure loss ratio?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ___________________ Date ________

Comments as a result of supervisory review.

Reviewer _________________ Date ________
Overview

Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the insurer transfers or cedes to the reinsurer all or part of the financial risk of loss for claims incurred under insurance policies sold to the policyholder. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding company for all or part of the loss that the ceding company may sustain from claims. Reinsurers may, in turn, transfer or retrocede some of the risk assumed under reinsurance contracts. This form of reinsurance is known as retrocession, and the reinsurer of reinsurance is known as the retrocessionaire. Retrocessions are simply reinsurance for reinsurers.

One of the basic functions of reinsurance is to spread the risk of loss throughout the property/casualty industry and increase the amount of coverage insurers can provide. Through reinsurance, an insurer can share its risk with another insurer or insurers and limit its losses on claims incurred under policies written. An insurance company generally limits the amount of coverage it is willing to underwrite relative to its surplus. Through reinsurance, an insurer can reduce its loss reserves by the amount of risk transferred to the reinsurer and, as a result, increase its capacity to write more business.

Reinsurance does not modify in any way the obligation of the primary insurer to pay policyholder claims. Only after loss claims have been paid can the primary company seek reimbursement from a reinsurer for its share of paid losses. Generally, a reinsurer has no direct relationship or responsibility to policyholders.

Insurers operating in the U.S. may obtain reinsurance from insurance companies that specialize in assuming reinsurance, referred to as professional reinsurers, reinsurance departments of primary insurers, and alien reinsurers (i.e., a reinsurer domiciled in another country). Generally, any primary insurer may assume reinsurance for those lines of business in which it is licensed. Reinsurance is also available from pools, which are groups of insurers organized to jointly underwrite reinsurance. According to the booklet Offshore Reinsurance in the U.S. Market: 2013 Data, which was produced by the Reinsurance Association of America (RAA), total U.S. premiums ceded to offshore insurers in 2013, affiliated and unaffiliated, totaled $65.7 billion, and net recoverables totaled $111.2 billion.

The basic objective of reinsurance is to spread the risk of loss. Through reinsurance, an insurer can limit its losses under policies issued, as the reinsurer assumes the obligation to indemnify the insurer. There are four primary reasons why an insurer enters into reinsurance transactions:

- **Increase Underwriting Capacity**
  Reinsurance increases an insurer’s capacity to write greater amounts of policy coverage than it could cover on its own. Some risks (e.g., commercial risks) would be too large for any company to insure alone. Prudent management and certain insurance regulations demand limits on any one potential loss proportionate to the size of the insurer’s surplus. By transferring risks in excess of this prudent retention, an insurer can write policies with greater amounts of coverage without having to bear the full impact of potential losses under such policies. This function is crucial for small and medium size insurers to compete with larger insurers in meeting policyholders’ coverage needs.

- **Stabilize Underwriting Results**
  Reinsurance can serve to stabilize an insurer’s overall underwriting results by allowing an insurer to pass along losses to reinsurers that occurred during bad years in exchange for sharing profits that occurred during good years. Like other businesses, an insurance company tries to avoid wide fluctuations in profits and losses from year to year. As discussed above, an insurer limits exposure to an individual risk by retaining a portion of the original risk and reinsuring the
balance. To some extent, an insurer may also limit aggregate losses sustained over a specific period, such as a year, by reinsuring losses in excess of a predetermined cap.

Reinsurance also stabilizes underwriting results by reducing the possible impact of any one line of business or geographic area on overall results. To adjust its mix of business or geographic spread of risk, an insurer may reinsure certain (e.g., more hazardous or unprofitable) lines of business or policies concentrated in a particular geographic region. Also, insurers may rely on reinsurers for underwriting assistance when entering new lines of business.

- **Protect Against Catastrophic Losses**

Reinsurance protects insurers against large aggregate losses due to natural or man-made catastrophes, such as hurricanes or riots. While individual losses may be small, an insurer may not be able to absorb the accumulation of multiple losses due to a single event or occurrence. Protecting against catastrophic losses is related to stabilizing underwriting results because catastrophes are major causes of loss instability.

- **Increase Financial Strength**

Reinsurance provides a form of financing for insurance companies. Generally, an insurance company limits the amount of insurance it is willing to underwrite relative to its surplus. Upon issuing a policy, an insurer must recognize the unearned portion of premiums as a liability. However, the insurer must also pay its expenses at the beginning of the policy. Since premium income is deferred over the policy period and expenses are charged-off immediately, an insurer’s surplus shrinks, thus reducing its capital base to finance new growth. Reinsurance can relieve the impact of this accounting allocation. When reinsuring its policies, an insurer transfers a portion of its unearned premiums to the reinsurer and receives a ceding commission from the reinsurer. As a result, the ceding company’s surplus rises by an amount equal to the ceding commission. This function of reinsurance is referred to as surplus aid.

### Discussion of Level 2 Annual Procedures

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. Reinsurance is a complicated and potentially high-risk area for the insurer. While there are many legitimate business uses for reinsurance, it can be used to mask an insurer’s financial problems or expose the insurer to significant collectability or credit risk. Reinsurance abuses have been linked to several major insolvencies in the property/casualty industry.

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. The analyst should also consider the insurer’s corporate governance that includes the assessment of the risk environment facing the insurer, in order to identify current or prospective solvency risks, oversight provided by the board of directors, and the effectiveness of management, including the code of conduct established by the board of directors.

*Procedure #1* assists the analyst in determining whether the insurer has a reinsurance program in place that adequately supports its overall risk profile. The objective is to determine whether the insurer is taking on more risk than its level of surplus can reasonably absorb. Insurers that primarily write long-tail liability lines of business (e.g., medical professional liability, other liability, workers’ compensation, products liability, etc.) without adequate reinsurance protection may be absorbing a higher-than-prudent level of risk. In addition, insurers with significant concentrations of risks in specific geographic areas may be potentially exposed to catastrophic losses.
Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns that the reinsurer’s risk profile is not adequately supported by its reinsurance program. A particularly helpful source of information in this regard is the supporting reinsurance information the insurer prepares for the rating agencies. While this information is not a required filing to the insurance department, the major rating agencies generally require it in connection with the rating process. For example, if the insurer has elected to apply for an A.M. Best rating, a detailed questionnaire on reinsurance must be prepared. This questionnaire requires the insurer to describe each major reinsurance contract, disclose the maximum exposure (gross and net) on any single loss, and provide extensive information about exposures to catastrophes. Questions such as these can provide excellent background information to the analyst.

Procedure #2 assists the analyst in determining whether significant errors exist relating to the accounting for reinsurance. Generally, the major concern will relate to the manner in which the insurer accounts for credits or reductions in the liability for loss reserves relating to recognition of estimated reinsurance recoverables. The Model Law on Credit for Reinsurance defines the specific circumstances when the insurer can record such a credit or reduction in the liability for loss reserves. In summary, a credit for reinsurance can be recorded when the assuming insurer is authorized (i.e., licensed or approved by the ceding insurers’ state of domicile or accredited). When the assuming insurer is unauthorized (i.e., neither licensed or approved by the ceding insurer’s state of domicile nor accredited) then a credit for reinsurance may only be recorded when adequate security exists in the form of trust accounts, letters of credit, etc. In November 2011, the NAIC adopted revisions to the Credit for Reinsurance Model law (#785) and Credit for Reinsurance Model Regulation (#786) to allow credit for reinsurance ceded to a certified reinsurer. These revisions effectively reduce the collateral requirements for reinsurers meeting certain minimum criteria that would otherwise be considered unauthorized. To be eligible for collateral reduction, a reinsurer must (1) be domiciled and licensed in a qualified jurisdiction; (2) be certified in the ceding insurer’s domiciliary state; and (3) secure its obligations and comply with other requirements pursuant to the Credit for Reinsurance Models. States that enact these revisions are required to publish a list of certified reinsurers and qualified jurisdictions.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding the insurer’s accounting treatment of ceded reinsurance. The analyst should consider reviewing the largest reinsurers, as well as a random selection of the remaining reinsurers, to ensure that the reinsurers are classified correctly, security balances appear reasonable, and provisions for unauthorized, certified and overdue authorized reinsurance were calculated properly.

Procedures #3 and 4 assist the analyst in determining whether reinsurance recoverables are significant and, if so, whether the amounts are collectable. Under a reinsurance contract, the primary insurer transfers or cedes to another insurer (the reinsurer) all or part of the financial risk of loss for claims incurred under insurance policies sold to the policyholder. Reinsurance does not modify, in any way, the obligation of the primary insurer to pay policyholder claims. Only after loss claims have been paid can the primary company seek reimbursement from a reinsurer for its share of paid losses. As a result, the collectability of the recoverables, as well as the overall credit-worthiness of the reinsurers, is a key concern. Another important accounting issue relates to the provision for reinsurance. Under statutory accounting practices, the insurer must establish a liability by a formula that considers (1) the amount of overdue reinsurance recoverable on paid losses due from authorized insurers; (2) any collateral deficiency with respect to the
amount of reinsurance recoverable on paid and unpaid losses due from certified reinsurers; (3) the amount of overdue reinsurance recoverable on paid losses due from authorized reinsurers; and (4) the amount of reinsurance recoverable on paid and unpaid losses due from unauthorized insurers.

Reinsurance is generally obtained from one of two types of insurers:

- Professional reinsurers - The main business of professional reinsurers is assuming reinsurance from non-affiliated insurers. In general, the large and well-capitalized professional reinsurers will not pose a serious collectability concern.
- Reinsurance departments of primary insurers - Many insurers assume reinsurance from non-affiliates that also write significant business on a direct basis. These types of insurers may pose a larger collectability concern than professional reinsurers because the insurer may not possess historical reinsurance expertise.
- Alien Insurers - Reinsurers domiciled in another country may pose the most significant collectability concern.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst may perform additional steps if there are concerns regarding collectability. The fundamental issue involved with evaluating collectability is an assessment of the financial stability of the underlying reinsurers and, if applicable, specific retrocessionaires involved throughout the chain of reinsurance. To evaluate the collectability of reinsurance recoverables, the analyst should consider the need to collect as much financial information as possible about the reinsurers. In addition to reviewing the reinsurer’s Analyst Team Validated Level, the analyst should consider various regulatory and governmental filings, rating agency reports, and financial analyses available from industry analysts. A final recoverability issue may involve the treatment of disputed amounts. Occasionally, a reinsurer will question whether an individual claim is covered under a reinsurance contract or may even attempt to nullify an entire treaty. A ceding insurer, depending on the individual facts, may or may not choose to continue to take credit for such disputed balances. The ceding insurer may not take credit for reinsurance recoverables in dispute with an affiliate.

The I-SITE application Global Receivership Information Database (GRID) allows the regulator to review the status of a receivership (i.e., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal data, financial data, and reporting data. Receivables and recoverables due from companies in liquidation proceedings may be partially collected; however, collection will likely be delayed. It is practically certain that balances due at the time a liquidation is closed (the last action date that may be entered in GRID) will never be collected. Evaluating the collectability of reinsurance recoverables requires understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained.

Procedure #5 assists the analyst in identifying whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another. A group of affiliated insurance companies may use reinsurance as a mechanism to diversify the portfolios of individual companies and to allocate premiums, assets, liabilities, and surplus among affiliates. Intercompany pooling, where each company reinsures a fixed proportion of business written by pool members, is a standard practice among companies under common management. From an economic standpoint, reinsurance transactions between affiliated insurance companies do not reduce risk for the group but instead shift risk among affiliates. Reinsurance
between affiliated companies presents opportunities for manipulation and potential abuse. In a group of affiliated insurers, intercompany reinsurance may serve to obscure one insurer’s financial condition by shifting loss reserves from one affiliate to another. 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.

Procedure #6 assists the analyst in performing additional steps if there are concerns regarding whether pyramiding exists. The chain of reinsurance does not end once a primary insurer cedes business to a reinsurer. Since a reinsurer purchases reinsurance for the same reasons as a primary insurer, the reinsurer may, in turn, retrocede a portion of its assumed reinsurance business to another reinsurer. Each ceding company may rely on many reinsurance agreements with multiple reinsurers participating in each agreement. Therefore, retrocessions further complicate assessing how reinsurance affects an insurer’s financial condition. Retrocessions serve to spread the risk of loss on reinsurance throughout the industry, both domestically and worldwide. While shifting the loss exposure among individual insurers, retrocessions do not reduce the overall liability to the primary insurer for policies sold to the policyholder. The primary insurer remains directly liable to the policyholder for the full amount of the policy. However, as each party deducts its commissions and fees from the premiums, the costs of extra layers of retrocessions and intermediaries can reduce funds available to the ultimate assuming company to cover losses. Retrocessions by the apparent reinsurer may transfer risk to parties unknown to the original ceding company. However, it is difficult to track the retrocession chain from the original ceding company to the ultimate reinsurers. The Annual Financial Statement for an insurer identifies its reinsurers and the amounts recoverable on reinsurance. Similarly, reinsurers list retrocessionaires on the Annual Financial Statement. Reinsurers and retrocessionaires also disclose ceding companies and the amounts payable on reinsurance. Despite these disclosures in the Annual Financial Statement, a ceding company cannot readily assess the identity or financial condition of each retrocessionaire from its reinsurers’ Annual Financial Statement. While a ceding company remains liable for all claims filed by its policyholders before seeking reimbursement from its reinsurers, an insurer’s continued solvency may be impaired if the reinsurance chain fails. In addition, the insolvency of retrocessionaires can ripple through the reinsurance chain to affect the original ceding companies.

Procedure #7 assists the analyst in determining whether reinsurance is being used for fronting purposes and, if so, whether any potential abuses exist. Fronting is a procedure under which the ceding company (the primary or fronting company) cedes the risk it has underwritten to its reinsurers with the ceding company retaining none or a very small portion of that risk for its own account. Fronting can be subject to potential abuse by either the ceding company or the reinsurer. For example, where fronting commissions received by the ceding company from the reinsurer exceed the ceding company’s costs of selling policies, the insurer has incentive to write additional business to generate commissions and profits. An insurer may underwrite poor risks at underpriced rates because it believes it will not have to pay all the resulting losses. In fact, the ceding company may not have adequate details about the business being written by its representatives to assess its potential losses. This practice may be used to circumvent state licensing requirements and thus avoid regulatory oversight. Although an insurance company must first be licensed in a state to sell insurance directly to the public, a reinsurer may assume reinsurance without a license in that state. Through a fronting arrangement, a company not licensed in a state may reinsure all or nearly all of the liabilities for policies that it cannot directly write.

Procedure #8 assists the analyst in determining whether any significant and/or unusual reinsurance intermediary or reinsurance assumed agreements exist. While some major professional reinsurers are direct marketers, intermediaries (e.g., brokers, managers, or managing general agents) may arrange reinsurance agreements between a ceding company and a reinsurer in exchange for commissions or fees. A reinsurance broker negotiates agreements for a ceding company but does not have the authority to bind.
the insurer to a reinsurance agreement. On the other hand, a reinsurance manager acts as the agent for a reinsurer and has the authority to bind a reinsurer to an agreement. Finally, a managing general agent may have authority both to underwrite primary insurance and to bind reinsurance agreements on that business for the ceding company. An intermediary has an incentive to place reinsurance with sound reinsurers when its commission is tied to the success of the business being reinsured. However, when commissions are based on volume of business, reinsurance placed through an intermediary may be subject to conflicts of interest and potential abuse. To generate more income, a managing general agent may cede business to reinsurers who later are unable or unwilling to pay losses, or a reinsurance manager may assume poor, underpriced risks. The intermediary bears no financial risk in the event of underpriced or poor underwriting or placement with a troubled reinsurer. But poor performance by an intermediary can affect both ceding companies and reinsurers.

Procedure #9 assists the analyst in identifying unusual reinsurance transactions where a review of the transfer of risk criteria may be important. The essential ingredient of a reinsurance contract is the shifting of risk. The reinsurer must indemnify the ceding company in form and in fact, against loss or liability relating to the original policy. Unless the contract contains this essential element of risk transfer, the ceding company may not account for it as a reinsurance recoverable. Determining whether a contract involves true transfer of risk requires a complete understanding of the contract between the ceding company and the reinsurer. All contractual features that limit the amount of insurance risk to the reinsurer (such as through experience refunds, cancellation provisions, adjustable features, or additions of profitable lines of business to the reinsurance contract) or delay the timely reimbursement of claims by the reinsurer (such as through payment schedules or accumulating retentions from multiple years) should be thoroughly understood. Transfer of risk requires that the reinsurer assume significant insurance risk under the reinsured portions of the underlying insurance contracts, and that it is reasonably possible that the reinsurer may realize a significant loss from the transaction.

The analyst should be particularly alert to two unusual types of transactions - commutations and loss portfolio transfers (LPT). A commutation is a transaction that results in the complete and final settlement and discharge of all present and future obligations between parties to a reinsurance agreement. Commutations frequently occur because of the perceived financial instability of the reinsurer, inefficiencies associated with the run-off of longer tailed liabilities, significantly different evaluation of ultimate loss costs, or the reinsurer’s withdrawal from the reinsurance marketplace. In commutation agreements, the present value of the reinsurer’s estimated ultimate losses is paid by the reinsurer to the ceding insurer. The ceding insurer immediately establishes the ultimate loss reserve as its liability and the cash received as a negative paid loss, thus creating a reduction in surplus equal to the difference between the ultimate and present value of the loss reserve.

An LPT is an agreement that is applied retroactively, in which the ceding company transfers a portfolio of losses (i.e., loss reserves) to another company along with consideration for assuming such loss reserves. LPTs are complicated transactions, and it is often difficult to distinguish between those that provide indemnification through transfer of risk and those that are merely financing arrangements. LPT agreements are normally executed because it is the objective of the ceding company to record, as a credit to surplus, the difference between the loss reserves transferred and the consideration paid. However, statutory accounting practices do not allow such a credit to surplus until the risk has been transferred and the liability of the ceding company has been terminated.
Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are intended to identify whether amounts recoverable from reinsurers are significant, amounts recoverable from reinsurers are collectable, any significant changes may have been made to the insurer’s reinsurance program, or any unusual reinsurance transaction was completed during the quarter.
III. Annual Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

1. Determine whether the insurer is a member of a holding company group and whether the corporate structure elevates concerns about affiliated transactions.
   a. Review General Interrogatories, Part 1, #1.1, #1.2, and #1.3.
      i. Is the insurer a member of an insurance holding company system consisting of two or more affiliates, one or more of which is an insurer? If “yes,” what is the name of the ultimate controlling person or entity as reported on the holding company system registration statement?
      ii. If the answer to 1a(i) is different from the prior year, discuss the differences.
      iii. Review Schedule Y, Parts 1 and 2, along with the General Interrogatories and the Notes to Financial Statements. Is there any information noted that contradicts the above response to 1a(i)?
      iv. Is the company required to file a holding company registration statement with the insurance department?

If responses to questions 1a(i) through 1a(iv) are all “no,” do not proceed with the remaining Affiliated Transactions Procedures and skip to the next financial analysis topic.

   b. Review General Interrogatory, Part 1, #1.2. Did the insurer fail to file a registration statement in accordance with the NAIC Insurance Holding Company System Regulatory Act (#440)?

   c. Review Schedule Y, Part 1 - Organizational Chart for the current and prior year.
      i. Were there any significant changes to the corporate structure during the year (e.g., acquisitions, divestitures, mergers)?
      ii. If the answer to 1b(i) above is “yes,” and the change involved ownership of the insurer or a transaction with an affiliate, did the insurer fail to receive proper regulatory approvals?
      iii. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?
      iv. Does the insurer have an agency or brokerage subsidiary?

   d. Review Schedule Y, Part 1A - Detail of Insurance Holding Company System for the current year.
      i. Review Schedule Y, Part 1 and Part 1A. Identify the ultimate controlling entity(ies)/person(s) and summarize any financial concerns.
      ii. If there is more than one group listed on Part 1A, summarize the interrelationship and understand the rationale for the distinct groups.
      iii. Summarize any concerns that the analyst has with regard to non-insurance entities.

Additional procedures and prospective risk considerations, if further concerns exist:

   e. Obtain and review the financial statements of the parent holding company (available with Form B filing) in order to understand its debt and equity structure.
   f. Determine the level of debt service required by the holding company, and gain an understanding of its primary source(s) of revenue.
g. If the primary sources of revenue are dividends and fees from the insurer, evaluate these sources to determine the revenue’s validity and reasonableness.

h. Obtain and review U.S. Securities and Exchange Commission (SEC) filings, if available.

2. Identify whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.

      i. Are any unusual items noted, such as significant new affiliated transactions or modified intercompany agreements from the prior year or significant increases in transaction amounts?
      ii. Does it appear that a different schedule is included for other affiliates?
      iii. Has the insurer forwarded to any affiliate funds greater than 15 percent of the insurer’s surplus?
      iv. Were the management fees paid to affiliates greater than 15 percent of total expenses incurred?

   b. Review the Notes to Financial Statements, Note #10 - Information Concerning Parent, Subsidiaries, and Affiliates.
      i. Were any unusual items noted, such as significant new or modified affiliated transactions or significant increases in transaction amounts?
      ii. Do any transactions described appear to conflict with the transactions disclosed in Schedule Y, Part 2 - Summary of Insurer’s Transactions with Any Affiliates?
      iii. Are any transactions disclosed with an affiliate that is not listed on Schedule Y, Part 2 - Summary of Insurer’s Transactions with Any Affiliates?
      iv. Do affiliated undertakings resulting in a contingent liability to the insurer involve financial exposure greater than 25 percent of surplus?
      v. Review the description of management agreements and service contracts. Is an allocation basis involved other than one designed to estimate actual cost?

   c. Review the Notes to Financial Statements, Note #13 - Capital and Surplus, Shareholders’ Dividend Restrictions, and Quasi-Reorganizations.
      i. If the insurer paid a dividend, was the amount at a level that required prior regulatory approval or notification?
      ii. If the response to 2c(i) is “yes,” did the insurer fail to obtain proper prior regulatory approvals?
      iii. Does the amount of the dividend paid differ from the amount reported in the Annual Financial Statement, Cash Flow?
      iv. Does the amount of the dividend declared differ from the amount reflected in the Annual Financial Statement, Statement of Income?

Additional procedures and prospective risk considerations, if further concerns exist:

   d. Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
III. Annual Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

e. If the concern relates to the economic substance of the transaction, obtain and review supporting documents.

f. If the concern relates to the fair value used to record the transaction:
   i. Obtain and review an appraisal of the asset transferred.
   ii. Consider consulting an independent appraiser.

g. If the concern involves a management agreement or service contract:
   i. Determine whether appropriate regulatory approvals were received and that the insurer is complying with the terms as approved.
   ii. Obtain and review the supporting contract.
   iii. Determine whether the amounts involved are reasonable approximations of actual costs.
   iv. Determine whether the actual amounts paid are in agreement with the supporting contract.
   v. For any agreement based on a cost plus formula or percent of premiums formula, request justification from the insurer for amounts in excess of the actual cost of providing the service.
   vi. For those services being performed by/for an affiliate and that are also provided by unrelated third-party vendors (e.g., data processing, actuarial, investment management), contact such vendors or review vendor pricing schedules in order to determine the reasonableness of the intercompany transfer pricing level.
   vii. Evaluate whether any portion of such fees is in substance dividends that should be evaluated in the context of dividend regulations.

3. Determine whether affiliated investments are significant.
   a. Is the total of all investments in affiliates (Five-Year Historical Data) greater than 20 percent of surplus?
   b. Review details of affiliated investments as reported in Schedules A, B, and D, and compare with prior years.
      i. Has the total of all investments in affiliates changed by greater than +/- 20 percent from the prior year-end?
      ii. Has there been a shift in any affiliated investment category of more than +/- 10 percent from the prior year-end?
   c. Are affiliated investments in violation of state statutes?
   d. Obtain an understanding of the primary business activity of the affiliate and determine whether such an investment complies with regulatory requirements.

4. Determine whether investments in affiliates are properly valued in accordance with statutory accounting practices.
   a. If investments in common stocks of parent, subsidiaries, and affiliates involve publicly traded securities, are the investments valued on a basis other than fair value?
b. If investments in common stocks of parent, subsidiaries, and affiliates do not involve publicly traded securities, are the investments valued on a basis other than the net worth/surplus of the affiliate?

Additional procedures and prospective risk considerations, if further concerns exist:

c. Review the components of investment income reflected on the Exhibit of Net Investment Income and Exhibit of Capital Gains (Losses).
   i. Calculate the return on investment for current and prior years.
   ii. Review the components of investment income, and determine whether the source is cash or merely an increase in accrued interest income.
   iii. If a substantial portion of investment income relates to an increase in the accrual, determine whether such revenue recognition is legitimate and reasonable.
   iv. Determine whether accrued interest on investments in affiliates has grown to a significant level.

d. Obtain and review the Audited Financial Report and Annual Financial Statement of the affiliate, if available.

e. Determine the current ratings of the affiliate from the major rating agencies, if available.

f. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.

g. Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.

h. Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.
   i. Using the Global Receivership Information Database (GRID) within I-SITE, review the status of any relevant multi-state, single state, or alien affiliate company under departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).

5. Determine whether other affiliated transactions are legitimate and properly accounted for.

a. Review the balance sheet asset receivable from parent, subsidiaries and affiliates, as well as the liability payable to parent, subsidiaries, and affiliates. Are either of these items greater than 10 percent of surplus?

   i. Were any open depositories a parent, subsidiary, or affiliate?
   ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the insurer?

c. Review the Notes to Financial Statements, Note #9 - Income Taxes.
   i. Is the insurer included in a consolidated federal income tax return?
   ii. If the answer to 5c(i) is “yes,” are there any concerns about the manner in which federal income taxes are allocated to the insurer?
III. Annual Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

iii. Obtain and review the financial statements of the parent or affiliates and evaluate any collectability risk to the insurer.

iv. Review the tax-sharing agreement and verify whether the terms are being followed.

v. Verify whether the amount recoverable from the prior year-end has been paid.

vi. Are federal income tax recoverables greater than 5 percent of surplus?

vii. If the answer to 5c(vi) is “yes,” are federal income tax recoverables due from an affiliate?

d. Review the Notes to Financial Statement, Note #27 - Structured Settlements.

i. Has the insurer acquired structured settlements from an affiliated life insurance company?

ii. If the answer to 5d(i) is “yes,” is the amount of the loss reserves eliminated by annuities greater than 15 percent of surplus?

iii. Determine the current ratings of the affiliates from the major rating agencies, if available.

iv. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.

v. Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.

vi. Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.

vii. Determine whether any required regulatory approvals were obtained.

e. Review General Interrogatories, Part 2, #5. In the case of reciprocal exchanges:

i. Are any unusual items noted regarding compensation of the attorney-in-fact?

ii. Is there an approved agreement on file with the insurance department?

iii. If the response to 5e(ii) is “yes,” review the Articles of Agreement.

f. Review General Interrogatories, Part 1, #7.1 and #7.2.

i. Does any foreign entity directly or indirectly control 10 percent or more of the insurer?

ii. If the response to 5f(i) is “yes,” did the insurer fail to properly disclose the investment on Schedule Y, Part 2 - Summary of Insurer’s Transactions with Any Affiliates?

g. Review General Interrogatories, Part 1, #20.1 and #20.2.

i. Was the total amount loaned during the year to directors, other officers, or stockholders greater than 10 percent of statutory net income?

ii. Was the total amount of loans outstanding at the end of the year to directors, other officers, or stockholders greater than 5 percent of surplus?
III. Annual Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

h. Review General Interrogatories, Part 1, #18.
   i. Has the insurer failed to establish a conflict of interest disclosure policy?
   ii. Is there any evidence that activities of directors, officers, or shareholders were in violation of state statutes?

i. Review Schedule SIS - Stockholder Information Supplement. Are any unusual items noted regarding transactions with, or compensation to, directors and officers?

j. Assemble a list of all affiliates and other related parties.
   i. Summarize the financial impact of each transaction.
   ii. Identify any other unusual transactions and investigate for reasonableness.
   iii. Determine that any required regulatory approvals were obtained.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding affiliated transactions. In developing a conclusion, consider the above procedures as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating affiliated transactions 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
- Request consolidating holding company schedules
- Require additional interim reporting from the insurer
- Refer concerns to examination section for targeted examination
- Consult an independent appraiser to evaluate transactions involving material transfers of assets.
- Meet with the insurer’s management
- Recommend that a cease and desist order and/or fines be issued for holding company violations that were detected during the review
- Obtain a corrective action plan from the insurer
- Recommend that action be taken to reverse or modify contracts that are harmful to insurer
- Other (explain)

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
III. Quarterly Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

1. Determine whether the insurer is a member of a holding company system and, if so, whether the corporate structure or any changes in the corporate structure elevate concerns pertaining to affiliated transactions.
   a. Was the insurer a member of an insurance holding company system as of the prior year-end?
      i. Review Schedule Y - Information Concerning Activities of Insurer Members of a Holding Company Group, along with the General Interrogatories. Is there any information noted that contradicts the answer to the above question?
         A. Review Part 1 and Part 1A. Identify the ultimate controlling entity(ies)/person(s) and summarize any financial concerns.
         B. If there is more than one group listed on Part 1A, summarize the interrelationship and understand the rationale for the distinct groups.
         C. Summarize any concerns that the analyst has with regard to non-insurance entities.
   b. Has the Department directed the insurer to file a Holding Company System Registration Statement?
   c. Did the insurer fail to file a registration statement in accordance with the Model Holding Company System Regulatory Act?

If the answers to the above procedures are all “no,” do not proceed with the remaining Affiliated Transactions Procedures.

   d. Review General Interrogatories, Part 1, #2.1. Has there been a change in the insurer’s capital structure?
   e. Review General Interrogatories, Part 1, #3.2-#3.3. Have there been substantial changes in the organizational chart?
      i. If the answer to 1e is “yes,” and the change involved ownership of the insurer or a transaction with an affiliate, did the insurer fail to receive proper regulatory approvals?
   f. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?
   g. Does the insurer have an agency or brokerage subsidiary?
   h. Review General Interrogatories, Part 1, #5. Have there been changes to any management agreement in terms of the agreement or principals involved?

2. Determine whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.
   a. Review the Statement of Income, capital and surplus line item dividends to stockholders.
      i. Is the amount of the stockholder dividend at a level that required prior regulatory approval or notification?
III. Quarterly Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

ii. If the answer to 2ai is “yes,” did the insurer fail to obtain proper prior regulatory approvals?

b. Review Schedule A, Part 2 - Real Estate Acquired and Additions Made During the Current Quarter and Schedule BA, Part 2 - Other Long-Term Invested Assets Acquired and Additions Made During the Current Quarter.
   i. Did any such acquisitions involve an affiliate or other related party?
   ii. Is the amount of the acquisition greater than 5 percent of surplus?
   iii. If the answers to 2bi and 2bii are “yes,” is there any reason to believe that the acquisition was recorded on a basis other than fair value?

c. Review Schedule A, Part 3 - Real Estate Disposed During the Current Quarter and Schedule BA, Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid During the Current Quarter.
   i. Did any such dispositions involve an affiliate or other related party?
   ii. Is the amount of the disposition greater than 5 percent of surplus?
   iii. If the answers to 2ci and 2cii are “yes,” is there any reason to believe the sale was recorded on a basis other than fair value?

3. Determine whether investments in affiliates are significant.
   a. Is the total of all investments in affiliates greater than 20 percent of surplus?
   b. Has the total of all investments in affiliates changed by greater than +/- 20 percent from the prior year-end?

4. Determine whether other affiliated transactions are legitimate and are recorded properly.
   a. If federal income tax recoverables exceed 5 percent of surplus, have they increased more than 10 percent from the prior quarter or 20 percent from the prior year-end?
   b. If the receivable from parent, subsidiaries, and affiliates is greater than 10 percent of surplus, has it changed by greater than +/- 25 percent from the prior year-end?
   c. If the payable to parent, subsidiaries, and affiliates is greater than 10 percent of surplus, has it changed by greater than +/- 25 percent from the prior year-end?
   d. Review Schedule E, Part 1 - Cash (Month-End Depository Balances).
      i. Were any open depositories a parent, subsidiary, or affiliate?
      ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the insurer?

5. Identify any other significant or unusual transactions that may involve an affiliate or other related party, and document any concerns.

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

SSAP No. 25 - Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties defines an affiliate as an entity that is within the holding company system or a party that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. Control is defined as the possession, directly or indirectly, of the power to direct or cause the direction of management and policies of a person or entity through the ownership of voting securities. 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.

Transactions between affiliates and other companies within the same holding company system shall be fair and reasonable. The accounting for assets transferred between affiliates is generally determined by an analysis of the economic substance of the transaction. An economic transaction is an arm’s length transaction that results in the transfer of risks and rewards of ownership and represents a consummated act. An arm’s length transaction is defined as one in which a willing buyer and seller, each being reasonably aware of all relevant facts and neither under compulsion to buy, sell or loan, are willing to participate. Such a transaction must represent a bonafide business purpose demonstrable in measurable terms, such as the creation of a tax benefit, an improvement in cash flow position, etc. A transaction that results in the mere inflation of surplus without any other demonstrable and measurable improvement is not an economic transaction.

Determining that the risks and rewards of ownership have been transferred to the buyer requires an examination of the underlying facts and circumstances. The following circumstances may raise questions about the transfer of risks:

- A continuing involvement by the seller in the transaction or in the assets transferred, such as through the exercise of managerial authority to a degree usually associated with the ownership, perhaps in the form of a remarketing agreement or a commitment to operate the property.

- Absence of significant financial investment by the buyer in the asset transferred as evidenced, for example, by a token down payment or by a concurrent loan to the buyer.

- Repayment of debt that constitutes the principal consideration in the transaction dependent on the generation of sufficient funds from the asset transferred.

- Limitations or restrictions on the purchaser’s use of the asset transferred or on the profits from it.

- Retention of effective control of the asset by the seller.

Security swaps of similar issues between or among affiliated companies are considered non-economic transactions. Swaps of dissimilar issues accompanied by exchanges of liabilities between or among affiliates are considered non-economic transactions. The appearance of permanence is also an important criterion in establishing the economic substance of a transaction. If subsequent events or transactions reverse the effect of an earlier transaction, the question is raised as to whether economic substance existed in the case of the original transaction. In order for a transaction to have economic substance and thus warrant revenue (loss) recognition, it must appear unlikely to be reversed.

A bonafide business purpose would exist, for example, if an asset were transferred in order to create a specific advantage or benefit. The advantage or benefit must be to the benefit of the insurer. A bonafide business purpose would not exist if the transaction was initiated for the purpose of inflating (deflating) a particular insurer’s financial statement, including effects on the balance sheet or income statement.
When accounting for a specific affiliated transaction, the following valuation methods should be used, according to SSAP No. 25:

- Economic-based transactions between affiliates should be recorded at prevailing fair values at the date of the transaction.
- Non-economic-based transaction between affiliated insurers should be recorded at the lower of existing book/adjusted carrying values or prevailing fair values at the date of the transaction.
- Non-economic-based transaction between an insurer and an entity that has no significant ongoing operations other than to hold assets that are primarily for the direct or indirect benefit or use of the insurer or its affiliates should be recorded at the prevailing fair value at the date of the transaction. However, to the extent that the transaction results in a gain, that gain should be deferred until such time as permanence can be verified.
- Transactions that are designed to avoid statutory accounting practices shall be included as if the insurer continued to own the assets or to be obligated for a liability directly, instead of through a subsidiary.

Assets may be valued on a different basis if held by a life insurer versus a property/casualty insurer. Therefore, the regulator must take this into consideration when using the general guidelines. In the absence of specific guidelines or where doubt exists as to the propriety of a special accounting method, the domiciliary state should be consulted.

**Discussion of Level 2 Annual Procedures**

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The challenge to the analyst in this area is to understand, in substance, the various transactions between affiliates and recognize those transactions that are intended to circumvent existing regulations. Many of the procedures may require a prior knowledge of the insurer or a past knowledge of the holding company structure. A review of the insurer’s holding company files may assist in this regard.

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. The analyst should also consider the insurer’s corporate governance that includes the assessment of the risk environment facing the insurer, in order to identify current or prospective solvency risks, oversight provided by the board of directors, and the effectiveness of management, including the code of conduct established by the board of directors.

*Procedure #1* assists the analyst in understanding the insurer’s corporate structure. Significant changes in corporate structure may materially impact the insurer’s future financial condition and generally require prior regulatory approval. The analyst should closely analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure, the analyst may be able to foresee future problems and take appropriate action. For example, a common corporate structure the analyst may encounter involves a holding company whose only significant asset is the stock of the insurer. The holding company may have financed the acquisition of the insurer through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the insurer. This type of corporate structure warrants close attention by the analyst to ensure that dividends are valid and in compliance with the applicable dividend restrictions, and that any other payments by the insurer to the holding company are legitimate, rather than dividends in disguise. The analyst should also be alert to a corporate structure that includes affiliated brokers or intermediaries that...
may be recording unusual or significant levels of commissions and fees. When a corporate structure is
involved that includes multiple tiers of affiliates where significant levels of surplus are composed of
investments in affiliates, the analyst should focus on the level of surplus on a consolidated basis. The
analyst may perform additional steps if the insurer’s corporate structure elevates concerns about affiliated
transactions. The primary objective is to understand the financial position of the parent company. By
understanding the financial commitments of the parent, the analyst will be able to better understand the
parent’s motivation for entering into transactions with the insurer or other affiliates. Financial statements
of affiliates may reveal unauthorized transactions in progress.

Procedure #2 assists the analyst in understanding and evaluating the summary of transactions reported in
Schedule Y, Part 2. Several types of affiliated transactions are reported in Schedule Y, Part 2, and
explanatory comments are provided in the Notes to Financial Statements, #10 - Information Concerning
Parent, Subsidiaries, and Affiliates. The analyst should refer to both sources of information in order to
develop an understanding of the underlying affiliated transactions.

The following briefly describes the key concerns to the analyst for several of the major affiliated
transactions. For shareholder dividends, the major concern relates to whether the level of dividends is
within the regulatory guidelines and whether the dividends should be considered extraordinary, and
therefore requires prior regulatory approval. For capital contributions from the insurer to another affiliate,
the analyst should determine that such contributions do not substantially impact the financial condition of
the insurer. For non-cash capital contributions into the insurer, the analyst should determine that the
infusion is recorded at fair value so as to not arbitrarily inflate surplus. In the case of purchases, sales or
exchanges of loans, securities, real estate, mortgage loans, or other investments, the concern to the analyst
is primarily one of valuation. These types of transfers should be at arm’s length and recorded at fair value.
The analyst should also be alert to possible abuses regarding the transfer of assets between
property/casualty and life/health affiliates merely to impact the risk-based capital calculation of the
affiliates. For management agreements and service contracts, the main concerns to the analyst relate to the
type of service being performed and the reasonableness of the cost. This is a common area for abuse when
parent companies desire to withdraw funds from the insurer but do not want to or would not be permitted
to classify it as a shareholder dividend. The analyst should understand why the parties were motivated to
enter into such contracts and particularly, the benefit to the insurer. For those services provided by an
affiliate where a market already exists (such as data processing, actuarial, or investment management), an
effective way for the analyst to determine whether an arm’s length transaction exists is to contact one of
the vendors and request a proposal or fee estimate for a similar service.

Procedures #3 and 4 assist the analyst in determining whether investments in affiliates are significant 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 affiliates. It is only through this process that the
analyst can detect situations where the investment may be substantially overvalued. In particular, the
analyst should review the level of return on the investment in the affiliate, including the source of the
investment income (e.g., cash or merely an increase in the accrual). The analyst should not only be alert to
the level of investments in the affiliate but also the level of accrued interest relating to investments in the
affiliate.

Procedure #5 assists the analyst in evaluating all other affiliated transactions. The analyst’s primary
objective in this area is to understand the substance of the transactions and to determine whether the
transactions are economic-based. The analyst should review the extent of transactions with officers and
directors to ensure that the transactions are at arm’s length and are not detrimental to the financial
condition of the insurer. The analyst should closely monitor other affiliated transactions to ensure that the
insurer is not exposed to significant collectability risk. For example, if the insurer is included in a
consolidated federal income tax return and a significant asset for federal income tax recoverable is
recorded on the financial statements of the insurer, the analyst should closely review the financial statements of the parent to determine the parent’s ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectability risk to the insurer. When the amounts of structured settlements are significant, the analyst should review and understand the financial statements of the life insurance affiliate.

**Discussion of Level 2 Quarterly Procedures**

The Level 2 Quarterly Procedures are intended to identify whether the insurer is a member of a holding company group and, if so, whether the corporate structure or any changes in the corporate structure elevate concerns about affiliated transactions. Additionally, the procedures are intended to identify whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines, whether investments in affiliates are significant, whether other affiliated transactions are legitimate and are recorded properly, or any other significant or unusual transactions that may involve an affiliate or other related party.
1. Determine whether concerns exist due to a significant amount of the insurer’s direct premiums being written through managing general agents (MGAs) and third-party administrators (TPAs).

   a. Review General Interrogatories, Part 1, #4.1 and #4.2. Did any agent, general agent, broker, sales representative, non-affiliated sales/service organization, or any combination thereof under common control (other than salaried employees of the insurer) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of either the sale of new business or renewals?

   b. Review the Notes to Financial Statements, Note #19 - Direct Premiums Written/Produced by Managing General Agents/Third-Party Administrators. Was the aggregate amount of direct premiums written through MGAs and TPAs greater than 10 percent of total direct premiums written?

   Additional procedures and prospective risk considerations, if further concerns exist:

   c. Review the Notes to Financial Statements, Note #19 - Direct Premiums Written/Produced by Managing General Agents/Third-Party Administrators (which lists all individual MGAs and TPAs whose direct writings are greater than 5 percent of surplus). Determine the following: (1) which MGAs and TPAs are being utilized and whether any are affiliated with the insurer, (2) the types and amount of direct business written by the MGAs and TPAs, and (3) the types of authority granted to the MGAs and TPAs by the insurer.

   d. For those lines of business in which a significant amount of the insurer’s direct premiums are written through MGAs and TPAs, determine if the incurred loss and LAE ratios are comparable to industry averages (review procedure #2n in Level 2 Annual Procedures - Unpaid Losses and LAE).

   e. For those lines of business in which a significant amount, but not all, of the insurer’s direct business written is written through MGAs and TPAs, request information from the insurer to evaluate the comparability of the incurred loss and LAE ratios on the business written by the MGAs and TPAs with that written directly by the insurer.

   f. For the more significant MGAs and TPAs, request information from the insurer to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether that reinsurance was arranged for by the MGA or TPA. If the MGA or TPA arranged for the reinsurance, determine whether the MGA or TPA is affiliated with the reinsurer, and consider reviewing the reinsurance agreements to determine whether the terms are reasonable.

   g. For the more significant MGAs and TPAs, request information from the insurer regarding commission rates and any other amounts paid to the MGAs and TPAs. Review the information for reasonableness and compare the commission rates to those paid by the insurer to other agents.

   h. Determine whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid certificates of authority. In some states, an insurer may utilize an MGA who is not licensed if biographical questionnaires have been submitted for each individual owning more than 10 percent of the MGA. If this provision is applicable and the MGA is not licensed, verify that the required biographical questionnaires have been submitted.
iii. If the MGA establishes loss reserves, the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA.

iv. Documentation supporting the insurer’s periodic (at least semi-annual) on-site review of the MGA’s underwriting and claims processing operations.

l. For the more significant TPAs utilized by the insurer, request and review the following:
   i. The most recent annual report of the TPA.
   ii. Documentation supporting the insurer’s periodic (at least semi-annual) review of the operations of the TPA. (The NAIC Managing General Agents Model Act requires at least one of the semi-annual reviews to be an on-site audit of the operations of the TPA.)

m. If there are concerns regarding the business placed with the insurer by an MGA or TPA, consider determining if other insurers are utilizing the same MGA or TPA and perform the following:
   i. Compare the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether the contracts are similar; (e.g., contain the same commission rates).
   ii. Compare the insurer’s loss and LAE ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer may be receiving a disproportionate amount of “bad” business from the MGA or TPA.

**Summary and Conclusion**

Develop and document an overall summary and conclusion regarding whether concerns exist due to a significant amount of the insurer’s direct premiums being written through MGAs and TPAs. 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 insurer’s use of MGAs and TPAs under the specific circumstances involved.

Recommendations for further action, if any, based on the conclusion above:
- Contact the insurer for explanations or additional information.
- Obtain the insurer’s business plan.
III. Annual Procedures – B.8. Level 2 MGAs and TPAs (Property/Casualty)

- Require additional interim reporting from the insurer.
- Refer concerns to examination section for targeted examination.
- Refer concerns regarding a particular MGA or TPA to the examination section for examination of the MGA or TPA.
- 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 ________
1. Review General Interrogatories, Part 1, #5. If the Company is subject to a management agreement, have there been any significant changes regarding the terms of any agreements with MGAs or TPAs?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer’s use of MGAs and TPAs. 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 insurer’s use of MGAs and TPAs under the specific circumstances involved.

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

   Analyst ________________   Date ________

Comments as a result of supervisory review.

   Reviewer ________________   Date ________
Overview

Managing general agents (MGAs) and third party administrators (TPAs) produce or solicit business for an insurer and also provide one or more of the following services: underwriting, premium collection, claims adjustment, claims payment, and reinsurance negotiation. (See section B6 of the Analyst Reference Guide for a detailed discussion of reinsurance, including reinsurance intermediaries, fronting, etc.). Insurers are required to have written contracts with MGAs and TPAs that set forth the specific responsibilities of each party. MGAs and TPAs have been used by insurers to increase the volume of business written without having to expand internal staffing and to facilitate entry into new lines of business or geographical locations. However, the more authority delegated to MGAs and TPAs, the greater the opportunity for abuse. If the insurer relinquishes too much control, management may not be able to effectively guide and monitor the insurer’s operations. MGAs and TPAs may have priorities or needs that conflict with those of the insurer. For example, there is an inherent conflict for MGAs and TPAs between writing quality business and being compensated by commissions based on the volume of business written. When MGAs and TPAs are compensated based on the volume of business written, their incentive is to write as much business as possible, which may compromise underwriting. These types of conflicts have played a significant part in the failure of several insurers. It is important that the insurer actively supervise, control, and monitor the performance of MGAs and TPAs on an ongoing basis to help avoid these conflicts.

To effectively monitor MGAs and TPAs, insurers should obtain and review the MGAs’ and TPAs’ annual independent financial examinations and financial reports. In addition, the NAIC model acts regarding MGAs and TPAs require insurers to periodically perform on-site reviews of the underwriting and claims processing operations of each MGA and TPA utilized. If an MGA establishes loss reserves, the insurer must also obtain the opinion of an actuary regarding the adequacy of loss reserves established on the business produced by the MGA.

The NAIC Managing General Agents Act (#225) (MGA Act) defines an MGA as any person who (1) manages all or part of the insurance business of an insurer (including the management of a separate division, department, or underwriting office), and (2) acts as an agent for such insurer who, with or without the authority, produces directly or indirectly and underwrites an amount of gross direct written premiums equal to or more than five percent of the insurer’s surplus in any one quarter or year and either adjusts or pays claims or negotiates reinsurance on behalf of the insurer. However, the MGA Act exempts certain persons from being considered MGAs, including employees of the insurer, underwriting managers under common control with the insurer whose compensation is not based on the volume of premiums written, and attorneys-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

The NAIC Third Party Administrator Statute (#90) (TPA Statute) defines a TPA as any person who, directly or indirectly, solicits or effects coverage of; underwrites; collects charges, collateral or premiums from; or adjusts or settles claims in connection with life or health insurance coverage, annuities, employee benefit stop-loss, or workers’ compensation insurance. However, the TPA Statute exempts certain persons from being considered TPAs including, among others, insurers, licensed agents whose activities are limited exclusively to the sale of insurance and licensed adjusters whose activities are limited to the adjustment of claims and MGAs.

Discussion of Level 2 Annual Procedures

The Annual Financial Statement contains information regarding the MGAs and TPAs utilized the types and amount of direct premiums written by each, and the types of authority granted to each. The Level 2 Annual Procedures are designed to assist the analyst in identifying those insurers that may have problems due to significant reliance on MGAs and TPAs.
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. The analyst should also consider the insurer’s corporate governance that includes the assessment of the risk environment facing the insurer, in order to identify current or prospective solvency risks, oversight provided by the board of directors, and the effectiveness of management, including the code of conduct established by the board of directors.

Procedure #1 assists the analyst in determining whether a significant amount of the insurer’s direct premiums are being written through MGAs and TPAs. While the amount of direct premiums written by MGAs and TPAs is not necessarily an indication of a problem or concern, these procedures alert the analyst of the insurer’s exposure to potential abuse by MGAs and TPAs. MGAs and TPAs who had been delegated significant authority without insurer oversight have played a major role in the insolvency of several large insurers.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst:

The analyst should consider reviewing the information in the Notes to Financial Statements, #19 - Direct Premiums Written/Produced by Managing General Agents/Third-Party Administrators, in more detail to determine which MGAs and TPAs are being utilized, whether any of the MGAs or TPAs are affiliated with the insurer, the types and amount of direct premiums written by each, and the types of authority granted to each by the insurer. The analyst might compare incurred loss and LAE ratios for those lines of business in which a significant amount of the insurer’s direct premiums are written through MGAs and TPAs to industry averages. The analyst might also compare incurred loss and LAE ratios on the business written by MGAs and TPAs to those for the business written directly by the insurer for the same lines of business to determine whether it appears that underwriting standards may have been relaxed by the MGAs and TPAs.

For the more significant MGAs and TPAs, the analyst should consider requesting information from the insurer to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether the MGA or TPA arranged for that reinsurance. If the MGA or TPA arranged for the reinsurance, the analyst might consider determining whether the MGA or TPA is affiliated with the reinsurer. In addition, the analyst should consider reviewing the reinsurance agreements to determine whether the terms are reasonable. For the more significant MGAs and TPAs, the analyst should also consider requesting information from the insurer regarding commission rates and any other amounts paid to the MGAs and TPAs, reviewing that information for reasonableness and comparing the commission rates to those paid by the insurer to other agents. Any arrangement involving sliding scale commissions based on loss ratios or a sharing of interim profits on business where the MGA or TPA establishes loss reserves or controls claim payments should be reviewed closely to determine if there is potential for abuse by the MGA or TPA. In addition, the analyst might also consider determining whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid Certificates of Authority.

The more authority that is delegated to an MGA or TPA, the more important it is for the insurer to provide active ongoing oversight into the MGA’s or TPA’s operations. To evaluate the insurer’s oversight of significant MGAs and TPAs, the analyst should consider requesting from the insurer copies of its contracts with the MGAs and TPAs to determine compliance with the minimum contract provisions per the MGA Act and the TPA Statute and/or the applicable provisions of the insurance code. The analyst should also consider requesting from the insurer copies of financial statements for the significant MGAs
and TPAs and documentation supporting the insurer’s periodic (at least semi-annual) review of the underwriting and claims processing systems. If an MGA establishes loss reserves, the analyst should consider requesting a copy of the Actuarial Opinion attesting to the adequacy of those loss reserves established for losses incurred and outstanding on business produced by the MGA. If there are concerns regarding the business placed with the insurer by an MGA or TPA, the analyst should consider determining if other insurers are utilizing the same MGA or TPA and compare the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether the contracts are similar (e.g., contain the same commission rates). The analyst should also consider comparing the insurer’s loss and LAE ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer may be receiving a disproportionate amount of underperforming business from the MGA or TPA.

**Discussion of Level 2 Quarterly Procedure**

The Level 2 Quarterly Procedure assists in identifying any significant changes regarding the terms of agreements with MGAs or TPAs that have occurred since the prior year Annual Financial Statement and/or the prior Quarterly Financial Statement.
1. Determine whether the insurer’s investment portfolio appears to be adequately diversified to avoid any undue concentration of investments by type or issue.

a. Are the total of industrial and miscellaneous bonds (unaffiliated) owned greater than 50 percent of total net admitted assets (excluding separate accounts)?

b. Are residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS) or other loan-backed and structured securities (LBaSS) owned greater than 20 percent of total net admitted assets (excluding separate accounts)?

c. Are foreign bonds owned greater than 5 percent of total net admitted assets (excluding separate accounts)?

d. Are preferred stocks owned greater than 5 percent of total net admitted assets (excluding separate accounts)?

e. Are common stocks owned greater than 10 percent of total net admitted assets (excluding separate accounts)?

f. Are mortgage loans owned greater than 20 percent of total net admitted assets (excluding separate accounts)?

g. Is real estate owned (before encumbrances), including home office real estate, greater than 10 percent of total net admitted assets (excluding separate accounts)?

h. Are total derivatives greater than 1 percent of total net admitted assets (excluding separate accounts)?

i. Is the counterparty exposure or potential exposure of derivative instruments open greater than 1 percent of total net admitted assets (excluding separate accounts)?

j. Are collateral loans in force greater than 5 percent of total net admitted assets (excluding separate accounts)?

k. Are other invested assets (Schedule BA) greater than 5 percent of total net admitted assets (excluding separate accounts)?

l. Are aggregate write-ins for invested assets greater than 5 percent of total net admitted assets (excluding separate accounts)?

m. Are investments in affiliates greater than 10 percent of total net admitted assets (excluding separate accounts)?

n. Is any one single investment (excluding federal issues and affiliated investments) greater than 3 percent of total net admitted assets (excluding separate accounts)?

o. Has the insurer failed to comply with state specific investment laws, regulations or guidelines for diversity and limitations?

Additional procedures and prospective risk considerations if further concerns exist:

p. Determine whether the insurer’s investment portfolio is in compliance with the investment limitations and diversification requirements per the state’s insurance laws.

q. For Life/A&H insurers, review the Percentage Distribution of Total Assets in the Annual Financial Profile Report for significant shifts in the mix of investments owned during the past five years.
III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

r. For Life/A&H insurers, compare the insurer’s distribution of invested assets per the Percentage Distribution of Total Assets in the Annual Financial Profile Report to industry averages to determine any significant deviations from the industry averages.

s. Request a copy of the insurer’s investment plan that discusses investment objectives and strategy, with specific guidelines as to quality, maturity, and diversification of investments and:
   i. Evaluate whether the investment plan appears to result in investments and practices that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs.
   ii. Determine whether the insurer appears to be adhering to the investment plan.

t. Review the maturity distribution of bonds in Schedule D – Part 1A – Section 1 (Quality and Maturity Distribution of all Bonds Owned) and consider the liquidity of the insurer’s investments to determine whether the insurer’s investment portfolio appears reasonable, based on the types of business written.

u. If the insurer’s investments include a significant amount of foreign bonds, consider the insurer’s potential foreign currency exposure from holding bonds denominated in a foreign currency.

v. If there are concerns regarding liquidity or cash flows, review the Statement of Actuarial Opinion for comments regarding cash flow testing performed and the results obtained. (See Procedure B in the Statement of Actuarial Opinion Supplemental Procedures.)

2. Determine whether the board of directors approves purchases and sales of all investments and whether all securities owned as of December 31 of the current year are under the exclusive control of the insurer and in the insurer’s possession.

a. Review General Interrogatories, Part 1, #16. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof?

b. Review General Interrogatories, Part 1, #24.01 and #24.02. Were any securities owned, over which the insurer has exclusive control, not in the actual possession of the insurer, except as shown by the Schedule of Special Deposits?

c. Review General Interrogatories, Part 1, #25.1 and #25.2. Were any assets owned by the insurer not exclusively under the control of the insurer?

d. Review General Interrogatories, Part 1, #21.1 and #21.2. Were there any assets reported subject to a contractual obligation to transfer to another party without the liability for such obligation being reported? If “yes,” comment on the purpose and the amount.

e. Review the summary detail on restricted assets provided in the Notes to Financial Statements, Note #5-H - Investments. Were there any restricted assets greater than 10 percent of total cash and invested assets? If “yes,” provide details.

Additional procedures and prospective risk considerations if further concerns exist:

f. Request a copy of the insurer’s investment plan to determine who is authorized to purchase and sell investments and what approvals are required for investment transactions.

g. If the insurer has securities under its exclusive control that are not in its actual possession, review General Interrogatories, Part 1, #24.01 and #24.02 to determine the reason the
securities are not in the insurer’s possession, who holds the securities, and whether the securities qualify as admitted assets of the insurer.

h. If the insurer owns assets that are not under its exclusive control, review General Interrogatories, Part 1, #25.1, #25.2, and #25.3 to determine the reason the assets are not under the insurer’s exclusive control, who holds the assets, and whether the assets qualify as admitted assets of the insurer.

3. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Investment Analysis Office.

   i. Has the insurer failed to follow the filing requirements of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*?
   ii. If the answer to 3a(i) is “yes,” document the exceptions listed in General Interrogatories, Part 1, #32.2.

b. Review Schedule D – Part 1 (Bonds) and Schedule D – Part 2 (Preferred Stocks and Common Stocks). Does it appear that the insurer has failed to comply with the requirement to submit securities that are not filing exempt to the Securities Valuation Office (SVO) for a valuation (i.e., there are securities which were acquired prior to the current year with a “Z” suffix after the NAIC designation and/or there is a significant number of securities which were acquired during the current year with a “Z” suffix after the NAIC designation)?

Additional procedures and prospective risk considerations if further concerns exist:

c. Review Schedule D – Part 1 (Bonds) to determine whether all bonds with an NAIC designation of 6 - bonds in or near default - have been valued at lower of amortized cost or fair value and all other bonds have been valued at their amortized cost.

d. Review Schedule D – Part 2 (Preferred Stocks and Common Stocks) to determine whether sinking fund preferred stocks have been valued at their cost and all other stocks have been valued at their fair value.

e. If securities are listed in Schedule D – Part 1 (Bonds) or Schedule D – Part 2 (Preferred Stocks and Common Stocks) with a “Z” suffix after the NAIC designation:
   i. Request verification from the insurer that the securities, if not filing exempt, have been submitted to, and subsequently valued by, the SVO.
   ii. If the securities do not qualify as filing exempt, compare the price or designation actually received from the SVO to that included in the Annual Financial Statement for significant securities.

f. For each of the securities listed in Schedule D – Part 1 (Bonds), Schedule D – Part 2 (Preferred Stocks and Common Stocks) and Schedule DA (Short-Term Investments), compare the CUSIP number, NAIC designation, and fair value included in the Annual Financial Statement to information on the NAIC Valuation of Securities (VOS) master file using Jumpstart Reports for investment analysis. Contact the insurer to follow up on any exceptions noted.
III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

4. Determine whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value.
   a. Review General Interrogatories, Part 1, #30 (which shows the aggregate statement value and the aggregate fair value of bonds and preferred stocks owned). Is the aggregate excess of the statement value over the fair value of bonds and preferred stocks owned greater than 10 percent of the statement value of bonds and preferred stocks owned?
   b. Is the aggregate excess of the statement value over the fair value of bonds and preferred stocks owned greater than 20 percent of capital and surplus and asset valuation reserve (AVR)?

Additional procedures and prospective risk considerations if further concerns exist:
   c. Review Schedule D – Part 1 (Bonds) and Schedule D – Part 2 (Preferred Stocks and Common Stocks) or request additional information from the insurer to determine which individual securities have a book/adjusted carrying value significantly in excess of their fair value. For those securities:
      i. Verify the NAIC designation assigned and, if not filing exempt, determine whether it has been updated recently by the SVO.
      ii. If filing exempt, determine the current rating by a Credit Rating Provider — CRP (e.g., Moody’s Investors Service, Standard & Poor’s, A.M. Best or Fitch Ratings).
      iii. Determine whether there has been an other-than-temporary decline in fair value.
   d. Request information from the insurer regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

5. Determine whether the fair value of common stock is significantly greater than or less than the cost.
   a. Review Schedule D – Part 2 – Section 2 (Common Stocks). Is the aggregate fair value of common stocks below the actual cost?
      i. If the answer to 5.a. is “yes,” is the difference greater than 10 percent of capital and surplus?
   b. Review Schedule D – Part 2 – Section 2 (Common Stocks). Is the aggregate actual cost of common stocks below the fair value?
      i. If the answer to 5.b. is “yes,” is the difference greater than 10 percent of capital and surplus?
   c. If an investment in one issue of common stock exceeds 5 percent of invested assets, does the fair value of the common stock exceed the actual cost by greater than 30 percent or is the fair value less than the actual cost by greater than –20 percent?
Additional procedures and prospective risk considerations if further concerns exist:

d. Review Schedule D – Part 2 – Section 2 (Common Stocks) or request additional information from the insurer to determine which individual common stocks have a cost significantly in excess of their fair value. For those securities:

i. If the stock is listed on a market or an exchange (designated by the symbol “L” or “U”) - such as the New York Stock Exchange, American Stock Exchange, NASDAQ National Market System, or a foreign exchange - verify the price and total market value.

ii. If the stock is designated “A” (analytically determined by the SVO), determine whether it has been updated recently by the SVO.

iii. Determine whether there has been an other-than-temporary decline in the fair value of the common stock.

e. Request information from the insurer regarding investment strategies and short-term cash flow needs to determine whether common stock with a cost that is significantly in excess of fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

f. Is the insurer aware of any market conditions that could threaten the value of the insurer’s investment portfolio?

6. Determine whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year.

a. Review Schedule D – Part 3 (Long-Term Bonds and Stocks Acquired During Current Year). Were significant amounts of bonds or stocks purchased near the beginning or the end of the year? If so, determine the types of securities purchased at or near the beginning and the end of the year, and the vendors used for those purchases. Refer to the “Financial Summary Investment Activity” section of the insurer’s “Financial Profile” for information regarding long-term bonds and stocks acquired near the beginning or the end of the year.

b. Review Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year). Were significant amounts of bonds or stocks disposed of near the beginning or the end of the year? If so, determine the types of securities sold and the purchasers of those securities. Refer to the “Financial Summary Investment Activity” section of the insurer’s “Financial Profile” for information regarding long-term bonds and stocks sold, redeemed or otherwise disposed of near the end of the year.

c. Review Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year). Were significant amounts of bonds or stocks acquired near the beginning of the year and disposed of near the end of the year? If so, determine the types of securities purchased, the vendors used for those purchases and the purchasers of those securities. Refer to the “Financial Summary Investment Activity” section of the insurer’s “Financial Profile” for information regarding long-term bonds and stocks acquired near the beginning of the year and disposed of near the end of the year.

Additional procedures and prospective risk considerations if further concerns exist:

d. Review Schedule D – Part 3 (Long-Term Bonds and Stocks Acquired During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the types of securities purchased at or...
III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

near the beginning and the end of the year, and the vendors used for those purchases. Refer to the “Financial Summary Investment Activity” section of the insurer’s “Financial Profile” for information regarding long-term bonds and stocks acquired near the beginning or the end of the year.

e. Review Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the types of securities sold at or near the beginning and the end of the year, and the purchasers of those securities. Refer to the “Financial Summary Investment Activity” section of the insurer’s “Financial Profile” for information regarding long-term bonds and stocks sold, redeemed or otherwise disposed of near the end of the year.

f. Based on the results of 6.d. and 6.e., determine whether the insurer might have engaged in “window dressing” of its investment portfolio (i.e., replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end).

7. Determine whether concerns exist due to significant turnover of long-term bonds, preferred stocks or common stocks during the year.

a. Review Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year). Is the long-term bond turnover ratio greater than 50 percent?

b. Review Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year). Is the stock turnover ratio greater than 50 percent?

c. Review Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year). Is the total long-term bond and stock turnover ratio greater than 50 percent?

Additional procedures and prospective risk considerations if further concerns exist:

d. Determine whether all brokers used by the company for investment transactions are licensed and in good standing with the U.S. Securities Exchange Commission (SEC).

e. Review Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the amount of bonds and stocks disposed of during the current year.

i. Review Schedule D – Part 3 (Long-Term Bonds and Stocks Acquired During Current Year). Determine the quality of bonds acquired, noting any “Z” rated (not rated by the SVO) securities. Also note any NAIC designations of 3, 4, 5, or 6 (non-investment grade bonds).

ii. Review Schedule D – Part 3 (Long-Term Bonds and Stocks Acquired During Current Year). Determine the quality of preferred and common stocks acquired. Evaluate any “U” (unlisted) or “A” (analytically determined) rated stocks.
f. High turnover of investments can result in realized capital gains. Review the Exhibit of Capital Gains (Losses) to determine the degree of reliance on capital gains to increase surplus.

g. Review the Statement of Actuarial Opinion. Determine whether any concerns about investment turnover are noted.

8. Determine whether there are concerns due to the level of investment in non-investment grade bonds.
   a. For non-health insurers, is the weighted ratio of non-investment grade bonds and non-investment grade short-term investments to capital and surplus greater than 25 percent?
   b. If investments in non-investment grade bonds and non-investment grade short-term investments currently exceed 3.5 percent of invested assets, have such investments increased by greater than 15 percent over the prior year?

Additional procedures and prospective risk considerations if further concerns exist:

   c. Review Schedule D – Part 1A – Section 1 (Quality and Maturity Distribution of all Bonds Owned) and compare the insurer’s holdings of non-investment grade bonds to the limitations included in the NAIC Investments in Medium and Lower Grade Obligations Model Regulation (#340):
      i. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 3, 4, 5, or 6 is less than 20 percent of total net admitted assets (excluding separate accounts).
      ii. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 4, 5 or 6 is less than 10 percent of total net admitted assets (excluding separate accounts).
      iii. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 5 or 6 is less than 3 percent of total net admitted assets (excluding separate accounts).
      iv. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 6 is less than 1 percent of total net admitted assets (excluding separate accounts).

   d. Request a copy of the insurer’s plan for investing in non-investment grade bonds and review the guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location.

   e. Determine whether the insurer appears to be adhering to its plan for investing in non-investment grade bonds.

   f. For the more significant non-investment grade bonds, request the following current information regarding the issuer from the insurer to determine the issuer’s financial position and ability to repay its debt:
      i. Audited Financial Statements.
      ii. Report from a CRP (e.g., Moody’s Investors Service, Standard & Poor’s, A.M. Best or Fitch Ratings).
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9. Review Schedule D – Part 1A – Section 2 to determine whether there are concerns due to the level of investment in RMBS, CMBS and LBaSS.
   a. Is the ratio of all RMBS, CMBS and LBaSS owned to capital and surplus and AVR greater than 200 percent?
   b. If investments in all RMBS, CMBS and LBaSS currently exceed 15 percent of cash and invested assets, have these investments increased by greater than 20 percent over the prior year?
   c. Is the ratio of RMBS to cash and invested assets greater than 5 percent?

Additional procedures and prospective risk considerations if further concerns exist:
   d. Review the RMBS, CMBS and LBaSS categories in Schedule D – Part 1 (Bonds) for bonds with a book/adjusted carrying value significantly in excess of par value, which could result in a loss being realized if bond prepayments occur faster than anticipated.
   e. Review the RMBS, CMBS and LBaSS categories in Schedule D – Part 1 for bonds with an unusually high effective yield.
   f. Request information from the insurer regarding the percentage distribution and amounts of each type of RMBS, CMBS and LBaSS held; planned amortization class (PAC), support bonds, interest only (IO) tranches, and principle only (PO) tranches to evaluate the level of prepayment risk in the portfolio.
   g. Request and examine information from the insurer regarding the estimated prepayment speeds on its RMBS.
   h. Request information from the insurer regarding the background and expertise in structured securities of its investment advisors (in-house and/or contractual) and its analytical system capabilities. Determine whether the advisors and systems are adequate to allow the insurer to continuously monitor its structured securities investments.
   i. Review the calculation of the insurer’s C-3 Interest Rate Risk Component of its Risk-Based Capital formula.
   j. Review the Statement of Actuarial Opinion for comments regarding the modeling of the RMBS portfolio in the cash flow testing performed.
   k. Consider having the RMBS, CMBS and LBaSS modeled by an independent actuary as a part of an independent cash flow analysis.

10. Determine whether there are concerns due to the level of investment in private-placement bonds.
    a. Is the ratio of private-placement bonds owned to capital and surplus and AVR greater than 100 percent?
    b. If the ratio of investments in private-placement bonds to invested assets is greater than 5 percent, have such bonds increased by greater than 15 percent over the prior year?

Additional procedures and prospective risk considerations if further concerns exist:
    c. Review Schedule D – Part 1A – Section 1 (Quality and Maturity Distribution of all Bonds Owned) and determine the following:
       i. The total amount of privately-placed bonds owned.
       ii. The types of issues with privately-placed bonds.
III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

iii. The NAIC designations of the privately-placed bonds.
iv. The maturity distribution of the privately-placed bonds.
v. The amount of total privately-placed bonds that are freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

d. For the more significant privately-placed bonds, request current audited financial information regarding the issuer from the insurer and evaluate the issuer’s financial position and ability to repay its debt.

11. Determine whether there are concerns due to the level of investment in structured notes.
   a. Are investments in structured notes greater than 10% of capital and surplus plus AVR?

Additional procedures and prospective risk considerations if further concerns exist:

   b. Review the Notes to Financial Statements, Note #5 - Investments and Schedule D, Part 1, to identify the types of structured notes and the interest rate reported.

   c. Review the most recent financial examination for any risks noted.

   d. Inquire of the insurer:

      i. Has management adequately reviewed the structured note portfolio and does management understand the underlying yields, cash flows and their volatility?

      ii. Gain an understanding of the concentration by collateral type, subordination in the overall structure of the structured note transactions, and any trend analysis management has performed on the underlying assets to ensure appropriate valuation of the structured note.

      iii. Gain an understanding of management’s process for valuing the structured notes so as to assess if the notes are valued appropriately.

      iv. What is the insurer’s intended use of these structured notes and purpose within the insurer’s portfolio?

      v. Does management have an appropriate level of expertise with this type of security?

      vi. Does the insurer have controls implemented to mitigate the risks associated with this investment type?

12. Determine whether there are concerns due to the level or quality of investment in real estate and mortgage loans.
   a. For non-health companies, is the ratio of total real estate and mortgage loans to capital and surplus and AVR greater than 150 percent?

   b. If the ratio of total real estate and mortgage loans to cash and invested assets exceeds 10 percent, have such investments increased by greater than 15 percent over the prior year?

   c. For non-health companies, is the ratio of problem real estate and mortgage loans to capital and surplus and AVR greater than 15 percent?

   d. Utilizing postal codes and property type reported in Schedule A – Part 1 (Real Estate Owned), identify if real estate owned is concentrated in one or a few geographical areas?
III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

e. Review General Interrogatories, Part 1, #12.1. Does the insurer own any securities of a real estate holding company or otherwise hold real estate indirectly?

f. Utilizing postal codes and property types reported in Schedule B – Part 1 (Mortgage Loans Owned), identify if mortgage loans are concentrated in one or a few geographical areas?

g. Review the Assets on page 2. Are there any “other than first liens” included in total admitted mortgage loans?

h. Is the ratio of commercial mortgages to total mortgages greater than 50 percent?

Additional procedures and prospective risk considerations if further concerns exist:

i. Review Schedule A – Part 1 (Real Estate Owned) to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the book/adjusted carrying value and reported fair value of the property, and the year of last appraisal.

j. Review Schedule A – Part 1 (Real Estate Owned) and:
   i. Investigate any instances where a property has a book/adjusted carrying value in excess of its cost.

   ii. Request information from the insurer regarding any increases by adjustment in book/adjusted carrying value during the year.

k. Review Schedule A – Part 1 (Real Estate Owned) for any properties owned that have a book/adjusted carrying value in excess of fair value and determine whether the asset should be written down.

l. Review Schedule B – Part 1 (Mortgage Loans Owned) and:
   i. Determine the amount of each type of mortgage loan owned.

   ii. Compare the book value/recorded investment of each loan to the value of the land and buildings mortgaged to determine whether the mortgage loans are adequately collateralized.

   iii. Review the date of last appraisal or valuation to determine whether updated appraisals should be obtained.

   iv. Request information from the insurer regarding any increases by adjustment in book value/recorded investment during the year.

   v. Determine whether any of the mortgage loans are to an officer, director, parent, subsidiary, or affiliate.

13. Determine whether there are concerns due to the level of investment in other (Schedule BA) invested assets.

   a. Is the ratio of Schedule BA assets to capital and surplus and AVR greater than 10 percent?

   b. If the ratio of investments in Schedule BA assets to cash and invested assets is greater than 3.5 percent, have such assets increased by greater than 10 percent over the prior year?
Additional procedures and prospective risk considerations if further concerns exist:

- **c.** Review Schedule BA (Other Invested Assets Owned) to determine the amount and types of other invested assets owned and to determine whether they are properly categorized as other invested assets.
- **d.** Review Schedule BA to determine if a significant amount of BA assets have NAIC ratings of 3, 4, 5, or 6 or have a “Z” designation.
- **e.** Request information from the insurer to support significant increases by adjustment in book/adjusted carrying value during the year.
- **f.** Request current Audited Financial Statements and other documents (partnership agreements, etc.) necessary to support the value of the insurer’s investment in partnerships and joint ventures.
- **g.** Request information necessary to support the value of significant other invested assets other than partnerships and joint ventures.
- **h.** Request information necessary to determine the fair value of collateral to the amount loaned to ensure the loan is adequately collateralized.

**14.** Determine whether there are concerns due to the level of investment in collateral loans.

- **a.** Is the ratio of collateral loans to capital and surplus and AVR greater than 20 percent?
- **b.** If the ratio of investments in collateral loans to cash and invested assets is greater than 3.5 percent, have such investments increased by greater than 10 percent over the prior year?

Additional procedures and prospective risk considerations if further concerns exist:

- **c.** Review Schedule BA (Other Invested Assets Owned) and Schedule DA (Short-term Investments) and perform the following for each such loan:
  - **i.** Determine whether the collateral for the loan is an acceptable asset.
  - **ii.** Compare the fair value of the collateral to the amount loaned thereon to determine whether the loan is adequately collateralized.
  - **iii.** Determine whether the collateral loan is to an officer, director, parent, subsidiary or affiliate.
- **d.** Verify the rate used to obtain the fair value of the securities held as collateral for the loans by reference to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*.

**15.** Determine whether there are concerns due to the level of investment in derivative instruments.

- **a.** Review the Notes to Financial Statements, Note #1 – Summary of Significant Accounting Policies, Note #5 – Investments, and Note #8 – Derivative Instruments; General Interrogatories, Part 1, #26; Assets (line 7), Liabilities (line 24.08); Exhibit of Net Investment Income (line 7); Exhibit of Capital Gains/Losses (line 7); Schedule DB, all parts; the MD&A; and the Audited Financial Report. Is the insurer engaging in derivative activity?
  
  **If “no,” do not proceed with the derivative procedures and skip to the conclusion of the investment section.**
b. Determine whether derivative holdings at year-end are significant. Review Schedule DB, Parts A, B, and C, Section 1. Is the total book adjusted carrying value at year-end greater than 5 percent or less than -5 percent of capital and surplus and AVR? If so, list total book adjusted carrying value and percentage of capital and surplus and AVR for hedging effective, hedging other, replication, income generation, other, and total derivative transactions.

c. Determine whether derivative activity during the year is significantly greater than holdings at prior year-end.
   i. Review Schedule DB – Part A – Section 1. Is the initial cost (original value) of call and put options, warrants, caps, floors, collars, swaps, and forwards acquired or opened during the year greater than 150 percent of the initial cost (original value) of derivatives owned or open at prior year-end?
   ii. Review Schedule DB – Part B – Verification. Is the current year statement value of future contracts greater than 150 percent of the book adjusted carrying value at prior year-end?

d. Review the Exhibit of Net Investment Income. Is the ratio of gross derivative investment income (line 7) to net investment income greater than 2 percent or less than –2 percent?

e. Review the Exhibit of Capital Gains (Losses) on Investments for derivatives.
   i. Is the amount of realized capital loss attributed to derivatives (line 7) greater than the amount of any gain attributed to derivatives?
   ii. If the answer to 15e.i. is “yes,” is the amount of realized capital loss attributed to derivatives (line 7) greater than 3 percent of capital and surplus and AVR?

f. Review Schedule DB – Part A – Section 2, columns 22, 23, and 24, and Schedule DB – Part B – Section 2, columns 16, 17, and 18. If the sum of the aggregate gains and losses at disposal results in aggregate net losses on derivatives, then is the absolute value of these losses greater than 10 percent of capital and surplus and AVR? If “yes,” list (i) the net gain/(loss) amount; and (ii) percentage of capital and surplus and AVR for recognized, used to adjust basis, deferred, and aggregate gain/(loss).

g. Review Schedule DB – Part D (Counterparty Exposure for Derivative Instruments Open). Is the ratio of total off balance sheet exposure to capital and surplus and AVR greater than 5 percent?

h. Review the AVR Default Component Calculation to determine the quality of derivative instruments. Is the percentage of derivative instruments reported as medium quality or below (NAIC designation 3 through 6) greater than 20 percent of total derivative instruments?

i. Review detail provided in Schedule DB columns for Description of Items Hedged or used for Income Generation, Types of Risk(s), to determine if the insurers detailed use of derivatives appears to be consistent with the overall strategy that the reporting entity has described elsewhere. Where the detail reported in Schedule DB differs from other information provided by the insurer, request further clarifying information from the reporting entity.

j. Review detail provided in Schedule DB columns for Hedge Effectiveness at Inception and at Year-End. Note anything unusual or any variances from the insurer’s current hedging program description.
Additional procedures and prospective risk considerations if further concerns exist:

k. Obtain and review a comprehensive description of the insurer’s hedge program in order to obtain an understanding of the insurer’s use of derivative instruments to hedge against the risk of a change in value, yield, price, cash flow, quantity, or degree of exposure with respect to assets, liabilities, or future cash flows that the insurer has acquired or incurred (or anticipates acquiring or incurring) and:

   i. Evaluate whether the hedge program appears to result in hedges that are appropriate for the insurer based on its assets, liabilities and cash flow risks.

   ii. Determine whether the insurer appears to be adhering to the description of the hedge program.

l. Review Schedule DB (Derivative Instruments). For significant derivative instruments that are open at year-end, request the following information from the insurer:

   i. A description of the methodology used to verify the continued effectiveness of the hedge provided.

   ii. A description of the methodology to determine the fair value.

   iii. A description of the determination of the book/adjusted carrying value.

m. Consider having the insurer’s derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the insurer’s investments 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 examination section for targeted examination
- Engage an independent appraiser to value particular investments
- 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 ________
III. Quarterly Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

1. Determine whether the insurer’s investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type.
   a. Are preferred stocks owned greater than 5 percent of total net admitted assets (excluding separate accounts)?
   b. Are common stocks owned greater than 10 percent of total net admitted assets (excluding separate accounts)?
   c. Are non-investment grade bonds owned greater than 3.5 percent of total net admitted assets (excluding separate accounts)?
   d. Are mortgage loans owned greater than 20 percent of total net admitted assets (excluding separate accounts)?
   e. Is real estate owned (less encumbrances), including home office real estate, greater than 10 percent of total net admitted assets (excluding separate accounts)?
   f. Are other invested assets (Schedule BA) greater than 5 percent of total net admitted assets (excluding separate accounts)?
   g. Are aggregate write-ins for invested assets greater than 5 percent of total net admitted assets (excluding separate accounts)?
   h. Are investments in affiliates greater than 10 percent of total net admitted assets (excluding separate accounts)?

2. Determine whether the insurer has significantly increased its holdings since the prior year-end in certain types of investments, which tend to be riskier and/or less liquid than publicly-traded investment grade bonds and stocks, cash and short-term investments.
   a. If the ratio of investments in non-investment grade bonds to invested assets exceeds 3.5 percent, have such investments increased by more than 15 percent over the prior year-end?
   b. If the ratio of investments in total real estate and mortgage loans to invested assets exceeds 10 percent, have such investments increased by more than 15 percent over the prior year-end?
   c. If the ratio of investments in Schedule BA assets to invested assets exceeds 3.5 percent, have such assets increased by more than 10 percent over the prior year-end?
   d. If the ratio of aggregate write-ins for invested assets to invested assets exceeds 3.5 percent, have such assets increased by more than 20 percent over the prior year-end?
   e. If the ratio of affiliated investments to invested assets exceeds 3.5 percent, have such assets increased by more than 20 percent over the prior year-end?

3. Determine whether there are concerns due to the level of investment in derivative instruments.
   a. Review Schedule DB – Parts A, B and C – Section 1. Is the total book adjusted carrying value greater than 5 percent of capital and surplus and AVR? If “yes,” list total book adjusted carrying value and percentage of capital and surplus and AVR for hedging, other and total derivative transactions.
   b. Review Schedule DB – Part A – Section 1 (Options, Caps, Floors, Collars, Swaps and Forwards Open as of Current Statement Date) and Schedule DB – Part B – Section 1
III. Quarterly Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

(Future Contracts Open as of Current Statement Date). If the ratio of potential exposure on futures contracts and options, caps, floors, collars, swaps and forwards to capital and surplus and AVR exceeds 3.5 percent, have such investments increased more than 10 percent over the prior year-end?

c. Review Schedule DB – Part D – Section 1 (Counterparty Exposure for Derivative Instruments Open as of Current Statement Date). If the ratio of potential exposure on counterparty exposure for derivative instruments to capital and surplus and AVR exceeds 3.5 percent, have such investments increased more than 10 percent over the prior year-end?

d. Review detail provided in Schedule DB columns for Description of Item(s) Hedged, Used for Income Generation, or Replicated and Type(s) of Risk(s) to determine if the insurer’s detailed use of derivatives appears to be consistent with the overall strategy that the reporting entity has described elsewhere. Where the detail reported in Schedule DB differs from other information provided by the insurer, request further clarifying information from the reporting entity.

e. Review detail provided in Schedule DB columns for Hedge Effectiveness at Inception and at Quarter-End. Note anything unusual or any variances from the insurer’s current hedging program description.

4. Determine whether all securities owned are under the control of the insurer and in the insurer’s possession by reviewing General Interrogatories, Part 1, #11.1. Were any of the assets of the insurer loaned, placed under option agreement or otherwise made available for use by another person (excluding securities under securities lending agreements)?

5. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Investment Analysis Office.

a. Review General Interrogatories for Investments – Part 1, #18.1. Has the insurer failed to follow the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office?

b. If the answer to 5.a. is “yes,” document the exceptions listed in General Interrogatories, Part 1, #18.2.

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the Annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ___________________ Date ________

Comments as a result of supervisory review.

Reviewer ___________________ Date ________
Overview

Insurers receive premiums from policyholders today in exchange for a promise to pay covered benefits in the future. These premiums, net of operating expenses paid, along with capital and surplus funds, are invested in a variety of different types of investments until needed to pay benefits. State insurance laws regulate an insurer’s investments and prescribe the types of investments which may be acquired by insurers. These laws also generally provide limitations on investments by type and issue. However, in most states, a large amount of the insurer’s assets may be invested at the discretion of management or the board of directors within the statutory limits. An insurer may become financially troubled if it invests heavily in speculative or high-risk investments that later result in losses or if it invests in securities with maturities that are inappropriately matched with its liabilities.

Investment income is often a key component in the pricing of insurance products, and management may be pressured into strategies to maximize investment yields when policy benefits are higher than was anticipated at the time products were priced. Higher investment yields generally involve higher risk. A shift to higher yield investments may result in the ownership of investments with questionable quality or value.

Another important investment consideration is the proper matching of assets and liabilities. An insurer must manage its investment portfolio to match investment maturities with its cash flow needs to pay benefits. Poor matching may result in the insurer being forced to liquidate long-term investments at a loss to provide the currently needed cash flows.

Investment risk may also involve a failure to adequately diversify an investment portfolio. A concentration of assets in one type of investment may not adequately spread the investment risk and may result in more volatile investment returns. A high concentration of investments that are not readily marketable may also indicate increased investment risk and may raise concerns as to the value of the investments.

Life insurers have historically invested primarily in long-term bonds and mortgage loans. While this still holds true, the industry’s approach to investments has changed significantly in recent years. In the past, when the principal focus of the products sold was insurance, the primary objective of an insurer’s investment strategy was the preservation of capital, and insurers invested in long-term bonds with stable interest rates and predictable cash flows. However, with the advent of interest sensitive products, where one of the principal focuses of the product is on the investment aspect, investment returns became more important. This change in focus has prompted insurers to turn to assets of higher risk and lower quality in exchange for higher investment yields. Many insurers currently have significant investments in noninvestment-grade bonds, privately placed bonds, residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS) and other loan-backed and structured securities (LBaSS). Investments today are also much more complex and sophisticated than in the past. This requires that insurers have investment advisors (in-house and/or contractual) with appropriate background and expertise as well as analytical systems which are capable of continuously monitoring the constantly changing marketplace. It is also important that the investment advisors communicate with personnel responsible for liability cash flows to help assure that projected asset and liability cash flows are adequately matched.

As a result, investment analysis is more important today than it was in the past. The principal areas of concern to the analyst in reviewing an insurer’s investment portfolio are: 1) diversification, 2) liquidity, 3) quality, 4) valuation, and 5) asset/liability matching. First, an insurer’s investment portfolio should be adequately diversified to prevent an undue concentration of investments by type or issue. Second, the investment portfolio should be structured in such a way that it is appropriately liquid to allow for the cash
flows necessary to cover the insurer’s benefit commitments as they become due. Sufficient assets should be readily convertible to cash and the sale of necessary assets should not involve significant losses caused by changes in the market. Third, default or credit risk is a function of investment quality. As the quality of an investment decreases, the probability that principal will be returned and that the expected yield will be realized tends to decrease. Fourth, invested assets are generally valued at cost or amortized cost, except for common stocks and perpetual preferred stocks which are valued at fair value. However, the analyst should be alert for investments which should be written down to fair value due to other than temporary declines in value. Fifth, the analyst should be alert for investment portfolios with cash in-flows which do not match with projected liability cash out-flows.

Discussion of the Level 2 Annual Procedures

The Level 2 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of concern regarding an insurer’s investment portfolio are diversification, liquidity, quality, valuation and asset/liability matching. Most of the procedures are designed to assist the analyst in identifying undue concentrations of investments by type or issue and investments which have been improperly valued in the Annual Financial Statement.

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 is crucial during the consideration of these procedures. The analyst should also consider the insurer’s corporate governance, which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst.

Procedure #1 assists the analyst in determining whether the insurer’s investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue. The ratios of the various types of investments to total net admitted assets (excluding separate accounts) are a measure of the diversity of the insurer’s investment portfolio by type of investment. The results of these ratios may also provide some indication of the insurer’s liquidity. Ratios are included for most types of investments except for government and agency bonds and cash and short-term investments, which are generally very liquid. In addition, the ratio of the investment in any one issue or issuer to total net admitted assets (excluding separate accounts) is a measure of the diversity of the insurer’s investment portfolio by issue.

Additional steps the analyst may perform are available if there are concerns regarding whether the insurer’s investment portfolio is adequately diversified to avoid an undue concentration of investments by type or issue. The analyst should consider determining whether the insurer’s investment portfolio is in compliance with the investment limitations and diversification requirements per the state’s insurance laws. The analyst might also review the Percentage Distribution of Assets in the Financial Profile Report for significant shifts in the mix of investments owned during the past five years. The analyst should compare the insurer’s distribution of invested assets to industry averages to determine significant deviations from the industry averages. In addition, the analyst might also request a copy of the insurer’s formal adopted investment plan. This should be evaluated to determine if the plan appears to result in investments that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs and to determine whether the insurer appears to be adhering to its plan. The analyst might also review Schedule D – Part 1A to evaluate the quality and maturity distribution of all bonds owned; and consider the liquidity of the insurer’s investments to help determine whether the insurer’s
investment portfolio appears reasonable, based on the types of business written. If the analyst has concerns regarding liquidity or cash flows, he or she should consider reviewing the Statement of Actuarial Opinion for comments regarding cash flow testing performed and the results obtained; or consider having a cash flow analysis performed by an actuary.

Procedure #2 assists the analyst in determining whether purchases and sales of all investments are approved or authorized by the insurer’s board of directors, and whether all securities are owned by the insurer as of December 31 of the current year, are under the exclusive control of the insurer and are in the insurer’s possession. Most states require investment transactions to be approved by the insurer’s board of directors or a subordinate committee thereof, and General Interrogatory #16 indicates whether this has been done. General Interrogatory #24 indicates whether the stocks, bonds, or other securities, of which the insurer has exclusive control (defined by the NAIC as the exclusive right by the insurer to dispose of an investment at will, without the necessity of making a substitution therefore), are in the actual possession of the insurer. If the insurer owns securities, which are not in its possession, they should be held by a custodian under a properly executed custodial agreement in order to be considered admitted assets. General Interrogatory #25 indicates whether any of the stocks, bonds or other assets of the insurer are not exclusively under its control. Assets which are not under the insurer’s control might not meet the state’s requirements to be considered admitted assets.

Additional steps the analyst may perform are available if there are concerns regarding investment approval or control and possession. If there are concerns regarding investment approval, the analyst should consider requesting a copy of the insurer’s formal adopted investment plan to determine who is authorized to purchase and sell investments, as well as what approvals are required for investment transactions. If there are concerns regarding investments that are held by someone other than the insurer, the analyst should review General Interrogatory #24 in more detail to determine the reason the securities are not in the insurer’s possession and who holds the securities in order to evaluate whether they qualify as admitted assets of the insurer under the state insurance laws or whether there are concerns regarding the insurer’s ability to have access to the securities when needed. If there are concerns regarding investments that are not under the insurer’s exclusive control, the analyst should consider reviewing General Interrogatory #25 in more detail to determine the reason the assets are not under the insurer’s exclusive control (e.g., loaned to others, subject to repurchase or reverse repurchase agreements, pledged as collateral, placed under option agreements) and who holds the assets in order to evaluate whether they qualify as admitted assets for the insurer under the state insurance laws or whether there are other concerns.

Procedure #3 assists the analyst in determining whether the securities owned by the insurer have been valued in accordance with the standards promulgated by the NAIC SVO. Beginning in 2004, the provisional exemption (PE) in the Purposes and Procedures Manual of the NAIC Investment Analysis Office was changed to filing exempt (FE). This change expands the exemption to preferred stocks and all NAIC equivalent designations and removes several of the optionality requirements. In conjunction with this change, the SVO compliance certificate was changed to a general interrogatory in the investment section. According to NAIC requirements, all securities purchased that are not filing exempt per the Investment Analysis Office P&P Manual should be submitted to the SVO for valuation within 120 days of the purchase. In accordance with the NAIC Annual Statement Instructions, if the SVO provides an NAIC designation or price, that designation or price should be utilized. Insurers are required to complete the general interrogatory on compliance filing requirements of the Investment Analysis Office P&P Manual and list exceptions as a component of the Annual Financial Statement. This interrogatory should indicate the following: 1) all prices or NAIC designations for the securities owned by the insurer that appear in the VOS product have been obtained directly from the SVO, 2) all securities previously valued by the insurer and identified with a “Z” suffix (which indicates that the security is not filing exempt, does
not appear in the SVO Valuations of Securities (VOS) product or has not been reviewed and approved in writing by the SVO) have either been submitted to the SVO for a valuation or disposed of, and 3) all necessary information on securities which have previously been designated NR (not rated due to lack of current information) by the SVO has been submitted to the SVO for a valuation or that the securities have been disposed. In addition, the analyst should review Schedule D – Part 1 (Bonds) and Schedule D – Part 2 (Preferred Stocks and Common Stocks) to determine whether it appears that the insurer is complying with the requirement to submit securities to the SVO for valuation. There should be no securities which were acquired prior to the current year that have a “Z” suffix after the NAIC designation.

Additional steps the analyst may perform are available if there are concerns regarding whether securities have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office. The analyst should consider reviewing Schedule D – Part 1 to determine whether all bonds with an NAIC designation of 6—bonds in or near default—have been valued at the lower of cost or fair value and all other bonds have been valued at amortized cost value in accordance with the NAIC Accounting Practices and Procedures Manual (AP&P Manual). The analyst should also consider reviewing Schedule D – Part 2 to determine whether sinking fund preferred stocks have been valued at cost and all other stocks have been valued at fair value in accordance with the AP&P Manual. For those securities listed in Schedule D – Part 1 (Bonds) or Schedule D – Part 2 (Preferred Stocks and Common Stocks) with a “Z” suffix after the NAIC designation, the analyst might request verification from the insurer that the securities are filing exempt or have been submitted to, and subsequently valued by, the SVO and compare the price or designation subsequently received from the SVO to that included in the Annual Financial Statement for significant securities. The analyst should also consider using the Examination Jumpstart investment analysis tool (available on I-SITE) to compare the CUSIP number, NAIC designation, and fair value for each of the securities listed in Schedule D – Part 1 (Bonds), Schedule D – Part 2 (Preferred Stocks and Common Stocks), and Schedule DA (Short-Term Investments) to information on the SVO master file.

Procedure #4 assists the analyst in determining whether the statement value of bonds and sinking fund preferred stocks is significantly greater than fair value. General Interrogatory #30 shows the aggregate statement value and the aggregate fair value of bonds and preferred stocks owned and requires the insurer to indicate how the fair values were determined. If the statement value of bonds and sinking fund preferred stocks is significantly greater than fair value, the insurer could realize significant losses if it were forced to sell these investments to cover unexpected cash flow needs due to larger than anticipated policy surrenders or claims. In determining whether there is a concern regarding the excess of the statement value of bonds or sinking fund preferred stocks over fair value, the analyst should also consider the insurer’s interest maintenance reserve and the results of its cash flow testing.

Additional steps the analyst may perform are available if there are concerns regarding the significance of any excess of the book/adjusted carrying value over the fair value of bonds and sinking fund preferred stocks. The analyst should consider reviewing Schedule D – Part 1 (Bonds) and Schedule D – Part 2 (Preferred Stocks and Common Stocks) or requesting information from the insurer to determine which individual bonds and sinking fund preferred stocks have a book/adjusted carrying value significantly in excess of fair value. The analyst should be aware that the value for those securities with an “AV” (amortized value) designation in the rate used to obtain the value column in Schedule D does not represent a true fair value for the securities. For those securities with a book/adjusted carrying value significantly in excess of fair market value, the analyst might consider verifying the NAIC designation assigned and determine whether it has recently been reviewed by the SVO, determine the current rating by a Credit Rating Provider (CRP), and evaluate whether there has been an other-than-temporary decline in fair value. For bonds and sinking fund preferred stocks with other-than-temporary declines, the analyst should consider whether the investment should be written down to its fair value to properly reflect the value of the investment. If the insurer has experienced negative cash flows or has other liquidity
problems, the analyst should consider requesting information from the insurer regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

Procedure #5 assists the analyst in determining whether the cost of common stocks is significantly greater than fair value. Schedule D – Part 2 – Section 2 shows the insurer’s common stock portfolio and indicates the cost and fair value of each issue. If the cost of common stocks is significantly greater than the fair value, the insurer could realize significant losses if it were forced to sell these investments to cover unexpected cash flow needs. Furthermore, increases and decreases in net unrealized gains/losses impact capital and surplus. If the stock market declines significantly, the cost of common stocks could be significantly greater than the fair value, and the insurer’s capital and surplus could be significantly impacted. In determining whether there is a concern regarding the excess of the cost of common stocks over fair value, the analyst should also consider the insurer’s asset valuation reserve and more specifically, the equity component of this reserve.

Additional steps the analyst may perform are available if there are concerns regarding the significance of any excess of cost over fair value of common stocks owned. The analyst should consider reviewing Schedule D – Part 2 – Section 2 to determine which individual common stocks have a cost significantly in excess of fair value. The analyst should also determine whether the stock is listed on a national exchange and verify the price per stock and the total fair value listed in the statement. If the NAIC designation of the stock is “A” (unit price of the share of common stock is determined analytically by the SVO), review the date that the price per share was last analyzed by the SVO. The analyst should also consider whether the common stock has had an other-than-temporary decline in its value. The analyst should consider requesting the Audited Financial Statement and other documents necessary to support the value of the common stock. The analyst should also consider requesting information from the insurer regarding investment strategies and short-term cash flow needs.

Procedure #6 assists the analyst in determining whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year. The analyst can identify significant purchases or sales of securities by reviewing Schedule D – Part 3 (Long-Term Bonds and Stocks Acquired During Current Year), Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year). If significant purchases or sales of securities occurred near the beginning and/or end of the year, the insurer might have “rented securities” or engaged in “window dressing” of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring the same or similar lower quality investments after year-end) in an attempt to avoid asset valuation reserve (AVR) and other penalties and additional regulatory scrutiny which would have occurred with the insurer’s lower-rated investment portfolio.

Additional steps the analyst may perform are available if there are concerns regarding significant purchases or sales of securities near the beginning and/or end of the year. The analyst should consider reviewing Schedule D – Part 3 (Long-Term Bonds and Stocks Acquired During Current Year), Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the types of securities purchased and sold at or near the beginning and the end of the year, the vendors used for investment purchases, and the purchasers of investments sold.

Procedure #7 assists the analyst in determining whether concerns exist due to the level of investment turnover. The analyst can identify significant turnover by reviewing Schedule D – Part 4 (Long-Term
Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year). The turnover ratio represents the degree of trading activity in long-term bonds, preferred and common stock investments that has occurred during the year. Investment turnover is an indication of whether a buy-and-hold or sell based on short-term fluctuation strategy is utilized. A high turnover of investments generally leads to greater transaction costs, operating expenses and the acceleration of realized capital gains. Sales result from securities reaching a price objective, anticipated changes in interest rates, changes in credit worthiness of insurers or general financial or market developments.

Additional steps the analyst may perform are available if there are concerns regarding investment turnover. The analyst should consider reviewing Schedule D – Part 3 (Long-Term Bonds and Stocks Acquired During the Current Year), Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the types of securities purchased and sold. This information can assist the analyst in determining the types of securities sold and acquired, as well as the length of time each security was held and the quality of the security. The analyst should also review realized capital gains from the sale of securities to determine any reliance on these gains. The analyst should also consider having a specialist review the insurer’s investment program. The analyst should also review the Statement of Actuarial Opinion to determine whether any concerns about investment turnover are noted.

Procedures #8-14 assist the analyst in determining whether concerns exist regarding the level of investment in certain types of investments which tend to be riskier and/or less liquid than publicly traded bonds and stocks and cash and short-term investments. In addition to the steps for the types of investments included in procedures #8 through 14, the analyst should review procedures #3 and 4 in the Affiliated Transactions section of the Level 2 Annual Procedures regarding investments in affiliates.

Additional steps the analyst may perform are available if there are concerns regarding the level of investment in certain types of investments which tend to be riskier and/or less liquid than publicly traded bonds and stocks and cash and short-term investments. In addition to the steps for the types of investments included in supplementary procedures #8-14, the analyst should consider reviewing Procedures #3 and #4 in the Affiliated Transactions section of the Level 2 Annual Procedures and the additional Level 2 procedure for Affiliated Transactions for procedures regarding investments in affiliates.

Procedure #8 assists the analyst in determining whether concerns exist due to the level of investment in noninvestment-grade bonds. Bonds which have NAIC designations of 3, 4, 5, or 6 are considered noninvestment-grade bonds and represent a significantly higher credit or default risk to the insurer than do investments in investment-grade bonds. In addition, the prices of noninvestment-grade bonds are frequently more volatile than the prices of investment-grade bonds. The NAIC has adopted the Investments in Medium and Lower Grade Obligations Model Regulation (#340). This model regulation establishes limitations on the concentration of noninvestment-grade bonds, because of concerns that changes in economic conditions and other market variables could adversely affect insurers having a high concentration of these types of bonds.

Additional steps the analyst may perform are available if there are concerns regarding the level of investment in noninvestment-grade bonds. The analyst should consider reviewing Schedule D – Part 1A – Section 1 (Quality and Maturity Distribution of all Bonds Owned) and compare the insurer’s holdings of noninvestment-grade bonds to the limitations included in Model #340 by NAIC designation. The insurer should have a plan for investing in noninvestment-grade bonds that has guidelines for the quality of issues.
invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location. The analyst might consider requesting a copy of this plan from the insurer to determine whether the insurer appears to be adhering to its plan for investing in noninvestment-grade bonds. For the more significant noninvestment-grade bonds, the analyst might also consider requesting from the insurer audited financial statements and a rating agency report for the issuer of the bonds to assess the issuer’s current financial position and ability to repay its debt.

Procedure #9 assists the analyst in determining whether concerns exist due to the level of investment in RMBS, CMBS and LBaSS. Of the structured securities, RMBS are generally the most complex and volatile. RMBS convert a pool of mortgage loans into a series of securities that have expected maturities which vary significantly from the underlying pool as a result of slicing the pool into numerous tranches with different repayment characteristics. RMBS are either issued or backed by the U.S. government, carry very little credit risk and are commonly stated at par value. As a result, many RMBS have been designated category 1 by the SVO. However, the credit rating does not consider the prepayment or interest rate risk inherent in the RMBS investment. If the underlying mortgage loans are repaid by the borrowers faster or slower than anticipated, the RMBS repayment streams will be affected and the expected durations will either contract or extend. Thus, the cash flows on these investments are much more unpredictable than those for more traditional bonds and for mortgage pass-through certificates. If the RMBS prepayments are significantly faster than anticipated, and the insurer had paid a large premium for the RMBS when it was acquired, the insurer could experience a significant loss on the investment even though the par value was received. In addition, cash flows on RMBS are harder to match with corresponding payments on policy liabilities which leads to the risk that prepayments may not be able to be reinvested in investments earning comparable yields in order to support the liability payment streams.

Additional steps the analyst may perform are available if there are concerns regarding the level of investment in RMBS. The analyst should consider reviewing the RMBS, CMBS and LBaSS securities categories in Schedule D – Part 1 for bonds with a book/adjusted carrying value significantly in excess of par value, which could result in a loss being realized if bond prepayments occur faster than anticipated. The analyst should also consider reviewing a listing of the effective yield on each of the insurer’s RMBS, CMBS and LBaSS securities. The effective yield on most debt securities is generally linked to its credit risk and duration. However, significant prepayment risk can also increase the effective yield.

There are many different types of RMBS, each of which have different characteristics and inherent risks. Therefore, the analyst might consider requesting information from the insurer regarding the amount of each type held (e.g., planned amortization class (PAC), support bonds, interest only (IO), and principal only (PO)) to help evaluate the riskiness of the portfolio.

The analyst might consider requesting information from the insurer regarding estimated prepayment speeds on its RMBS. Several standardized forms of calculating the rate of prepayments of a mortgage security exist in the market. The constant prepayment rate (CPR) and the standard prepayment model of the Bond Market Association (PSA curve) are the most common methods used to measure prepayments. The analyst should consider further analysis in those instances that prepayment risk appears high.

This additional analysis might include a review of the insurer’s life risk-based capital (RBC) formula or its Statement of Actuarial Opinion. The life RBC formula includes a C-3 Interest Rate Risk Component that charges insurer’s for securities that have not been cash flow tested. The insurer is charged 0.5 times the excess of the statement value over the value of the security if all of the collateral was immediately repaid. Alternatively, or in addition to this procedure, the Statement of Actuarial Opinion should be reviewed for comments regarding the modeling of the RMBS portfolio in the cash flow testing performed.
The analyst might also consider having the RMBSs modeled by an independent actuary as a part of an independent cash flow analysis.

The rationale behind parts f, g and h of the procedure is to provide the analyst with some insight regarding the level of prepayment risk the insurer holds in its RMBS portfolio and the measurement and monitoring tools the insurer uses to manage this risk. Parts f and g ask the insurer to break down its RMBS portfolio by general definitional classes, each of which has its own relative level of prepayment and cash flow volatility risk. Individual insurers may use different measures and monitoring techniques. If an insurance company cannot supply this data with reasonable ease, the analyst may want to look more closely at the management and monitoring systems in place for the RMBS portfolio.

Procedure #10 assists the analyst in determining whether concerns exist due to the level of investment in private placement bonds. Significant investments in privately-placed bonds may cause the analyst to have concerns regarding the insurer’s liquidity because many of these types of investments cannot be resold, while those that can be resold frequently have restrictions on who they can be sold to. There is no structured market for privately-placed bonds like there is for publicly-traded bonds. Therefore, even if the privately-placed bonds can be sold, it may be difficult to find a willing buyer. Insurance companies commonly purchase these debt obligations in order to avoid the uncertainties of the market, to engage in private negotiations, and to avoid U.S. Securities and Exchange Commission (SEC) restrictions.

The analyst may perform additional steps if there are concerns regarding the level of investment in private placement bonds. The analyst should consider reviewing Schedule D – Part 1A – Section 1 (Quality and Maturity Distribution of all Bonds Owned) to determine the amount, issue type, NAIC designations, maturity distribution of privately-placed bonds owned, and the amount of privately placed bonds that are freely tradeable under SEC Rule 144 or qualified for resale under SEC Rule 144A. For the more significant privately placed bonds, the analyst should also consider requesting from the insurer current audited financial information regarding the issuer to evaluate the issuer’s financial position and ability to repay its debt.

Procedure #11 assists the analyst in determining whether concerns exist due to the level of structured notes held by the insurer. If the amount is material as compared to the insurer’s capital and surplus plus AVR, the analyst should consider steps to gain a better understanding of the prospective risks of these investments and the insurer’s level of investment expertise regarding these types of notes.

The analyst should refer to the FAQ guidance of the Blanks (E) Working Group at the following link, www.naic.org/documents/committees_e_app_blanks_related_structured_notes_faq.pdf for the definition of structured notes and information about different types of structured notes.

Structured notes are issuer bonds where the cash flows are based upon a referenced asset and not the issuer credit. These Notes differ from structured securities in that they do not have a related trust and, as such, are not valued in accordance with SSAP 43R, but instead are valued in accordance with SSAP 26. Mortgage referenced securities are examples of these structured notes and most recently this type of security has been issued by the Federal Home Loan Mortgage Corporation (FHLMC) (e.g., Structured Agency Credit Risk or STACR) and the Federal National Mortgage Association (FNMA). These mortgage referenced securities are not filing exempt (FE) and the Structured Security Group (SSG) assigns their NAIC designation based upon modeling assumptions; although other structured securities still are FE. If an insurer has a material amount of structured notes, the analyst should, through discussion with the insurer, determine whether management has adequately reviewed the insurer’s structured note portfolio and understands the underlying yields, cash flows and volatility. The analyst should consider the following risks related to structured notes: collateral type concentration, subordination in the overall structure of the transactions, and trend analysis of underlying assets to ensure appropriate valuation. The
analyst should assess if the notes are valued appropriately so as to ensure the insurer is not undercapitalized. The analyst should also refer to any recent examination findings. The procedures also instruct the analyst to inquire of the insurer on such items as the structured note’s use, valuation, the insurer’s level of expertise with this type of security and controls the insurer has implemented to mitigate this risk.

*Procedure #12* assists the analyst in determining whether concerns exist due to the level or quality of investment in real estate and mortgage loans. These investments are less liquid than many other types of investments. In addition, the analyst may also have concerns regarding the fair value of the real estate, whether it is the underlying investment or the collateral for a mortgage loan. Real estate in certain parts of the country has experienced significant declines in fair values from time to time. Most states restrict mortgage loan investments to first liens on property, with some states allowing second liens in instances where the insurer also owns the first lien. Second liens are more risky because, in the event of default, the holder of the first lien would be repaid out of any proceeds from the sale of the underlying property prior to the holder of the second lien.

The analyst may perform additional procedures if there are concerns regarding the level or quality of investment in real estate and mortgage loans. If there are concerns regarding real estate owned, the analyst should consider reviewing Schedule A – Part 1 (Real Estate Owned) to determine whether updated appraisals should be obtained for any of the properties owned, based on the location of the property, the book/adjusted carrying value and reported fair value of the property, and the year of the last appraisal. In addition, for those properties with book/adjusted carrying values in excess of fair value, the analyst might consider whether the asset should be written down. The analyst should also consider investigating any instances where a property has a book/adjusted carrying value in excess of its cost and requesting information from the insurer regarding any increases in book/adjusted carrying value during the year. If there are concerns regarding mortgage loans, the analyst should consider reviewing Schedule B (Mortgage Loan Owned) to determine the amount of each type of mortgage loan owned. Commercial mortgages have historically been riskier investments than farm mortgages and residential mortgages. The analyst might also consider comparing the book/adjusted carrying value of each loan to the value of the land and buildings mortgaged. The analyst should determine whether the mortgage loans are adequately collateralized and whether any of the mortgage loans are to officers, directors, or other affiliates of the insurer. For those loans that have had an increase in book/adjusted carrying value during the year, the analyst might consider requesting information from the insurer regarding the increase to determine whether the increase should be considered an admitted asset. In addition, for those loans with interest overdue or are in process of foreclosure, the analyst should consider reviewing the year of last appraisal of the underlying land and buildings to determine whether updated appraisals should be required. For both real estate and mortgage loans, the analyst should utilize postal code and property type information along with the city and state location information in Schedule A and B to identify geographic concentrations and to identify differences in volatility based on the property type and geographic location.

*Procedure #13* assists the analyst in determining whether concerns exist due to the level of investment in other invested assets (Schedule BA). The types of investments included in Schedule BA include collateral loans, joint ventures and partnerships, oil and gas production and mineral rights. Joint ventures and partnerships typically involve real estate. These types of assets also tend to be fairly illiquid and may contain significant credit risk.

The analyst may perform additional procedures if there are concerns regarding the level of investment in other invested assets (Schedule BA). The analyst should consider reviewing Schedule BA to determine the amount and types of other invested assets owned and to determine whether they are properly categorized as other invested assets. Information might be requested from the insurer to support any
increases by adjustment in book/adjusted carrying value during the year. In addition, the analyst should consider requesting current audited financial statements and other documents (e.g., partnership agreements, etc.) necessary to support the book/adjusted carrying value of the insurer’s investment in partnerships and joint ventures and information to support the book/adjusted carrying value of significant other invested assets (e.g., other than partnerships and joint ventures).

Procedure #14 assists the analyst in determining whether concerns exist due to the level of investment in collateral loans. The analyst should review Schedule BA (Other Invested Assets) and Schedule DA (Short-Term Investments). In most states, collateral loans are required to be secured or collateralized by assets which have a value in excess of the amount of the loan and which are considered admitted assets for an insurer. While the underlying collateral may be very liquid, the collateral loan itself is generally illiquid. In addition, the analyst may also have concerns regarding the quality or value of the underlying collateral for the loans.

The analyst may perform additional procedures if there are concerns regarding the level of investment in collateral loans. The analyst should consider reviewing Schedule BA (Other Invested Assets) and Schedule DA (Short-Term Investments) to determine whether the collateral for the loan is an acceptable asset and whether any of the collateral loans are to officers, directors, or other affiliates of the insurer. The analyst should also consider comparing the fair value of the collateral to the amount loaned to determine whether the loan is adequately collateralized. In those instances where the underlying collateral is comprised of securities, the analyst might consider verifying the rate used to obtain the fair value of the securities by referencing the Purposes and Procedures Manual of the NAIC Investment Analysis Office.

Procedure #15 assists the analyst in determining whether concerns exist due to the level of investment in derivative instruments. A derivative instrument is a financial market instrument which has a price, performance, value, or cash flow based primarily on the actual or expected price, performance, value, or cash flow of one or more underlying interests. Derivative instruments (which consist of options, caps, floors, collars, swaps, forwards, and futures) are used by some insurers to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to its assets, liabilities, or anticipated future cash flows. If an insurer invests in derivative instruments, it is important for the analyst to understand the impact that these derivative instruments have on the risk return profile of the insurer’s cash market investment portfolio under different scenarios. For insurers with significant investments in derivative investments, this will probably require the analyst to obtain the assistance of an actuary.

The analyst may perform additional procedures if there are concerns regarding the level of investment in derivative instruments. The analyst should consider obtaining a comprehensive description of the insurer’s hedge program in order to obtain an understanding of the insurer’s use of derivative instruments to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to the insurer’s assets, liabilities, or expected cash flows. The hedge program should be evaluated to determine whether it appears to result in hedges that are appropriate for the insurer, based on its assets, liabilities, and cash flow risks and whether the insurer appears to be adhering to the hedge program. For significant derivative instruments that are open at year-end, the analyst should consider requesting and reviewing a description of the methodology used by the insurer to verify the continued effectiveness of the hedge provided, a description of the methodology to determine the fair value of the derivative instrument, and a description of the determination of the derivative instrument’s book/adjusted carrying value, to determine whether the requirements of the NAIC AP&P Manual have been met. The analyst might also consider having the insurer’s derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.
Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for the investments section are designed to identify the following: 1) whether the insurer’s investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue, 2) whether the insurer has a significant portion of its assets invested, or has significantly increased its holdings since the prior year-end, in certain types of investments that tend to be riskier and/or less liquid than publicly-traded bonds and stocks and cash and short-term investments, 3) whether the insurer has significantly increased its holdings since the prior year-end in derivatives that tend to be riskier and/or less liquid than publicly traded bonds, stocks, cash and short-term investments, 4) whether any of the insurer’s assets have been loaned or otherwise made available for use by another person during the quarter, and 5) whether the insurer has complied with the requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office, which requires all securities to be valued in accordance with standards promulgated by the SVO.
Primer on Derivatives

Derivative instruments are financial instruments whose value and cash flows are based on other financial instruments, indices or statistics. Based on the current insurance regulatory framework, this definition is too broad. For example, some people call Collateralized Mortgage Obligations (CMOs), “mortgage-backed derivatives,” because the value and cash flows of a CMO are based on the value and cash flows of a pool of mortgages. For insurance regulatory purposes, only options, caps, floors, forwards, futures, swaps, collars and similar instruments are considered derivative instruments. The definitions of these instruments are contained in NAIC Accounting Practices and Procedures Manual (AP&P Manual).

This primer will concentrate on options, futures and swaps. It will describe the instruments from an operational standpoint and from a use standpoint. It will also discuss how derivative instruments are reported in statutory financial statements. Accounting will be discussed only in general terms. A discussion of accounting details is provided in SSAP No. 86—Accounting for Derivative Instruments and Hedging, Income Generation, and Replication (Synthetic Asset) Transactions.

Derivative Instrument Basics

Options

An option is an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate, or effect a cash settlement based on the actual or expected price level, performance or value of, one or more underlying interest. Underlying interest is the asset(s), liability(ies), or other interest(s) underlying a derivative instrument, including, but not limited to, any one or more securities, currencies, rates, indicies, commodities, derivative instruments, or other financial market instruments.

An insurer can either purchase an option or write (sell) an option. When an insurer buys an option, the insurer pays a premium for a right, but not an obligation, to exercise the option at a strike. When an insurer writes (sells) an option, the insurer receives a premium from the other party to the transaction (counterparty). The counterparty has the right, but not the obligation, to exercise the option at the strike. An example will help to illustrate these concepts.

Consider an insurance company that sells equity indexed annuities. The equity indexed annuity provides a floor guarantee as to interest with an additional guarantee that the policyholder will participate in the upside of an equity index if the growth in the equity index exceeds the guaranteed interest.

An insurer can purchase an option to hedge the equity risk in the annuity contract. The option purchased would be based on the same equity index as the annuity contract. The level of the strike in the option would be based on the amount determined by the guaranteed interest rate, the participation rate in the annuity contract, and any cap on index growth. If the index grew at a rate greater than the guaranteed interest rate in the annuity contract, the insurer would exercise the option to cover the equity indexed based obligation in the annuity contract. If the holder of the option does not exercise the option, the holder’s downside is limited to the initial premium paid for the option.

Futures

A futures contract is an agreement traded on an exchange, board of trade, or contract market, to make or take delivery of, or effect a cash settlement, based on the actual or expected price, level, performance, or value of one or more underlying interests.

Futures contracts are different from options in that an insurer entering a futures contract will participate in both gains and losses in the underlying financial instrument as measured from the date the futures contract is opened. For example, if an insurer takes a long position in U.S. Treasury futures, the insurer
will experience any gains or losses in the U.S. Treasury futures (the underlying) as measured from the
date of opening the position. If interest rates increase after the futures contract is opened, the U.S.
Treasuries will decrease in value and the insurer will have to make a payment to the counterparty. On the
other hand, if interest rates move down, the insurer will receive a payment from the counterparty. Since
the insurer shares in both the upside and downside of the futures contract, the insurer does not pay a
premium when entering a futures contract. If the futures contract is exchange traded, the insurer will
typically put up a deposit in cash or securities. This deposit is to protect the counterparty in the event the
insurer cannot make required payments.

Insurers exposed to interest rate risk can take short positions in U.S. Treasury futures contracts. In this
case, the insurer receives payments if interest rates increase and makes payments if interest rates decrease.
This is opposite of the situation when the insurer takes a long position. However, going short U.S.
Treasury futures can hedge the interest rate risk exposure on bonds that the insurer holds in its portfolio.
This is especially important for GAAP accounting purposes when bonds are reported on a fair value basis.

In the discussion above, taking a “long” position has the same financial characteristics as buying the
underlying instrument (in this case a bond). Taking a “short” position has the financial characteristics of
short selling the underlying instrument (in this case a bond).

Swaps
A swap contract is an agreement to exchange or net payments at one or more times based on the actual or
expected price, level, performance, or value of one or more underlying interests. A typical example is a
fixed or floating swap. An insurer can make payments to a counterparty based on a fixed rate, for example
6 percent, semi-annually and receive a floating London Inter Bank Offer Rate (LIBOR), for example, plus
a spread. Each six months, the insurer would pay the counterparty 3 percent times the notional amount,
$10,000,000 for example, and would receive an amount equal to $10,000,000 times the then current
LIBOR rate plus a spread. Of course, the amounts are netted so that a single payment is made by one
party to the other party. Depending on the LIBOR rate at any payment determination date, the insurer
may be making or receiving a payment. In swap transactions, the rates and spread are set so that neither
party pays an up-front premium to open the transaction. Also, the notional amount is never exchanged.

The floating rate of a swap transaction can be based on a multitude of different financial indices or rates.
For example, in a credit swap transaction, the floating rate can be based on the total rate of return of a
junk bond portfolio. In effect, the party that is paying the fixed rate can be exposed to junk bond market
risk through a transaction of this type.

Caps/Floors
A cap is an agreement obligating the seller to make payments to the buyer. Each payment is based on the
amount, if any, that a reference price, level, performance, or value of one or more underlying interests
exceed a predetermined number, sometimes called the stihe/cap rate or price. A floor is an agreement
obligating the seller to make payments to the buyer. Each payment is based on the amount, if any, that a
predetermined number, sometimes called the strike/floor rate or price, exceeds a reference price, level,
performance, or value of one or more underlying interests. Caps and floors are similar to options in that
one party, the purchaser of the instrument, pays a premium and receives a payment from the other party if
an index exceeds the “cap” or falls below the “floor”, a specified value, or “strike”. An insurer might
purchase a floor to protect itself against interest rates falling below the guarantees in the annuity contracts
it has sold. An insurer can either buy or write (sell) caps or floors.
Collars
A collar is an agreement to receive payments as the buyer of an option, cap, or floor and to make payments as the seller of a different option, cap, or floor. An insurer could buy a collar that includes the purchase of a cap and the sale of a floor. In effect, the insurer is protecting itself against an increase in interest rates and paying for the protection by selling the floor.

Forwards
A forward is an agreement (other than futures) to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests. It is an over-the-counter transaction as opposed to traded on an exchange, which makes it less liquid. It is customized to meet the needs of both parties whereas contracts traded on an exchange are standardized.

Warrants
A warrant is an agreement that gives the holder the right to purchase an underlying financial instrument at a given price and time (or at a series of prices and times) according to a schedule or warrant agreement.

Uses of Derivative Instruments
Besides analyzing derivative instruments from an operational standpoint, they can be analyzed by their use. From an insurance regulatory perspective, derivative instruments can be used in four ways: hedging, income generation, replication of other assets, and speculation. Rules concerning and income generation transactions are included in the NAIC Investments of Insurers Model Act (Defined Limits Version) (#280) and the AP&P Manual (SSAP No. 86).

Hedging
For a derivative instrument to qualify for hedge accounting, the item to be hedged must expose the company to a risk and the designated derivative transaction must reduce that exposure. Examples include the risk of a change in the value, yield, price, cash flow, quantity of, or degree of exposure with respect to assets, liabilities, or future cash flows which an insurer has acquired or incurred, or anticipates acquiring or incurring.

Some insurance companies that sell Guaranteed Investment Contracts (GICs) guarantee to the GIC contract holders an interest rate on future contributions for a specified period of time. The risk associated with this type of guarantee is that interest rates may drop before the GIC contract holder makes an additional contribution. The insurer can hedge this risk by using futures contracts.

Income Generation
Income generation transactions are defined as derivatives written or sold to generate additional income or return to the insurer. They include covered options, caps, and floors (e.g., an insurer writes an equity call option on stock which it already owns).

Because these transactions require writing derivatives, they expose the insurer to potential future liabilities for which the insurer receives a premium up front. Because of this risk, dollar limitation and additional constraints are imposed requiring that the transactions be “covered” (e.g., offsetting assets can be used to fulfill potential obligations). To this extent, the combination of the derivative and the covering asset works like a reverse hedge where an asset owned by the insurer in essence hedges the derivative risk.
An example is the writing (selling) of call options that are covered. Covering the call option means that the insurer writing (selling) the options owns the financial instruments or the rights to the financial instrument that can be called by the option holder. The insurer writing (selling) the option earns a profit (the premium) if the option is not exercised by the other party. If the option is exercised, the financial instrument subject to call is paid to the holder of the option. From a risk/return standpoint, writing a covered call generates income in the same way that a callable bond does as compared to a non-callable bond.

As with derivatives in general, these instruments include a wide variety of terms regarding maturities, range of exercise periods and prices, counterparties, underlying instruments, etc.

**Replication**

The basic idea behind replication transactions is to combine the cash flows from a derivative instrument and another financial instrument to replicate the cash flows of another financial instrument. The following is a typical example of a replication transaction: the insurer holds a high quality corporate bond that pays one 7 percent coupon per year. The insurer can enter into a swap transaction with another party in which the insurer receives 2 percent of the notional amount of the swap each year and, in turn, pays the counterparty the drop in fair value of a specific junk bond that would result if the junk bond would default. The insurer does not own the junk bond, but the combined cash flows of the high-grade corporate bond and the swap transaction replicate the cash flows of a junk bond.

**Reporting of Derivative Instruments**

On an annual basis, derivative instruments are reported in Schedule DB of the statutory financial statement. Options, caps, floors, collars, swaps and forwards are reported in Part A. Future contracts are reported in Part B, replications are reported in Part C, and counterparty exposure for derivatives instruments are reported in Part D.

Schedule DB, parts A and B contain two sections: 1) Section 1 identifies the contracts open as of the accounting date, and 2) Section 2 identifies contracts terminated during the year.

Schedule DB – Part C – Section 1 contains the underlying detail of replicated assets owned at the end of the year. Schedule DB – Part C – Section 2 is a reconciliation between years of replicated assets. The assumption underlying the NAIC RBC formula, that all derivative instruments are used for hedging purposes, is a central issue the NAIC is exploring in its revised disclosure in Schedule DB, and one that is being researched further.

Schedule DB – Part D – Section 1 of the annual statement is different. It collects information necessary for risk-based capital (RBC) purposes. Currently, the NAIC RBC formula assumes that all derivative instruments are used for hedging purposes and the only risk exposure to the insurer is that the counterparty may not perform according to the terms of the contract. The concepts of Potential Exposure and Off-Balance Sheet Exposure have been defined to quantify the risk of non-performance by the counterparty. The definition of these concepts is contained in the Blanks Instructions.

On a quarterly basis, the insurer only reports derivative instruments that are open as of the current statement date. Schedule DB – Part A – Section 1 lists the insurer’s open options, caps, floors, collars, swaps and forwards. Open futures are reported in Schedule DB – Part B – Section 1, replications are reported in Schedule DB – Part C – Section 1, and counterparty exposure for derivatives instruments are reported in Schedule DB – Part D.

**Accounting**

Statutory accounting guidance for derivative instruments used for hedging and income generation transactions is contained in the AP&P Manual. Beginning in 2003, accounting guidance for derivative transactions will vary based on the transaction or modification date of the transaction. For derivative transactions effective Jan. 1, 2003 and after, SSAP No. 86 will apply. The insurer is to disclose the transition approach that is being used. In order for a derivative instrument to qualify for hedge accounting treatment, the item to be hedged must expose the insurer to a risk and the designated derivative transaction must reduce that exposure.

An insurer should set specific criteria at the inception of the hedge as to what will be considered “effective” in measuring the hedge and then apply those criteria in the ongoing assessment based on actual hedge results. The penalty for failure to meet the effectiveness criteria varies from state to state.

The NAIC accounting guidance includes a discussion of required documentation. One item that is not mentioned is the “term sheet.” The term sheet is a document signed by both parties to an over-the-counter derivative transaction such as a swap. The term sheet contains a detailed description of all of the terms and conditions of the swap transaction.

In many cases, an insurer will enter into several over-the-counter transactions with a single party. In this situation, the insurer should have entered into a master netting agreement. The existence of such an agreement has implications for risk-based capital.

**Comprehensive Description of a Hedging Program**

When an insurer is actively engaged in derivative activity or when concerns exist regarding an insurer’s derivative activity, it may be necessary to obtain a comprehensive description of the insurer’s derivative program, a procedure included in the Level 2 Procedures.

States may have specific requirements for items to be included in a comprehensive description of an insurer’s derivative program. Items may include detailed information on the following:

- Authorization by the insurer’s board of directors, or other similar body to engage in derivative activity.
- Management oversight standards including risk limits, controls, internal audit, review and monitoring processes.
- The adequacy of professional personnel, technical expertise and systems.
- The review and legal enforceability of derivative contracts between parties.
- Internal controls, documentation and reporting requirements for each derivative transaction.
- The purpose and details of the transaction including the assets or liabilities to which the transaction relates, specific derivative instrument used, the name of the counterparty and counterparty exposure amount, or the name of the exchange and the name of the firm handling the trade.
- Management’s written guidelines for engaging in derivative transactions, for example:
  - Type, maturity, and diversification of derivative instruments.
  - Limitations on counterparty exposures.
  - Limitations based on credit ratings.

- Limitations on the use of derivatives.
- Asset and liability management practices.
- The liquidity and capital and surplus needs of the insurer as it relates to derivative activity.

• The relationship of the hedging strategies to the insurer’s operations and risks.
• Guidelines for the insurer’s determination of acceptable levels of basis risk, credit risk, foreign currency risk, interest rate risk, market risk, operational risk, and option risk.
• Guidelines that the board of directors and senior management comply with risk oversight functions and adhere to laws, rules, regulations, prescribed practices, or ethical standards.
III. Annual Procedures – C.2. Level 2 Life Reserves (Life/A&H)

1. Determine whether the insurer’s life reserves are valued in accordance with the minimum formula statutory valuation standards.
   a. Review the results of the Actuarial Opinion Procedures. Were any concerns noted regarding the valuation of the insurer’s life reserves in accordance with minimum formula statutory valuation standards?
   b. Review the Notes to Financial Statements, Note #31-Reserves for Life Contracts and Annuity Contracts. Are any unusual items noted regarding the valuation of life reserves?

   Additional procedures and prospective risk considerations if further concerns exist:
   c. Contact the qualified actuary to discuss the nature and scope of the life reserve valuation procedures performed.
   d. Review the insurer’s life insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits.
   e. Request that the field examination staff request a valuation listing by plan and issue year, and test a sample of individual policy reserves from each of the major life insurance plans for accuracy.
   f. Contact the policy forms section of the insurance department and inquire as to whether the insurer filed any new and unusual policy forms during the past twelve months.
   g. Contact the insurance department’s actuary for assistance in completing the analysis.

2. Determine whether any changes in life and annuity reserve valuation bases during the year were proper.
   a. Review Exhibit 5A – Changes in Bases of Valuation During the Year. Has there been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in capital and surplus greater than 5 percent of current year capital and surplus?
   b. Did changes in life and annuity reserve valuation bases receive appropriate regulatory approval, if required?

   Additional procedures and prospective risk considerations if further concerns exist:
   c. Review the specific changes in valuation bases noted in Exhibit 5A (Changes in Bases of Valuation During the Year) and determine that individual changes in specific mortality tables, interest rates, or valuation methods meet the minimum statutory valuation standards.
   d. Test check the calculations involved in applying a change in valuation basis.

3. Determine whether the insurer’s underlying assets are adequate to support the future obligations of its life insurance policies.
   a. If the insurer filed a statement of actuarial opinion based on an asset adequacy analysis, review the results of the Actuarial Opinion Procedures. Were any concerns noted regarding the adequacy of the insurer’s underlying assets to support future life insurance policy obligations?
   b. Is the net interest spread on life reserves (net investment income, less tabular interest, divided by average life reserves) less than 2 percent?
c. If available, review the Regulatory Asset Adequacy Issues Summary (RAAIS). Were the responses to the questions satisfactory?

d. Is the Change in Asset Mix (IRIS Ratio 11) greater than 5 percent?

Additional procedures and prospective risk considerations if further concerns exist:

e. Request a copy of the Statement of Actuarial Opinion and review the actuary’s comments regarding the analysis performed and conclusions reached.

f. Conduct an independent asset adequacy analysis.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding life reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating life reserves 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 examination section for targeted examination
- Engage an independent actuary to conduct a valuation of life reserves
- Engage an independent actuary to conduct an asset adequacy analysis
- 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 ________
III. Quarterly Procedures – C.2. Level 2 Life Reserves (Life/A&H)

1. If the aggregate reserve for life contracts exceeds 10 percent of capital and surplus, has such reserve changed by greater than +/-25 percent from the prior year-end?

2. Review the “Mix of Cash & Invested Assets” section of the Quarterly Financial Profile report. Have there been significant shifts (greater than +/-25 points) in any asset categories from the prior year-end?

3. Review, by line of business, the year-to-date direct premiums for the current and prior year in Exhibit 1 – Direct Premiums and Deposit-Type Contracts (lines 1, 2, 4, 5 and 10). Have direct premiums for any line of business changed by greater than +/-25 percent from the prior year, same quarter?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the Annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

Life insurance reserves represent the liability established by the insurer to pay future policy benefits such as a death benefit (payable if the insured dies within a specific period of time), an endowment benefit (if the policy is an endowment policy and is continued until the maturity date), and a cash surrender value upon policy surrender. Theoretically, life reserves represent the present value of future guaranteed benefits reduced by the present value of expected future net premiums. The insurance policy is a unilateral contract whereby the insured can cancel the agreement to pay premiums at any time. However, the insurer is “locked in” regardless of future experience and cannot forfeit on its guarantees as long as the premiums are paid. Life reserves are required in order to ensure that commitments made to policyholders and their beneficiaries will be met, even though the obligations may not be due for many years. Since the primary purpose of life reserves is to pay claims when they become due, life reserves must be adequate and the funds must be safely invested.

The NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) prescribes the minimum standards to be used in determining reserves. Appendix A-820, *Minimum Life & Annuity Reserve Standards*, of the AP&P Manual defines the minimum standards for all types of policy reserves, including life & annuity policies. Insurers may establish life reserves, which equal or exceed these minimum standards. These minimum life reserve standards specify: 1) a given mortality table; 2) a maximum rate of interest; and 3) a valuation method. The valuation method used to define minimum life reserves for statutory accounting purposes is referred to as the Commissioners Reserve Valuation Method (CRVM). The mortality rate assumptions are substantially higher than what the insurer can expect to realize from medically underwritten insurance policies. The interest rate assumptions are intended to be significantly lower than current money and capital market yields. Thus, the life reserves developed are generally conservative.

There are three general valuation methods used to value life reserves. The net level premium method does not provide for a first-year acquisition cost allowance in determining life reserves. Therefore, this method results in the most conservative, or highest, life reserve valuation of the three methods. The preliminary term method is the CRVM method. This method permits a first-year expense allowance and then assumes that the remaining premium stream is used to cover policy benefits. This method allows for a lower life reserve valuation than the net level premium method in the earlier years of the policy term. The modified preliminary term method is a variation of the two methods described above and results in a reserve valuation between the net level premium and preliminary term methods.

As described below, the type of life insurance policy dictates the amount of the life reserve that must be established and the duration for maintaining the reserve. In addition, special situations arise which require unique reserving techniques. The following summarizes the major types of life insurance policies, and the related reserving implications:

1. **Ordinary Life Reserves**

   Under a whole life plan of insurance, the insurer is obligated to maintain a reserve until the death of the insured. Term life insurance provides coverage only for the period that is specified in the policy. Under a term insurance plan, the insurer must maintain a reserve, which reduces to zero upon expiration of the term period. Similar to term insurance, endowment life insurance provides coverage for a period specified in the policies. Unlike term insurance, the proceeds of endowment insurance are payable if the insured lives to the end of the period. Policies, which permit flexible premium payments, are referred to as “universal life” policies and those with fixed premiums are referred to as “interest sensitive” policies. Universal life policies are accumulation type policies where the current account value is determined based upon the accumulation of premiums less mortality charges and expense charges, plus a current interest rate credit. The account value less
surrender charges is the cash value. Because of the unique features of universal life and interest sensitive types of policies, unique reserving requirements are specified for them in Appendix A-585, *Universal Life Insurance*, of the AP&P Manual. The minimum standard for universal life reserves consider guarantees within the policy at the time of issue, present value of future guaranteed benefits, account value and cash value.

2. **Group Life Reserves**

Most group life insurance is monthly renewable term insurance. For these policies, gross premiums are typically recalculated periodically, most often annually, using the age and sex census of the group along with experience adjustments. Therefore, the reserve is usually calculated as the unearned premiums or a percentage thereof to estimate the claim exposure. However, some group life insurance policies provide permanent or longer term benefits analogous to individual coverages. In these cases, the reserving methods are similar to those employed for individual insurance, using appropriate mortality tables. Appendix A-820 does not specify a mortality table for group life insurance but leaves that to the discretion and approval of the domiciliary state.

3. **Industrial Life Reserves**

Industrial life insurance is unique in that it involves higher unit premiums, smaller face amount policies and higher mortality expectations. The minimum standards for reserves are the same as the traditional life insurance except that a unique mortality table is used.

4. **Life Reserves Relating to Riders**

Life insurance policies frequently include riders for additional benefits such as accidental death and disability. The minimum valuation standards for reserves are the same as for the base life insurance except that specialized mortality tables are used and the net level premium valuation method is required.

5. **Miscellaneous Life Reserves**

There are various other special situations involving life reserves. First, a deficiency reserve may be required in situations where the actual policy premium is less than the net level premium valuation. This situation occurs when pricing assumptions are used that are different from the minimum reserve valuation standards. This does not necessarily indicate that the policy is being sold at a loss by the insurer, but rather is a reflection of the highly conservative nature of the minimum reserve valuation standards. Second, there may be unusual situations where the cash surrender value of a life insurance policy is greater than the minimum reserve standard. In these situations, life reserves must be increased by the amount of this excess. Finally, as a result of the asset adequacy analysis conducted by the qualified actuary, the actuary may conclude that the insurer’s assets are not adequate to cover future reserves. When this occurs, reserves must be increased by the estimated deficiency resulting from asset adequacy testing.

Due to the complexity in determining life reserves, insurers must rely on actuaries to assist with valuation of these reserves. Insurers are required to annually obtain an opinion regarding the reasonableness of the reserves by a qualified actuary. In the aggregate, policy reserves for all life insurance policies that are reported in the statutory financial statements must equal or exceed reserves calculated by using the assumptions and methods that produce the minimum formula standard valuation.
Discussion of the Level 2 Annual Procedures

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. The analyst should also consider the insurer’s corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. While the underlying actuarial techniques relating to life reserves are quite complicated, the analyst should remember that there are two basic objectives regarding life reserves. The first objective is that the insurer’s life reserves are accurately calculated in accordance with the minimum formula statutory valuation standards, and the second objective is that the insurer’s assets are adequate to support the future policy obligations. Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst.

Procedure #1 assists the analyst in determining whether the insurer’s life reserves are valued in accordance with the minimum formula statutory valuation standards. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary.

Procedure #2 assists the analyst in determining whether any changes in life reserve valuation bases during the year were proper. From time to time, an insurer may decide to change the valuation basis for a particular segment of the business. The insurer may change the mortality table used, the rate of interest or the valuation method. Reserve strengthening occurs when the insurer substitutes a more conservative basis of valuation for any given block of business. Reserve weakening may also occur but normally requires approval of the domiciliary state.

Additional steps the analyst may perform if there are concerns regarding the valuation of life reserves or changes in valuation bases essentially involve testing the actual reserve calculations for a sampling of individual life insurance policies to ensure that the minimum statutory valuation standards have been met.

Procedure #3 assists the analyst in determining whether the insurer’s underlying assets are adequate to support the future obligations of its life insurance policies. If the insurer filed a Statement of Actuarial Opinion based on an asset adequacy analysis, then the Statement of Actuarial Opinion itself, and the supporting actuarial memorandum, if requested, can provide the analyst with comfort in this regard. If a Statement of Actuarial Opinion that does not include an asset adequacy analysis is filed, the analyst can review net interest spread ratios for insights regarding the relationship of investment income with tabular interest.

Additional steps the analyst may perform if there are concerns as to the adequacy of the insurer’s underlying assets to support life reserves include a review of the actuarial memorandum, if available. This will provide the analyst with substantial analyses with regard to asset adequacy. If an actuarial memorandum is not available, the analyst should consider the need to have an independent asset adequacy analysis conducted.

Discussion of the Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are intended to identify significant changes in life reserves that have occurred since the prior year Annual Financial Statement, or the prior Quarterly Financial Statement.
III. Annual Procedures – C.3. Level 2 Accident and Health Reserves (Life/A&H)

1. Determine whether an understatement of A&H reserves would be significant.
   a. For non-life insurers, is the ratio of gross A&H reserves to capital and surplus greater than 300 percent?
   b. Is the ratio of net A&H reserves to capital and surplus greater than 150 percent?

2. Determine whether A&H policies appear to have been adequately reserved.
   a. Review the results of the Actuarial Opinion Procedures. Were any concerns noted regarding the valuation of the insurer’s A&H reserves in accordance with minimum statutory valuation standards?
   b. For non-life insurers:
      i. Is the ratio of A&H reserve deficiency greater than 5 percent?
      ii. Review the Schedule H claims test. Has there been an adverse trend or unusual fluctuation of one-year A&H loss development during the past five years?
      iii. Provide an explanation for any adverse loss development results.
   c. Has there been a significant point change in the A&H loss ratio from the prior year (+/- 20 points)?
   d. Review Exhibit 5A – Changes in Bases of Valuation During the Year. Has there been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in capital and surplus greater than 5 percent of current year capital and surplus?
   e. Review the Notes to Financial Statements, MD&A, or other correspondence with the insurer. Has the insurer initiated any internal changes that could impact the reserve estimates?

Additional procedures and prospective risk considerations if further concerns exist:
   f. Review Schedule H (Accident and Health Exhibit) and perform the following:
      i. Determine which A&H lines of business are being written by the insurer.
      ii. Review Part 3 (Test of Prior Year’s Claim Reserves and Liabilities) to determine which A&H lines of business had positive development during the year.
   g. Review the insurer’s A&H insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific features and benefits.
   h. Contact the policy forms section of the insurance department and inquire as to whether the insurer has filed any new and unusual A&H policy forms during the past year.
   i. Review the insurer’s description of the valuation standards used in calculating the additional contract reserves (which is required to be attached to and filed with the Annual Financial Statement) and consider whether the reserve basis, interest rates and methods appear reasonable.
   j. Request a copy of the qualified actuary’s Statement of Actuarial Opinion and review the actuary’s comments regarding the analysis performed and conclusions reached regarding A&H reserves.
   k. Contact the qualified actuary who signed the insurer’s Statement of Actuarial Opinion to discuss the nature and scope of the A&H reserve valuation procedures performed.
III. Annual Procedures – C.3. Level 2 Accident and Health Reserves (Life/A&H)

l. Contact the insurer to request if the insurer initiated any internal changes that could impact the reserve estimates.

m. Review the A&H loss percentage ratio for unusual fluctuations or trends between years.

n. Compare the A&H loss percentage ratio to the industry average to determine any significant deviations from the industry average.

o. Request that the field examination staff request a valuation listing of A&H policy reserves by policy and test a sample of policies to determine that the reserve factors used were appropriate and that the reserves were correctly computed.

p. Obtain information from the insurer regarding A&H claims paid after year-end that were incurred prior to year-end and test the reasonableness of the year-end claim liabilities established by the insurer.

q. Request an explanation from the insurer for any adverse loss development results or adverse trends indicated in the analyst’s review of the Schedule H claims test.

r. If there was a change in the valuation basis of the A&H policies during the year, consider performing the following:
   i. Obtain information regarding the reason for the change in valuation basis and support the change in the actuarial reserve as a result of the change in valuation basis.
   ii. Determine whether the change in valuation basis was approved by the domiciliary state insurance department, if required.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding A&H reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating A&H reserves 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 examination section for targeted examination
- Engage an independent actuary to review insurer’s A&H 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 ______
III. Quarterly Procedures – C.3. Level 2 Accident and Health Reserves (Life/A&H)

1. If aggregate reserve for A&H contracts exceeds 10 percent of capital and surplus, has such reserve changed by greater than +/-10 percent from the prior year-end?

2. If A&H policy and contract claims exceed 10 percent of capital and surplus, have such policy and contract claims changed by greater than +/-10 percent from the prior year-end?

3. If disability benefits and benefits under A&H contracts exceed 10 percent of capital and surplus, have such benefits changed by greater than +/-10 percent from the prior year, same quarter?

4. Is the ratio of aggregate reserve for A&H contracts to capital and surplus greater than 300 percent?

5. Review, by line of business, the year-to-date direct premiums for the current and prior year in Exhibit 1 – Direct Premiums and Deposit-Type Contracts (lines 7, 8, 9 and 10). Have direct premiums for any line of business changed by greater than +/-25 percent from the prior year, same quarter?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the Annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyzer ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

The purpose of accident and health (A&H) insurance is to protect the insured against economic losses resulting from accident and/or sickness. There are many different types of A&H policies issued by insurers. The economic losses covered, and the types of benefits provided, vary with the different types of A&H policies. For example, a medical insurance policy may provide reimbursement for hospital, surgical, medical and drug expenses and a dental insurance policy may cover dental expenses. Another type of A&H insurance policy issued is disability insurance which provides monthly benefits for loss of income due to disability on either a short-term or long-term basis. A&H insurance is provided through individual policies, group policies and certain special types of policies such as credit disability insurance.

A&H reserves are complex and difficult to analyze because of the wide variety of types of coverage included in the A&H lines of business and the diversity of benefits which must be reserved for. A&H reserves are comprised of two separate liability line items in the Annual Financial Statement: 1) the aggregate reserve for A&H policies and 2) the A&H policy and contract claims liability. These liabilities are discussed in more detail below.

1. Aggregate Reserve for A&H Policies

   The aggregate reserve for A&H policies consists of two different components: 1) policy reserves and 2) claim reserves.

   a. Policy Reserves

   Policy reserves are required in recognition of the fact that premiums cover future liabilities as well as current claims and expenses. Policy reserves include unearned premium reserves, additional contract and actuarial reserves, reserves for future contingent benefits, and reserves for rate credits. The various types of policy reserves are discussed in more detail below.

   Unearned premium reserves represent the amount of the premium applicable to coverage which extends beyond the valuation date (date of the statement). The unearned portion of the premium is generally computed on a pro rata basis.

   Additional contract reserves are required for those policies with level premiums where the risk of loss increases with the age of the insured. For these policies, the insurer is required to set aside a portion of the current premium to pay claims that experience indicates will be incurred as the policy continues in force. These reserves are actuarially determined and are similar in concept to life reserves with the added requirement to consider morbidity assumptions as well as mortality and interest assumptions. The NAIC Accounting Practices and Procedures Manual (AP&P Manual) prescribes the minimum standards used in determining the A&H policy reserves. Insurers may establish A&H policy reserves which equal or exceed these minimum standards. These minimum A&H policy reserve standards for most types of A&H insurance include: 1) a given morbidity table; 2) a maximum rate of interest; and 3) a valuation method. In no event, however, may the aggregate reserve for all policies be less than the unearned gross premiums under such policies. For financial statement purposes, the additional contract reserves represent the excess of the required A&H policy reserves over the unearned gross premiums on A&H policies. The insurer is required to attach to the Annual Financial Statement a description of the valuation standards used in calculating the additional contract reserves, specifying the reserve bases, interest rates and methods.
Determine if additional actuarial reserves are required as a result of actuarial cash flow testing and asset adequacy analysis (see Section IV.C.2. for a discussion of asset adequacy analysis).

If the A&H policy provides for future contingent benefits, a portion of the current premium must also be reserved for such coverage. For example, some A&H policies provide for deferred maternity benefits (which cover medical expenses incurred in childbirth for approximately nine months after the cessation of premium payments, even though the policy has been canceled, so long as conception occurred prior to the policy being canceled). An actuarially determined estimate of the costs associated with this future contingent benefit must be reserved for out of the current premium.

Some A&H policies provide for rate credits based on policy year experience. For these policies, a reserve is required to be established for the rate credits based on the amount of the expected credit as of the valuation date. The reserve for rate credits is a difficult liability to establish because many policy years do not end on the valuation date (date of the statement) and subsequent experience may cause the rate credit to be greater or less than the liability established. However, the liability established must be reasonable under the circumstances and consistently calculated.

b. **Claim Reserves**

Claim reserves (sometimes referred to as disabled life reserves) are required for claims which involve continuing loss. The claim reserves represent the actuarially determined present value of future benefits or future covered benefits not yet due as of the valuation date (date of the statement) which are expected to arise under claims which have been incurred as of the statement date. However, although the liability for future covered benefits which are expected to arise under claims which have been incurred as of the statement date on medical insurance policies should be included in claim reserves according to SSAP No. 55—*Unpaid Claims, Losses and Loss Adjustment Expenses*, some insurers include this liability in the A&H policy and contract claims liability which is discussed below.

2. **A&H Policy and Contract Claims Liability**

The A&H policy and contract claims liability includes: 1) due and unpaid claims; 2) claims in the course of settlement; and 3) incurred but not reported (IBNR) claims.

a. **Due and Unpaid Claims**

Due and unpaid claims are those which are complete except for the payment of the amount due. The amount of an insurer’s due and unpaid claims is generally very small and this liability is generally determined on an exact inventory basis of claims ready to be paid.

b. **Claims in the Course of Settlement**

Claims in the course of settlement include claims which have not been paid because all of the required information has not yet been received as of the statement date, resisted claims and the accrued portion (amount that is payable as of the statement date) of the next periodic payment on disability claims. The unaccrued portion of the next periodic payment on disability claims would be included in claim reserves discussed above. The liability for claims in the course of settlement, other than disability claims, may be
determined based on estimates for each outstanding claim or the development of average claim factors or formulas based on historical experience.

c. **IBNR Claims**

IBNR claims are those claims which have occurred but have not yet been reported to the insurer. Since neither the number nor dollar amount of IBNR claims are known as of the statement date, the liability for IBNR claims is difficult to estimate. The liability for IBNR claims is generally estimated based on an actuarial analysis of past experience or on the development of lag studies using historical experience.

Due to the variety of types of A&H policies issued and the complexity of determining the aggregate reserve for A&H policies and the A&H policy and contract claims liability, most insurers rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some insurers do not use actuaries to actually set the A&H reserves, insurers are required to annually obtain an opinion regarding the reasonableness of the established A&H reserves by a qualified actuary. Therefore, qualified actuaries are involved in setting and/or reviewing the A&H reserve liabilities established for virtually all insurers.

**Discussion of the Level 2 Annual Procedures**

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. The analyst should also consider the insurer’s corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The purpose of this section is primarily to assist the analyst in identifying those insurers that might have understated their A&H reserve liabilities. Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst.

**Procedure #1** assists the analyst in determining whether an understatement of A&H reserves would be significant to the insurer. The ratios of gross and net A&H reserves to capital and surplus are leverage ratios which are calculated gross and net of reinsurance ceded. The net A&H reserves to capital and surplus ratio indicates the margin of error an insurer has in estimating its A&H reserves. For an insurer with a net A&H reserves to capital and surplus ratio of 300%, a 33% understatement of its A&H reserves would eliminate its entire surplus. In evaluating these leverage ratios, the analyst should also consider the nature of the insurer’s business. For example, an insurer which has written primarily A&H business for many years and has proven that it can manage the business profitably is probably not as risky as an insurer which has just begun writing A&H business, even if both insurers have the same leverage ratio results.

Additional steps the analyst may perform if there are concerns regarding whether A&H policies have been adequately reserved include reviewing Schedule H – Accident and Health Exhibit to determine which A&H lines of business are being written and which A&H lines of business had positive development in reserves during the year. The analyst should also consider: 1) reviewing the insurer’s A&H insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits and 2) contacting the policy forms section of the insurance department and inquiring as to whether the insurer has filed any new and unusual A&H policy forms.
during the past year. In addition, the analyst could review the insurer’s description of the valuation standards used in calculating the additional contract reserves and consider whether the reserve bases, interest rates, and methods used appear reasonable. (The insurer’s description of the valuation standards used is required to be attached to the filed Annual Financial Statement). The analyst might want to contact the qualified actuary who signed the insurer’s Statement of Actuarial Opinion to discuss the nature and scope of A&H valuation procedures performed and/or request a copy of the qualified actuary’s actuarial memorandum to review for comments regarding the analysis of A&H reserves performed and the conclusions reached.

Other steps for the analyst to consider include the analyst reviewing the A&H loss ratio for the past five years for unusual fluctuations or trends between years and, if the loss ratio appears unusual, comparing it to the industry average loss ratio to determine any significant deviations from the industry average. The analyst might also consider requesting that the field examination staff request a valuation listing of A&H reserves by policy and testing a sample of policies to determine that the reserve factors were appropriate and that the reserves were correctly computed. If the adequacy of claim liabilities is a concern, the analyst might want to request information from the insurer regarding claims paid after year-end that were incurred prior to year-end, in order to test the reasonableness of the year-end claim liabilities established by the insurer. If there was a change in the valuation basis of A&H policies during the year, the analyst should consider the following: 1) obtaining information regarding the reason for the change in the valuation basis; 2) determining whether the amount of the change in the actuarial reserve as a result of the change in the valuation basis is reasonable; and 3) determining whether the change in the valuation basis was approved by the domiciliary state insurance department, if required.

Procedure #2 assists the analyst in determining whether A&H policies appear to have been adequately reserved. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary. Therefore, the analyst should review the results of the Statement of Actuarial Opinion Supplemental Procedures to determine whether any concerns were noted regarding the valuation of the insurer’s A&H reserves in accordance with Appendix A-010 of the AP&P Manual. The ratio of A&H reserve deficiency measures the adequacy of A&H reserves established in the prior year. A positive result for this ratio represents additional or “adverse” development on the reserves originally established by the insurer; if the insurer’s ratio results consistently show additional development, this could be an indication that the insurer is intentionally understating its A&H reserves. The A&H loss ratio is also reviewed as a part of this procedure. Significant increases in this ratio might be indicative of additional A&H reserves being established due to prior understatements while significant decreases might be indicative of current A&H reserve understatements. Other steps included in this procedure include the review of Exhibit 5A of the Annual Financial Statement to determine whether there has been a change in the valuation basis of the A&H policies during the year which resulted in a decrease in A&H reserves in an amount greater than 5 percent of capital and surplus.

Discussion of the Level 2 Quarterly Procedures

The five procedures included in the A&H reserves section of the Level 2 Quarterly Procedures are intended to identify significant changes in A&H reserves or A&H benefits that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.
III. Annual Procedures – C.4. Level 2 Annuity Reserves (Life/A&H)

1. Determine whether the insurer’s annuity reserves are valued in accordance with the minimum formula statutory valuation standards.
   a. Review the results of the Actuarial Opinion Supplemental Procedures. Were any concerns noted regarding the valuation of the insurer’s annuity reserves in accordance with minimum formula statutory valuation standards?
   b. Is the change in individual annuity reserves for the year as a percentage of individual annuity premiums (plus annuity investment income less annuity benefits and other fund withdrawals) greater than 120 percent or less than 50 percent?
   c. Is the change in group annuity reserves as a percentage of group annuity premiums (plus annuity investment income less annuity benefits and other fund withdrawals) greater than 120 percent or less than 50 percent?
   d. Review the Notes to Financial Statements, Note #31 - Reserves for Life Contracts and Annuity Contracts. Are any unusual items noted regarding the valuation of annuity reserves (surrender values promised in excess of the reserve, significant changes in components of reserves, etc.)?

Additional procedures and prospective risk considerations if further concerns exist:
   e. Contact the qualified actuary to discuss the nature and scope of the annuity reserve valuation procedures performed.
   f. Review the insurer’s annuity plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits.
   g. Request that the field examination staff request a valuation listing by plan and issue year and test a sample of individual policy reserves from each of the major annuity plans for accuracy.
   h. Contact the policy forms section of the insurance department and inquire as to whether the insurer filed new and unusual policy forms during the past 12 months.

2. Determine whether any changes in life and annuity reserve valuation bases during the year were proper.
   a. Review Exhibit 5A – Changes in Bases of Valuation During the Year. Has there been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in capital and surplus greater than 5 percent of current year capital and surplus?
   b. Did changes in life and annuity reserve valuation basis receive appropriate regulatory approval, if required?

Additional procedures and prospective risk considerations if further concerns exist:
   c. Review the specific changes in valuation basis noted in Exhibit 5A – Changes in Bases of Valuation During the Year – and determine that individual changes in specific mortality tables, interest rates, or valuation methods meet the minimum statutory valuation standards.
   d. Test check the calculations involved in applying a change in valuation basis.
III. Annual Procedures – C.4. Level 2 Annuity Reserves (Life/A&H)

3. Determine whether the insurer’s underlying assets are adequate to support the future obligations of its annuity policies.
   a. If the insurer filed a statement of actuarial opinion based on an asset adequacy analysis, review the results of the Actuarial Opinion Supplemental Procedures. Were any concerns noted regarding the adequacy of the insurer’s underlying assets to support future annuity policy obligations?
   b. Is the net interest spread (net investment income, less tabular interest, divided by average annuity reserves) on individual annuity reserves less than 0.5 percent?
   c. Is the net interest spread (net investment income, less tabular interest, divided by average annuity reserves) on group annuity reserves less than 0.25 percent?
   d. If available, review the Regulatory Asset Adequacy Issues Summary (RAAIS). Were the responses to the questions satisfactory?
   e. Is the Change in Asset Mix (IRIS Ratio 11) greater than 5 percent?

Additional procedures and prospective risk considerations if further concerns exist:

   f. Request a copy of the Statement of Actuarial Opinion and review the actuary’s comments regarding the analysis performed and conclusions reached.
   g. Conduct an independent asset adequacy analysis.

4. Determine whether any other concerns exist regarding the insurer’s annuity reserves.
   a. Are guaranteed interest contracts greater than 25 percent of capital and surplus?
   b. Are annuity benefits, surrenders and other fund withdrawals for individual and group annuities greater than 50 percent of capital and surplus?
   c. Did annuity benefits, surrenders, and other fund withdrawals for individual and group annuities and deposits, as a percentage of premiums, change by more than +/- 25 points from the prior year?
   d. Review the Notes to Financial Statements, Note #32 – Analysis of Annuity Actuarial Reserves and Deposit-Type Liabilities by Withdrawal Characteristics. Are significant amounts subject to withdrawal without any surrender charge or market value adjustment (i.e., amounts greater than 5 percent of capital and surplus)? If so, list the amount and percentage of total annuity reserves and deposit-type liabilities.

Additional procedures and prospective risk considerations if further concerns exist:

   e. Review the insurer’s annuity plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy withdrawal features and surrender charges.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding annuity reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating annuity reserves 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 examination section for targeted examination
- Engage an independent actuary to conduct a valuation of annuity reserves
- Engage an independent actuary to conduct an asset adequacy analysis
- 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 ________
III. Quarterly Procedures – C.4. Level 2 Annuity Reserves (Life/A&H)

1. Review the Quarterly Financial Statement Liabilities, Surplus and Other Funds page. If the liability for deposit-type contracts exceeds 5 percent of capital and surplus, has such liability changed by greater than +/−15 percent from the prior year-end?

2. Has the Summary of Operations line item surrender benefits and other fund withdrawals changed by greater than +/−25 percent from the prior year, same quarter?

3. Review the “Mix of Cash & Invested Assets” section of the Quarterly Financial Profile report. Have there been significant shifts (greater than +/−25 points) in any asset categories from the prior year-end?

4. Review, by line of business, the year-to-date direct premiums and deposit-type contract funds for the current and prior year in Exhibit 1 – Direct Premiums and Deposit-Type Contracts (lines 3, 6, 10 and 12). Have direct premiums for any line of business or deposit-type contract funds changed by greater than +/−25 percent from the prior year, same quarter?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the Annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

    Analyst ________________   Date ______

Comments as a result of supervisory review.

    Reviewer ________________   Date ______
Overview

Annuity reserves represent the liability established by the insurer to pay future policy benefits. While life insurance provides protection from the loss arising from dying too soon, an annuity protects against the loss from living too long. Theoretically, annuity reserves represent the present value of future guaranteed benefits reduced by the present value of expected future net premiums. An annuity can be in either an accumulation mode or a payout mode. Annuity policies take three forms: 1) annual premium deferred annuity, 2) single premium deferred annuity, and 3) single premium immediate annuity. Under an annual premium deferred annuity, annual premiums are paid during an accumulation period until such time as the policyholder (i.e., annuitant) receives income, surrenders the policy, or it terminates upon death. These annual premiums may be a specified amount or subject to the discretion of the owner under “flexible premium” annuities. Even if premiums are discontinued, the cash value of the policy will continue to accumulate until income is elected or the policy is otherwise terminated for its value. At income commencement, the annuitant receives the monthly income based upon cash value of the policy at that time and the annuity factor guaranteed in the policy or currently being applied, if more favorable, for the annuitant’s attained age. The single premium deferred annuity also accumulates until such time as the annuitant desires to take income or the policy is otherwise terminated. However, only a single premium is paid at the time the annuity is purchased.

NAIC Accounting Practices and Procedures Manual (AP&P Manual) prescribes the minimum standards to be used in determining reserves. Appendix A-820, Minimum Life & Annuity Reserve Standards of the AP&P Manual defines the minimum standards for all types of policy reserves, including life & annuity policies. Insurers may establish annuity reserves, which equal or exceed these minimum standards. These minimum annuity reserve standards specify a: 1) given mortality table (if applicable); 2) maximum rate of interest; and 3) valuation method. The valuation method used to define minimum annuity reserves for statutory accounting purposes is referred to as the Commissioners Annuity Reserve Valuation Method (CARVM). The mortality rate assumptions, if applicable, are substantially lower than what the insurer can expect to realize from medically underwritten insurance policies. The interest rate assumptions are intended to be significantly lower than current money and capital market yields. Thus, the annuity reserves developed are generally conservative.

As described below, the type of annuity dictates the amount of the annuity reserve that must be established and the duration for maintaining the reserve. In addition, special situations arise that require unique reserving techniques. The following summarizes the major types of annuities and the related reserving implications:

1. **Deferred Annuities (Annual Premium and Single Premium)**
   All deferred annuities are reserved using the CARVM method. The reserve on any specific valuation date requires a calculation of the present value of future guaranteed benefits less the present value of future required net premiums for the current duration of the policy and for each future duration. For purposes of calculating this series of “excesses,” premiums are only considered to be payable for the specific duration for which the excess is being calculated. The reserve is the greatest of these excesses. Reserves for guaranteed benefits must consider all contractual guarantees including cash values, death benefits, annuity income, etc. Cash values are those actually guaranteed under the policy provisions.

2. **Immediate Annuities**
   Immediate annuities are those that are in a payout mode. Reserves are determined using the CARVM method, except that, in the case of supplemental contracts without life contingencies, mortality tables are not used.
3. **Guaranteed Interest Contracts (GICs)**

GICs represent a type of funding vehicle used where group deferred annuities are involved. Under a basic GIC, the insurer accepts a single deposit from the plan sponsor (i.e., the employer) for a specified period of time, such as five years. Interest earned during the period may be accumulated until the period expires, or the earned interest may be paid out annually. At the end of the period, the account balance, including any accumulated interest, is returned to the plan sponsor. Numerous variations of this basic guaranteed interest contract have been developed that: 1) allow the plan sponsor to make monthly contributions rather than the single deposit and 2) provide that the principal and interest can be paid out in installments to make benefit payments to plan participants.

4. **Structured Settlements**

Structured settlements are a form of immediate annuity generally established in connection with the settlement of a property/casualty claim where a predetermined future benefit stream is desired. Reserves are determined using the CARVM method with special actuarial guidelines that prescribe specialized mortality tables and govern the use of lump sum balloon payments.

5. **Variable Annuities**

Variable annuities are annuities where the amount of each benefit payment is not specified in the annuity contract, but rather fluctuates according to the earnings of a separate account fund. The primary concern relating to variable annuities reserves relates to the treatment of the CARVM expense allowance in the general account. The CARVM method is generally used, but the current thinking is that CARVM may not be appropriate for certain types of variable annuities that do not include guaranteed benefits.

Due to the complexity in determining annuity reserves, insurers must rely on actuaries to assist with valuation of these reserves. Insurers are required to annually obtain an opinion regarding the reasonableness of the reserves by a qualified actuary. In the aggregate, policy reserves for all annuity policies that are reported in the statutory financial statements must equal or exceed reserves calculated by using the assumptions and methods that produce the minimum standard valuation.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the insurer’s corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. While the underlying actuarial techniques relating to annuity reserves are quite complicated, the analyst should remember that there are two basic objectives regarding annuity reserves. The first objective is that the insurer’s annuity reserves are accurately calculated in accordance with the minimum formula statutory valuation standards and the second objective is that the insurer’s assets are adequate to support the future policy obligations. Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst.

Procedure #1 assists the analyst in determining whether the insurer’s annuity reserves are valued in accordance with the minimum formula statutory valuation standards. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary. The analyst can also gain comfort in this regard by evaluating the change in reserves in relation to increases or decreases in premiums during the year.

Procedure #2 assists the analyst in determining whether any changes in annuity reserve valuation basis during the year were proper. From time to time, an insurer may decide to change the valuation basis for a particular segment of the business. The insurer may change the mortality table used, the rate of interest or the valuation method. Reserve strengthening occurs when the insurer substitutes a more conservative basis of valuation for any given block of business. Reserve weakening may also occur but normally requires approval of the domiciliary state.

Additional steps the analyst may perform if there are concerns regarding the valuation of annuity reserves or changes in valuation basis essentially involve testing the actual reserve calculations for a sampling of individual annuity policies to ensure that the minimum statutory valuation standards have been met.

Procedure #3 assists the analyst in determining whether the insurer’s underlying assets are adequate to support the future obligations of its annuity policies. If the insurer filed a Statement of Actuarial Opinion based on an asset adequacy analysis, then the actuarial opinion itself, and the supporting actuarial memorandum, if requested, can provide the analyst with comfort in this regard. If a Statement of Actuarial Opinion that does not include an asset adequacy analysis is filed, the analyst can review net interest spread ratios for insights regarding the relationship of investment income with tabular interest.

Additional steps are available for the analyst to perform if there are concerns regarding the adequacy of the insurer’s underlying assets to support annuity reserves. If an actuarial memorandum is available, this will provide the analyst with substantial analyses with regard to asset adequacy. If an actuarial memorandum is not available, the analyst should consider the need to have an independent asset adequacy analysis conducted.

Procedure #4 assists the analyst in identifying other areas of concern. For example, annuities can have a significant impact on the insurer’s liquidity position, particularly significant levels of guaranteed interest contracts or amounts subject to withdrawal at minimal or no surrender charge.

Discussion of Level 2 Quarterly Procedures

The procedures described in the Level 2 Quarterly Procedures are intended to identify significant changes in annuity reserves that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.
III. Annual Procedures – C.5. Level 2 Income Statement and Surplus (Life/A&H)

1. Determine whether concerns exist regarding the insurer’s income statement or operating performance.
   a. Is the ratio of Net Income to Total Income (Including Realized Capital Gains and Losses) (IRIS Ratio 3) less than or equal to zero?
   b. Is the ratio of Net Income to Total Income (Before Realized Capital Gains and Losses) less than zero?
   c. When the absolute value of the change in net income exceeds 3 percent of capital and surplus, is the ratio of change in net income less than –30 percent?
   d. Review net income in the Annual Financial Profile Reports. Has there been a net loss in two or more of the past three years?
   e. Is the ratio of return on capital and surplus less than 5 percent or greater than 20 percent?
   f. For non-health insurers, is the ratio of surrenders to net premiums greater than 30 percent?
   g. For non-health insurers, if group annuity surrenders exceed 20 percent of total surrenders, is the ratio of group surrenders to net group premiums in group annuities greater than 50 percent?
   h. For non-life insurers, is the ratio of commissions and administrative expenses to gross premiums greater than 30 percent? Display the results for each of the past five years.
   i. Does the company’s A&H loss ratio exceed 85 percent? Display the results for each of the past five years.
   j. Is the ratio of investment income to cash and invested assets greater than 10 percent or less than 4.5 percent? Display the results for each of the past five years.
   k. Is the ratio of Adequacy of Investment Income (IRIS Ratio 4) less than 125 percent?
   l. If the absolute value of net realized capital gains or losses exceeds 3 percent of capital and surplus, is the ratio of net realized capital gains to net income greater than +/- 25 percent?
   m. Review the Summary of Operations in the Annual Financial Statement.
      i. If aggregate write-ins for miscellaneous income exceed 3 percent of capital and surplus, is the ratio of aggregate write-ins for miscellaneous income to net income greater than +/- 25 percent?
      ii. If aggregate write-ins for deductions exceed 3 percent of capital and surplus, is the ratio of aggregate write-ins for deductions to net income greater than +/- 25 percent?

Additional procedures and prospective risk considerations if further concerns exist:

n. Review the Summary of Operations (Annual Financial Profile Reports) for the past five years for unusual fluctuations or trends between years in income or expense items.

o. Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on net revenues or net income, or a material impact on the relationship between benefits, losses, and expenses.
p. Compare the ratio of return on capital and surplus to industry average return on surplus to determine any significant deviation from the industry average.

q. Review the Analysis of Operations by Lines of Business in the Annual Financial Statement and the Financial Profile Report and:
   i. Determine which lines of business had significant surrender activity during the year or if there appears to be a negative trend in surrender activity over the past five years.
   ii. Determine which lines of business were profitable for the insurer and which lines of business generated a loss.
   iii. Determine if any lines of business indicate a negative trend in profitability over the past five years.
   iv. Determine whether commissions and expenses on any lines of business appear excessive based on the volume of premiums.

r. Review the ratio of commissions and administrative expenses to premiums (Annual Financial Profile Reports) for unusual fluctuations or trends between years.

s. Compare the ratio of commissions and administrative expenses to premiums (Annual Financial Profile Reports) to industry average commission and expense ratios to determine any significant deviations from industry averages.

t. Review General Interrogatories, Part 1, #34.1 and #34.2.
   i. Investigate any legal expenses paid if any such payment represented 25 percent or more of total legal payments made during the year.
   ii. Compare legal expenses with industry averages.

u. Review the detail of investment income in the Exhibit of Net Investment Income and the detail of realized gains or (losses) in the Exhibit of Capital Gains (Losses) for reasonableness.

v. Review the investment yield ratio (Annual Financial Profile Reports) for unusual fluctuations and trends between years.

w. Compare the ratio of investment income to cash and invested assets (Annual Financial Profile Reports) to the industry average investment yield to determine any significant deviation from the industry average.

x. Review the components of the Annual Financial Statement Summary of Operations line items Aggregate Write-ins for Miscellaneous Income and Aggregate Write-ins for Deductions for reasonableness.

2. Determine whether concerns exist regarding changes in the volume of premiums written and deposit-type funds or changes in the insurer’s mix of business (lines of business written and/or geographic location of premiums written).
   a. Is the ratio of change in net premiums, annuity considerations and deposit-type funds greater than +/- 30 percent?
   b. For non-health insurers, is the ratio of change in direct and assumed annuities and deposit-type funds greater than +/- 50 percent?
   c. Is the ratio of Change in Product Mix (IRIS Ratio 10) greater than 5 percent?
d. Review the Direct Premium Written by State.
   i. Has there been a significant change (+/– 50 percent) in direct premiums written in any one state in which current or prior year direct premium exceeds 10 percent of total direct premium?
   ii. Are premiums being written in any new state where that state’s premiums exceed 10 percent of total direct premiums written?

Additional procedures and prospective risk considerations if further concerns exist:

   e. Review the Mix of Business in the Annual Financial Profile Reports and:
      i. Determine which lines of business are being written.
      ii. Determine whether there has been a significant increase or decrease in direct premiums written for any line of business.
      iii. Determine whether any new lines of business are being written.

   f. Verify that the insurer is authorized to write all lines of business written.

   g. Determine whether the insurer has expertise (distribution network, underwriting, claims and reserving) in the lines of business written. Consider reviewing the insurer’s Management’s Discussion and Analysis and/or seeking additional information from the insurer to determine the insurer’s expertise in the lines of business written.

3. Determine whether the insurer may be excessively leveraged due to its volume of accident and health (A&H) business.
   a. Is the ratio of A&H business to net premiums and annuity considerations greater than 75 percent?
   b. If the response to 3.a. is “yes,” is the ratio of gross A&H premiums to capital and surplus greater than 500 percent?
   c. If the response to 3.a. is “yes,” is the ratio of net A&H premiums to capital and surplus greater than 300 percent?

Additional procedures and prospective risk considerations if further concerns exist:

   d. Compare ratios of gross A&H premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to determine any significant deviations from the industry averages.
   e. Review Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written.
   f. Review Schedule H – Accident and Health Exhibit to determine whether the A&H lines of business are profitable and whether A&H reserve adequacy has been maintained.
   g. Review the A&H loss percentage ratio (Annual Financial Profile Reports) for unusual fluctuations or trends between years.

   a. Did the insurer report an underwriting loss of either group or individual coverage?
   b. Did the insurer report a medical loss ratio greater than 85 percent on either group or individual coverage?
III. Annual Procedures – C.5. Level 2 Income Statement and Surplus (Life/A&H)

c. Did the insurer report an expense loss ratio greater than 15 percent on either group or individual coverage?

d. Did the insurer report a combined ratio greater than 100 percent on either group or individual coverage?

Additional procedures and prospective risk considerations if further concerns exist:

e. Obtain and review information regarding the contracted benefits, premium and cost sharing with the U.S. Centers for Medicare & Medicaid Services (CMS).

f. Review the types of products being written, including any enhanced benefit products.

g. Request information on and review the assumptions for reserves, utilization, and benefit costs projected in the development of the contract.

5. Determine whether concerns exist regarding the amount of the insurer’s capital and surplus.

a. Review the Five-Year Historical Data in the Annual Financial Statement. Is the ratio of Total Adjusted Capital to Authorized Control Level Risk-Based Capital less than 250 percent?

b. Is the ratio of capital and surplus and AVR to total assets (excluding separate accounts) less than 7 percent? Display the results for each of the past five years.

c. Is the ratio of Net Change in Capital and Surplus (IRIS Ratio 1) greater than 50 percent or less than –10 percent?

d. Is the ratio of Gross Change in Capital and Surplus (IRIS Ratio 2) greater than 50 percent or less than –10 percent?

e. Review the Five-Year Historical Data in the Annual Financial Statement. Is the current year-end capital and surplus position of the company 10 percent less than the ending balance for any of the prior four years?

f. Did the insurer declare dividends to stockholders during the year? Display the results for each of the past five years.

i. If the answer to 5.f. is “yes,” was the amount of the stockholder dividend at a level that required prior regulatory approval or notification?

ii. If the answer to 5.f.i. is “yes,” did the insurer fail to obtain proper prior regulatory approvals?

g. Provide details of any financial guaranty, of any form, in place between the company and any member within its holding company system.

h. Is the ratio of capital and/or surplus notes to capital and surplus greater than 10 percent?

i. Are write-ins for special surplus funds and/or write-ins for other than surplus funds greater than 10 percent of capital and surplus?

j. Does the absolute value of the current year change exceed 3 percent of current year capital and surplus for any of the following items: 1) net unrealized capital gains/losses; 2) net unrealized foreign exchange capital gains/losses; 3) net deferred taxes; 4) nonadmitted assets; 5) the liability for unauthorized reinsurance; 6) reserve valuation basis; 7) AVR; 8) surplus notes; or 9) change in accounting principle?
III. Annual Procedures – C.5. Level 2 Income Statement and Surplus (Life/A&H)

k. Review footnote (h) in the Exhibit of Net Investment Income. Did the insurer report interest expense on capital or surplus notes during the year?

Additional procedures and prospective risk considerations if further concerns exist:

l. Compare the ratio of capital and surplus and AVR to total assets (excluding separate accounts) to industry average capital and surplus to assets to determine any significant deviation from the industry average.

m. If the insurer has outstanding surplus notes issued, review Notes to Financial Statements, Note #13 – Capital and Surplus, Shareholders’ Dividend Restrictions and Quasi-Reorganizations, and consider the following:

   i. Date issued
   ii. Interest rate
   iii. Amount of note and current value
   iv. Interest paid-current year and in total
   v. Accrued interest
   vi. Date of maturity
   vii. Name of holder (and indication of whether holder is affiliated entity)
   viii. Description of assets received
   ix. Repayment conditions or restrictions

n. If the insurer has outstanding debt issued, review Notes to Financial Statements, Note #11 – Debt, and consider the following:

   i. Date issued
   ii. Interest rate
   iii. Amount of note and current value
   iv. Interest paid-current year and in total
   v. Accrued interest
   vi. Date of maturity
   vii. Name of holder (and indication of whether holder is affiliated entity)
   viii. Description of assets received
   ix. Repayment conditions or restrictions

o. If capital or surplus notes were issued during the year, determine whether they were approved by the domiciliary state insurance department.

p. If principal was repaid and/or interest was paid on surplus notes during the year, determine whether the principal repayments and/or the interest payments were approved by the domiciliary state insurance department.

q. If surplus notes represent a significant portion of capital and surplus, recalculate important ratios excluding the amount of surplus notes to determine the effect of surplus notes on the ratio results.
III. Annual Procedures – C.5. Level 2 Income Statement and Surplus (Life/A&H)

r. Review the write-ins for special surplus funds and for other than special surplus funds for reasonableness.

s. Review the Capital and Surplus Analysis (roll forward) for unusual fluctuations or trends in the changes in the individual components of capital and surplus between years.

t. Review the detail of unrealized gains/(losses) in the Exhibit of Capital Gains/(Losses) for reasonableness.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer’s income statement and surplus. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the insurer’s income statement and surplus 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 examination section for targeted 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 ________
III. Quarterly Procedures – C.5. Level 2 Income Statement and Surplus (Life/A&H)

1. Determine whether concerns exist regarding the insurer’s income statement or operating performance.
   a. Has there been a year-to-date net loss?
   b. If the absolute value of the change in net income from the prior year-to-date exceeds 10 percent of capital and surplus, is the change less than -30 percent?
   c. Is the ratio of surrenders to premiums greater than 30 percent?
   d. Is the ratio of commissions and administrative expenses to premiums and deposits (Quarterly Financial Profile report) greater than 50 percent?
   e. If the absolute value of net realized capital gains or losses exceeds 3 percent of capital and surplus, is the ratio of net realized capital gains to net income greater than +/-25 percent?
      i. If aggregate write-ins for miscellaneous income exceed 3 percent of capital and surplus, is the ratio of aggregate write-ins for miscellaneous income to net income greater than +/-25 percent?
      ii. If aggregate write-ins for deductions exceed 3 percent of capital and surplus, is the ratio of aggregate write-ins for deductions to net income greater than +/-25 percent?

2. Determine whether concerns exist regarding changes in the volume of premiums and deposit-type contract funds or changes in the insurer’s product mix.
   a. Is the ratio of change in net premiums and annuity considerations greater than +/-30 percent, from the prior year, same quarter?
   b. Review, by line of business, the year-to-date direct premiums and deposit-type funds for the current and prior year in Exhibit 1 – Direct Premiums and Deposit-Type Contracts. Have the direct premiums for any line of business changed by greater than +/-25 percent from the prior year, same quarter?

3. Determine whether the insurer may be excessively leveraged due to its volume of accident and health (A&H) business.
   a. Is the ratio of A&H premiums to net premiums and annuity considerations greater than 75 percent?
   b. If the response to a. above is “yes,” is the ratio of gross A&H premiums for the last four quarters to capital and surplus greater than 500 percent?
   c. If the response to a. above is “yes,” is the ratio of net A&H premiums for the last four quarters to capital and surplus greater than 300 percent?

4. Determine whether concerns exist regarding the amount of the insurer’s capital and surplus.
   a. Has capital and surplus changed by more than 50 percent or less than -10 percent from the prior year-end?
   b. Does the absolute value of the current year change exceed 3 percent of current year capital and surplus for any of the following items: 1) net unrealized capital gains/losses,
III. Quarterly Procedures – C.5. Level 2 Income Statement and Surplus (Life/A&H)

2) net unrealized foreign exchange capital gains/losses, 3) net deferred income tax, 4) nonadmitted assets, 5) the liability for unauthorized reinsurance, 6) reserve valuation basis, 7) AVR, 8) surplus notes, and/or 9) change in accounting principles?

c. If the insurer issued capital or surplus notes during the quarter, is the sum of the capital and surplus notes issued during the quarter greater than 10 percent of the current quarter capital and surplus? If the answer is “yes,” then list the amount of any new capital or surplus notes issued during the quarter.

d. Did the insurer repay any principal and/or pay any interest on capital or surplus notes during the quarter?

e. Did the insurer pay dividends to stockholders during the quarter?

i. If the answer to e. above is “yes,” was the amount of the stockholder dividend at a level that required prior regulatory approval or notification?

ii. If the answer to e.i. above is “yes,” did the insurer fail to obtain proper prior regulatory approvals?

5. If there are concerns (e.g., changes in: surplus, writings, reserves, investments) about the current level of RBC, has the analyst considered completing and/or requesting an interim RBC projection?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the Annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

Statutory accounting principles emphasize the balance sheet because statutory accounting is primarily directed toward the determination of an insurer’s financial condition on a specific date. However, the income statement is also important and should be reviewed as an integral part of the financial analysis process. Income statement analysis primarily focuses on the operating performance of an insurer. One of the most common measures of an insurer’s overall profitability and operating performance for a life/health insurer is the IRIS ratio of net income to total income (including realized capital gains and losses). This ratio considers the six principal factors which affect the insurer’s net gain: 1) mortality and morbidity experience; 2) adequacy of investment income; 3) commissions and expenses; 4) reinsurance transactions; 5) the relationship of statutory reserve requirements to prevailing interest and mortality rates; and 6) realized capital gains and losses. The return on capital and surplus, which considers net income as a percentage of capital and surplus, is another important measure of overall operating performance.

Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums may be an indication of an insurer’s entrance into new lines of business or sales territories which might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses, particularly if the insurer primarily writes accident and health (A&H) insurance.

In assessing financial condition, considerable emphasis is placed on the adequacy of an insurer’s capital and surplus (See section III.C.7. for a detailed discussion of risk-based capital [RBC]). Capital and surplus provides protection (or “cushion”) for policyholders against adverse underwriting results, inadequate policy reserve levels, insolvency of reinsurers, and fluctuations in the value of investments. In addition, capital and surplus provides underwriting capacity and allows an insurer to expand its business. The RBC formula (discussed in section III.C.7.) is designed to calculate a minimum threshold measure of capital and surplus adequacy based on each insurer’s unique mix of asset risk, insurance risk, interest rate risk, and business risk.

The components of capital and surplus can include common capital stock, preferred capital stock, gross paid-in and contributed surplus, surplus notes, unassigned funds (or retained earnings), and special surplus funds (usually established through an appropriation of unassigned funds). Each state has, by statute, established a minimum required amount of capital and surplus for insurers. In some states, these minimum amounts are based on the lines of business written while, in other states, the minimum amounts are based on the type of insurer. In addition, the RBC requirements must also be met.

Insurers may issue capital or surplus notes as a source of financing growth opportunities or to support current operations. Surplus notes (sometimes referred to as “surplus debentures” or “contribution certificates”) have the characteristics of both debt and equity. Surplus notes resemble debt in that they are repayable at interest and sometimes (dependent on the requirements of the domiciliary state insurance department) include maturity dates and/or repayment schedules. However, key provisions of the surplus notes make them tantamount to equity. These provisions include approval requirements as to form and content and the requirement that interest may be paid and principal may be repaid only with the prior approval of the domiciliary state insurance department. SSAP No. 41 – Surplus Notes, requires that interest on surplus notes is to be reported as an expense and a liability only after payment has been approved. Accrued interest that has not been approved for payment should be reflected in the Annual Financial Statement Notes to Financial Statements.
Provided that the domiciliary state insurance department has approved the form and content of the surplus notes and has approval authority over the payment of interest and repayment of principal, surplus notes are considered to be surplus and not debt. The proceeds from the issuance of surplus notes must be in the form of cash, cash equivalents or other assets having a readily determinable value satisfactory to the domiciliary state insurance department. Information regarding surplus notes must be reported in the Annual Financial Statement Notes to Financial Statements.

Insurers may also issue capital notes, which are reported as a liability by the insurer and are therefore treated as debt instruments, although, in liquidation, rank with surplus notes and are subordinate to the claims of policyholders’ claimants and general creditors. Capital notes are included in the insurer’s total adjusted capital for RBC calculations.

Like surplus notes, capital notes are repayable with interest and include maturity dates and/or repayment schedules. However, payments of interest and repayment of principal generally do not require regulatory approval. When total adjusted capital falls below certain levels or if other adverse conditions exist, capital note payments may be required to be deferred. While deferred, any interest on the capital note should not be reported as an expense or the accrual as a liability, but instead should be reflected in the Annual Financial Statement Notes to the Financial Statements, similar to surplus note interest payments that have not been approved.

Capital and surplus notes may have the effect of enhancing surplus or providing funds only on a temporary basis. The person or entity that holds the capital or surplus note may expect repayment on a scheduled basis and may exert pressure on the insurer to generate cash in order to be able to make the payments. As a result, the analyst should be cautious when reviewing insurers that rely heavily on these notes. Capital and surplus notes are not inherently bad. They have provided regulators with flexibility in dealing with problem situations to attract capital to insurers whose surplus levels are deemed inadequate to support current operations. They provide a source of capital to mutual and other types of non-stock entities who do not have access to traditional equity markets and provide an alternative source of capital to stock reporting entities.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the insurer’s corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The purpose of this section is primarily to assist the analyst in reviewing and analyzing the insurer’s operating performance with emphasis on the level of, and change in, the insurer’s premiums, policy surrender activity, investment income and net income, and changes in other components of the income statement and in capital and surplus. In addition, significant amounts of activity related to capital and surplus notes are identified. Separate sections of the Level 2 Annual Procedures provide specific guidance with respect to RBC, loss reserves, and reinsurance.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst.
Procedure #1 assists the analyst in determining whether concerns exist regarding the insurer’s income statement or operating performance. One of the most common measures of overall profitability and operating performance for a life/health insurer is the IRIS ratio of net income to total income (including realized capital gains and losses). Six principal factors affect the insurer’s net gain, as reflected in this ratio: 1) mortality and morbidity experience; 2) adequacy of investment income; 3) commissions and expenses; 4) reinsurance transactions; 5) the relationship of statutory reserve requirements to prevailing interest and mortality rates; and 6) realized capital gains and losses. This ratio is an indicator of the insurer’s overall profitability and operating performance without consideration of realized gains and losses. Another important measure of the insurer’s operating performance is the return on capital and surplus, which considers net income as a percentage of capital and surplus. Other steps are designed to assist the analyst in identifying unusual relationships and fluctuations in the insurer’s income statement, which could have an impact on operating performance.

Additional steps the analyst may perform if there are concerns regarding the insurer’s income statement or operating performance include reviewing the summary of the individual income and expense items for the past five years for unusual fluctuations or trends between years. In addition, the analyst might compare the ratio of return on capital and surplus to industry average results to determine any significant deviation from the industry average. By reviewing the Analysis of Operations by Lines of Business in the Annual Financial Statement, the analyst could determine which lines of business had significant surrender activity during the year, which lines of business were profitable, and which lines of business generated a loss, and whether commissions and expenses on any lines of business appear excessive, based on the volume of premiums and deposit-type funds. If the ratio of commissions and expenses to premiums appears high or if the ratio of investment yield appears unusual, the analyst should consider: 1) reviewing these ratio results for the past five years for unusual fluctuations or trends between years and 2) comparing the ratio results to industry averages to determine any significant deviations from the industry averages. If write-ins for miscellaneous income or deductions are significant, the analyst should consider reviewing the individual components of these amounts for reasonableness. In addition, the detail of investment income may be reviewed if there are concerns regarding the investment yield to determine if there are significant invested assets that are not producing an adequate return. The analyst might also review the detail of realized capital gains and losses and consider their impact on the insurer’s profitability. As a part of this review, the analyst should consider evaluating the impact of the insurer’s interest maintenance reserve (IMR) established to capture the realized capital gains and losses on investments sold prior to maturity. These capital gains and losses are amortized over the remaining life of the investments sold, rather than being recognized immediately.

Procedure #2 assists the analyst in determining whether concerns exist regarding changes in the volume of premiums and deposit-type funds or changes in the insurer’s mix of business (lines of business written and/or geographic location of premium written). Significant increases or decreases in premiums written may indicate a lack of stability in the insurer’s operations. In addition, a significant increase in premiums written may be an indication of the insurer’s entrance into new lines of business or sales territories that might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums might also be an indication that the insurer is engaging in cash flow underwriting to increase cash income in order to cover current benefit payments, particularly if the insurer primarily writes A&H insurance.

Additional steps the analyst may perform if there are concerns regarding changes in the volume of premiums and deposit-type funds or changes in the insurer’s mix of business (lines of business written and/or geographic location of the premiums written) include reviewing the insurer’s mix of business to determine: 1) which lines of business are being written; 2) which lines of business have increased or decreased significantly; and 3) whether any new lines of business are being written. The analyst should
also consider verifying that the insurer is authorized to write all lines of business being written. If new lines of business are being written or if premiums are being written in new states, the analyst should consider determining whether the insurer has expertise in the new lines of business or new sales territories. This would include expertise in distribution, underwriting, claims, and reserving. There is no information in the Annual Financial Statement to assist the analyst in making this determination. However, there may be helpful information in the insurer’s Management’s Discussion and Analysis. Otherwise, information may be requested from the insurer. The analyst should also consider determining if, as a result of changes in the mix of business, the insurer’s business is concentrated in specific geographic areas that could result in the insurer being potentially exposed to catastrophic losses.

Procedure #3 assists the analyst in determining whether the insurer is excessively leveraged due to its volume of A&H business. Capital and surplus can be considered as underwriting capacity, and the ratios of gross (direct plus assumed reinsurance) A&H premiums to capital and surplus and net (gross less reinsurance ceded) A&H premiums to capital and surplus measure the extent to which that capacity is being utilized and the adequacy of the insurer’s capital and surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross A&H premiums to capital and surplus ratio greater than 500 percent may indicate that the insurer is excessively leveraged and special attention should be given to the adequacy of the insurer’s reinsurance protection and the quality of the reinsurers. A net A&H premiums to capital and surplus ratio greater than 300 percent may also indicate that the insurer is excessively leveraged and lacks sufficient capital and surplus to finance the A&H business currently being written. In evaluating these leverage ratios, the analyst should also consider the nature of the insurer’s business. For example, an insurer that has written primarily A&H business for many years and has proven that it can manage the business profitably is probably not as risky as an insurer which has just begun writing A&H business, even if both insurers have the same leverage ratio results.

Additional steps the analyst may perform if there are concerns regarding whether the insurer may be excessively leveraged due to its volume of A&H business include comparing the ratios of gross A&H premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to help evaluate the insurer’s leverage. The analyst might also want to review Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written, determine whether the A&H lines of business have historically been profitable for the insurer, and determine whether A&H loss reserve adequacy has been maintained. As noted previously, an insurer that has historically written primarily A&H business might not be considered excessively leveraged, even though it has higher leverage ratio results, because the risk of significant under-pricing or adverse underwriting results is less than for an insurer that has just begun writing A&H business.

Procedure #4 assists the analyst in evaluating the underwriting performance of the Medicare Part D Prescription Drug coverage. The procedures utilize data in the Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, the analyst should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated when the contract was made. If the insurer is reporting unusual results, the analyst should consider if any delays in payments from the U.S. Centers for Medicare & Medicaid Services (CMS) are impacting results.

Additional steps the analyst may perform are provided in the procedures if there are concerns regarding the Medicare Part D business. Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for a period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If policyholders utilize more benefits than were projected in the contract, the insurer may experience losses because the income from CMS is set for a full year.
The analyst should consider obtaining and reviewing information on the contracted benefits, premium, and cost-sharing with CMS. The analyst should also evaluate a comparison of premiums, reserves, expected utilization, and benefit costs to actual experience on each plan.

Procedure #5 assists the analyst in determining whether concerns exist regarding the amount of the insurer’s capital and surplus. The RBC formula (which is discussed in detail in Section III.C.7.) is designed to calculate a minimum threshold of capital and surplus based on each insurer’s unique mix of asset risk, insurance risk, interest rate risk, and business risk. The level of, and changes in, premiums (procedure #3 above), reserves (Sections III.C.2., III.C.3. and III.C.4.) and reinsurance (Section III.C.9.) must also be considered in evaluating the amount of an insurer’s capital and surplus. Another measure of capital and surplus adequacy that is commonly considered is the ratio of capital and surplus and asset valuation reserve (AVR) to total assets (excluding separate accounts). AVR is included in this ratio because it is commonly considered “de facto” surplus. The purpose of AVR is to limit fluctuations in the insurer’s surplus due to changes in the value of its invested assets. The net and gross changes in capital and surplus IRIS ratios measure the improvement or deterioration in the insurer’s financial condition from the prior year. The net change in capital and surplus does not include capital and surplus paid in during the year whereas the gross change in capital and surplus does include capital and surplus paid in during the year. Even increases in the change in capital and surplus ratio, when significant, may indicate instability or mask financial problems attributable to fundamental changes in the insurer.

Another step is designed to assist the analyst in identifying dividend payments or declarations, to determine if any necessary approvals were obtained. Other steps in this procedure are designed to assist the analyst in identifying significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds. Also, significant changes in capital and surplus due to changes in the following: 1) net unrealized capital gains/losses; 2) foreign exchange capital gain/loss; 3) net deferred taxes; 4) nonadmitted assets; 5) the liability for unauthorized reinsurance; 6) reserve valuation basis; 7) AVR; 8) surplus notes; or, 9) change in accounting principle are reviewed. The final step in this procedure is designed to assist the analyst in identifying other activity during the year related to capital and surplus notes.

Additional steps the analyst may perform if there are concerns regarding the amount of the insurer’s capital and surplus include reviewing the RBC procedures. In addition, the ratio of capital and surplus and AVR to total assets (excluding separate accounts) may be compared to the industry average to determine any significant deviation. If the insurer has issued surplus notes that are significant, the analyst should consider reviewing the information regarding the surplus notes in the Notes to Financial Statements, Note #13 – Capital and Surplus, Shareholders’ Dividend Restrictions and Quasi-Reorganizations. If surplus notes were either issued or repaid, or if interest was paid during the year, the analyst should consider determining whether these transactions were approved by the domiciliary state insurance department. In addition, if surplus notes represent a significant portion of capital and surplus, the analyst should consider recalculating important ratios, excluding the surplus notes, to determine their effect on the ratio results. If the insurer has issued capital notes that are significant, the analyst should consider reviewing the information in the Notes to Financial Statements, Note #11 – Debt for pertinent information such as repayment, redemption price or interest features. Other steps to consider in this supplemental procedure #5 include the review of the detail of unrealized gains or (losses) and the review of other components of capital and surplus for reasonableness.

Discussion of Level 2 Quarterly Procedures

The five procedures included in the income statement and surplus section of the Level 2 Quarterly Procedures are designed to identify: 1) significant changes in net income or capital and surplus; 2) significant levels of policy surrenders, commissions and administrative expenses, and aggregate write-ins.
for miscellaneous income or deductions; 3) significant changes in the volume of premiums or the insurer’s mix of business (lines of business written and/or geographic location of premiums written); or 4) any changes in capital or surplus notes that have occurred or dividends paid to stockholders since the prior year Annual Financial Statement or prior Quarterly Financial Statement.
III. Annual Procedures – C.6. Level 2 Health Care Pursuant to Public Health Service Act (Life/A&H)

NOTE: As the U.S. Department of Health and Human Services (HHS) continues to provide further direction on issues related to the implementation of the Patient Protection and Affordable Care Act (PPACA), certain procedures and/or guidance in this chapter may be subject to change.

The intent of this chapter is to provide instruction and guidance to analysts regarding the new Supplemental Health Care Exhibit (SHCE). This Exhibit was developed in order to provide a mechanism to ensure that states have the ability to understand and review the elements that make up the numerator and denominator of the medical loss ratio (MLR) that will be calculated pursuant to federal law. **THIS EXHIBIT DOES NOT PERMIT A CALCULATION OF THE FINAL MLR FOR REBATE PURPOSES.**

The following procedures are intended to supplement other Level 2 Procedures in the Handbook and established analytical procedures of the insurance department.

1. Were the Supplemental Health Care Exhibit (SHCE) and the SHCE’s Expense Allocation Report filed in accordance with the Annual Statement Instructions?

2. Determine whether there are concerns regarding the components of the insurer’s Preliminary Medical Loss Ratio (MLR). Review the SHCE, identify the components of the Preliminary MLR calculation and consider the following:
   a. Is the Preliminary MLR (either the national Preliminary MLR or the state-level MLR) less than 80 percent for individuals or small group employers, or less than 85 percent for large group employers, (or the thresholds applicable under state law)? (See Reference Guide Discussion of Procedures for #2 for guidance on an aggregate vs. by state review of Preliminary MLR.)
   b. Review the trend in the Preliminary MLR (either the national Preliminary MLR or the state-level MLR). Did the Preliminary MLR increase or decrease by more than 5 percentage points from the prior year? (See Reference Guide Discussion of Procedures #2 for guidance on an aggregate vs. by state review of Preliminary MLR.)
   c. In the analyst’s review of the components of the Preliminary MLR, review and assess any material differences between the unadjusted and adjusted amounts for premium and claims.
      - Health Premium Earned (Line 1.1) compared to Adjusted Premium Earned (Line 1.8)
      - Incurred Claims excluding prescription drugs (Line 2.1) compared to Total Incurred Claims (Line 5.0)
   d. Review the Financial Profile Report’s PMPM data and explain any amounts that appear unusual.
   e. Did the analyst note any components that appear unusual, or that increased or decreased materially from the prior year that would indicate further review is warranted?
   f. Review the SHCE – Part 3 and the Expense Allocation Report including the expense allocation methodology to determine whether quality improvement (QI) expenses are appropriate and properly accounted for.

Document any unusual items or areas of concern.
III. Annual Procedures – C.6. Level 2 Health Care Pursuant to Public Health Service Act (Life/A&H)

3. Determine whether there are concerns regarding the impact by line of business to the insurer’s overall operating results and financial solvency.
   a. Is the Preliminary MLR (either the national Preliminary MLR or the state-level MLR) greater than 90 percent for individuals or small group employers, or greater than 95 percent for large group employers? If “yes,” assess the financial solvency of the plan and the impact of the plan on the overall financial solvency of the insurer.
   b. Compare the results of your analysis of the Preliminary MLR to your analysis of the existing MLR calculations (refer to Financial Profile Report or Handbook chapter III.C.5. Income Statement and Surplus) and assess the impact to the overall solvency of the insurer.
   c. Analyze the underwriting gain/(loss) result by line of business. Did any line of business on the SHCE report an underwriting loss?
      i. If “yes,” determine the reasons for the loss.
      ii. Assess the impact of each line of business to the overall operating results of the insurer.

Document any unusual items or areas of concern.

4. Review the liability for rebate as reported in the Notes to the Financials as well as reported on the NAIC SHCE – Part 1 and in the final rebate reporting to HHS (June 1st).
   a. If the amount reported is material (e.g., greater than 5 percent of capital and surplus), determine whether there are concerns regarding the insurer’s liability for rebates.
   b. Compare the MLR rebate liability as provided in the SHCE and the actual rebate calculation in the HHS Medical Loss Ratio Reporting Form. Were any material differences identified? If so, consider requesting an explanation of the differences from the insurer.

5. Determine whether there are concerns regarding recent rate filing requests.
   a. Contact internal state insurance department staff responsible for the rate review and request information on any recent rate reviews. Were any concerns noted by the rate review staff? (e.g., were rate adjustment requests disapproved or modified) If “yes,” explain.
   b. Review the trend in rate filing requests. Are there any concerns with the frequency or amount of the requests? If “yes,” explain.
   c. Review the Financial Profile Report’s PMPM premium data and compare it to rate increases. Explain any results that appear unusual.

6. During the review of the health care business pursuant to the Public Health Service Act and all applicable filings, did the analyst note any unusual items or areas of concern, not previously noted above, that indicate further review is warranted? If “yes,” explain.

Summary and Conclusion
Develop and document an overall summary and conclusion regarding health care business pursuant to the Public Health Service Act. In developing a conclusion, the analyst should consider the above procedures,
as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the insurer 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 examination section for targeted 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 ________
III. Quarterly Procedures – C. 6. Level 2 Health Care Pursuant to Affordable Care Act (Life/A&H)

1. Determine whether the insurer wrote accident and health insurance premium which is subject to the Affordable Care Act risk-sharing provision and if the amount of premium written exceeded projections and ascertain whether the insurer’s level of capital can support the impact of underestimation of the qualified premium.

2. Review operating results including the A&H loss and total expense ratios to determine whether the insurer may be experiencing difficulties in covering claims and expenses at current premium levels.

3. Determine whether the insurer has limited access to capital or has low liquidity levels.

4. Review the insurer’s current RBC to identify if it’s at a deteriorating level due to ACA risk-sharing provisions or as a result of the ACA fee assessment payable.

5. Analyst review of reinsurance and risk-adjustment accruals to identify insurers that:
   a. Might not be adequately accruing liabilities for premium adjustments payable and for risk adjustment user fees payable.
   b. That might be overestimating premium and adjustments receivables, or;
   c. That might have liquidity issues because payments will be delayed until final determination can be made.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding health care business pursuant to the Affordable Care Act. 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 insurer under the specific circumstances involved.

Does the analyst recommend that one or more of the Additional Procedures in the Annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

   Analyst ________________ Date ________

Comments as a result of supervisory review.

   Reviewer ________________ Date ________
NOTE: As the U.S. Department of Health and Human Services (HHS) continues to provide further direction on issues related to the implementation of the federal Patient Protection and Affordable Care Act, certain procedures and/or guidance in this chapter may be subject to change.

The intent of this chapter is to provide instruction and guidance to analysts regarding the Supplemental Health Care Exhibit. This Exhibit was developed in order to provide a mechanism to ensure that states have the ability to understand and review the elements that make up the numerator and denominator of the medical loss ratio (MLR) that will be calculated pursuant to federal law. THIS EXHIBIT DOES NOT PERMIT A CALCULATION OF THE FINAL MLR FOR REBATE PURPOSES.

Overview

The federal Patient Protection and Affordable Care Act (Pub. L. 111–148) (PPACA) was enacted on March 23, 2010 and the federal Health Care and Education Reconciliation Act (Pub. L. 111–152) was enacted on March 30, 2010. The two statutes collectively are referred to as the federal Affordable Care Act (ACA). The ACA reorganizes, amends, and adds to the provisions of Part A of title XXVII of the federal Public Health Service Act (PHSA) relating to group health plans and health insurance issuers in the group and individual markets.

On May 19, 2011, the U.S. Department of Health and Human Services (HHS), working in partnership with States, issued a final regulation to implement consumer protection regarding rate increase disclosure and review from the ACA.

On Oct. 21, 2010, the NAIC adopted uniform definitions and standard methodologies for medical loss ratios (MLRs) as required in section 2718 of the PHSA as added by the PPACA. The definitions and standards are contained in the NAIC model regulation, The Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2012 and 2013 (Per Section 2718 (b) of the Public Health Service Act), (Model #190). The NAIC transmitted this model, which contains its recommendations regarding the uniform definitions and standard methodologies to HHS on Oct. 27, 2010. On Dec. 1, 2010, HHS published its Interim Final Rule (IFR) which adopted many – but not all – of the NAIC recommendations. (See 45 CFR part 158 at 75 Fed Reg 74864, Dec. 1, 2010). The IFR to date has not been finalized.

The PHSA, Model #190 and the Annual Statement Instructions contain definitions for individual, small group and large group health plans. These three sets of definitions are not necessarily the same, and state law may also differ. In all cases, state law will control. For the purposes of financial analysis of the supplemental health care exhibit (SHCE), analysts should refer either to the Annual Statement Instructions (in the absence of a state law definition) or to state law for a definition of individual, small group and large group health plans. Per the Annual Statement Instructions:

- Individual comprehensive health coverage plans include health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes group conversion policies.

- Small group employer comprehensive health coverage plans include all policies issued to Small Group Employers. Small group health plan means a health plan offered in the small group market as such term is defined in the state law, consistent with the group’s state of situs reporting.
Large group employer comprehensive health coverage includes all policies issued to Large Group Employer (including Federal Employees Health Benefit Program and similar insured State and local fully insured programs, and TRICARE plans).

**Mini-Med and Expatriate Plans**

The Federal Interim Final Regulation defines mini-med and expatriate policies as follows:

Mini-med plans: “For the 2011 MLR reporting year, an issuer with policies that have a total annual limit of $250,000 or less must report the experience from such policies separately from other policies.”

Expatriate plans: “For the 2011 MLR reporting year, an issuer with group policies that provide coverage for employees working outside their country of citizenship, employees working outside their country of citizenship and outside their employer’s country of domicile, and citizens working in their home country, must aggregate the experience from these policies but report the experience from such policies separately from other policies.”

**Annual Statement Reporting**

As stated in the *Annual Statement Instructions*, the purpose of the SHCE is to assist state and federal regulators in identifying and defining elements that make up the MLR as described in Section 2718(b) of the PHSA and for purposes of submitting a report to the HHS Secretary required by Section 2718(a) of the PHSA. The SHCE is also intended to track and compare financial results of health care business as reported in the annual financial statements. Thus, the numbers included in the SHCE are not the exact numbers that will be utilized for rebate purposes due to possible revisions for claim reserve run-off subsequent to year end, statistical credibility concerns and other defined adjustments (Note: regulators will continue to consider the need for a reconciliation from the data in this supplemental exhibit to the data used for rebate purposes).

Comprehensive health care business as defined in the PHSA is written primarily by health entities, life and accident and health insurers, and to a lesser extent, property and casualty insurers and fraternal societies. The SHCE is filed by insurers on April 1st. The analyst should refer to the *Annual Statement Instructions* for specific guidance on reporting requirements.

MLR rebates required by the PHSA and various state laws should follow the guidance in *Statement of Statutory Accounting Principles* SSAP No. 66 – *Retrospectively Rated Contracts*. Beginning in 2011, MLR rebate disclosures are included as an inset to various liability lines of the annual statement and the Notes to the Financial Statements, Note #24 – Retrospectively Rated Contracts and Contracts Subject to Redetermination, disclosures include paid and incurred MLR rebates.

**State Insurance Department Analyst’s Roles and Considerations**

*State’s responsibility regarding Analysis of Supplemental Health Care Exhibit Filings, Medical Loss Ratios, Rebates and Other Confidential Filings*

A state’s primary responsibility for analysis of the SHCE, MLRs, rebates and other filings generally focuses on financial solvency assessment; however, as part of this overall assessment, other


responsibilities for analysts and benefits resulting from analysis performed may exist. For example, in some states, analysts may also be responsible for rate review.

Analysis of SHCE, MLR, rebates and other filings includes, but is not limited to:

- Analysis of the SHCE filings and other related filings should assess completeness and accuracy of the filings. (In some states, this may be performed by financial examiners.)
- Analysis should assess the financial solvency of the plan.
- Analysis should assess the impact of MLR requirements on the overall solvency of the insurer, including assessing if any solvency issues are the results of MLR requirements.
- Analysis may assess quality improvement expenses and/or trends for reasonableness.
- Analysis results may assist in facilitating the communication with staff responsible for rate review and market conduct, and assist in the analysis of rate filings.
- Analysis provides ongoing assessment of risks that should be communicated to the financial examiner.
- Analysis should assist in the subsequent review of the final MLR reporting.
- Analysis results may assist in facilitating communication with and reporting to HHS.

Special Considerations Based on the Type of Business Written

Health coverage will be issued on a guaranteed basis beginning Jan. 1, 2014. Many state high-risk pools will be eliminated or significantly modified because of the ACA. People that were previously uninsurable will be able to obtain coverage under the new law. The ACA makes provisions to reduce the impact of the guaranteed issue requirement by:

- Requiring states to provide for reinsurance on high-cost services for at least three years.
- Providing for risk-sharing between insurers and the federal government through risk corridors similar to those used in the Medicare Part D program. The corridors will also be in place for three years.
- An ongoing risk adjustment mechanism to limit the risk of companies with a higher risk population.

The reinsurance and risk corridor allow insurers time to adjust their pricing strategy for changes in the market as a result of ACA.

The small group line of business will have the risk adjustment mechanism noted above. There are no such provisions for large group business because this line of business is typically experience-rated.

For group coverage written across multiple states, the allocation of premiums and claims should be based on the situs of the contract, namely the jurisdiction in which the contract is issued or delivered as stated in the contract. In the case of an employer with employees in more than one state, the experience of the employer would be aggregated in the state where the contract was issued.

Where a group health plan involves health insurance coverage obtained from two affiliated issuers, one providing in-network coverage only and the second providing out-of-network coverage only, solely for the purpose of providing a group health plan that offers both in-network and out-of-network benefits,
experience may be treated as if it were all related to the contract provided by the in-network issuer. However, if the issuer chooses this method of aggregation, it must apply it for a minimum of three MLR reporting years.

Analysts should consider the allocations of premiums and claims between jurisdictions for reasonableness.

Communication with Financial Examiners on Examiners’ Review of the Accuracy of Reporting

Based on the results of the financial analysis, the analyst should communicate any areas of concern regarding the accuracy of reporting to the financial examiners. Analysts should also evaluate whether any issues were discovered by the financial examination staff with respect to the accuracy of the information reported on the exhibit or issues regarding an insurer’s allocation methodology. Such findings may affect the company’s rebate calculation. Analysts should determine the financial impact of the examination findings to factor into their analysis. (Refer also to the NAIC Financial Condition Examiners Handbook)

Communication with Market Analysis Staff on Outstanding Issues Regarding Rate Review

The ACA requires states to review unreasonable premium rate increases. The HHS will perform the review if a state lacks the authority to perform rate reviews. The ability of an insurer to raise rates may be hindered by the review process. Analysts in organizations that house the rate review function in a department separate from the analysis function should consult with the rate review staff as often as necessary to stay on top of any issues uncovered during the review of rates.

The results of the financial analysis process and the analyst’s concerns should be considered in the rate review process. The analysts should provide those responsible for the rate review a snapshot of the Company’s overall financial condition including, but not necessarily limited to, the following:

- Analysis of current year capital and surplus requirements; stability over the past three years; and percentage increase/decrease of capital and surplus between current and prior periods with a brief discussion of reasons for changes.
- Whether there have been capital infusions – changes in paid-in and contributed surplus.
- Whether there have been dividends paid to stockholders.
- Discussion about surplus notes, if applicable.
- Historical run out of the unpaid claim reserves. Does the company have a history of reserve deficiencies or redundancies?
- Risk-based capital (RBC).
- Minimum capital requirements and the company’s position in regard to the minimum to determine if the company is holding excess surplus.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary (IPS) 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. The analyst should also consider the insurer’s corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or
prospective solvency risks, oversight provided by the board of directors (board) and the effectiveness of management, including the code of conduct established by the board.

The procedures included in this section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The analyst may choose to perform these procedures in conjunction with other Level 2 Procedures, as applicable (e.g. III.C.5. Income Statement and Surplus). Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.

Procedure #1 asks the analyst to determine if the SHCE and the Supplemental Health Care Exhibit’s Expense Allocation Report have been filed in accordance with the Annual Financial Statement Instructions. Refer to the Annual Financial Statement Instructions for details on reporting requirements for insurers in run-off or that only have assumed and no direct business, insurers meeting the Aggregate 2% Rule, and insurers that have no business that would be reported in the columns for Comprehensive Health Care, Mini-Med Plans and Expatriate Plans.

If the insurer’s SHCE was reviewed or is under review by examination staff, the analyst should contact the examiner-in-charge (EIC) to inquire about any material examination findings.

Procedure #2 assists the analyst in a review of the components of the Preliminary MLR.

The ACA requires health insurers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the MLR. The ACA requires insurance companies to spend at least 80 percent of premium for individual and small group policies or 85 percent of premium for large group policies on medical care, with review provisions imposing tighter limits on health insurance rate increases. When reviewing the results of the preliminary MLR, by state, by line of business, the analyst should be aware that individual states can and may require a higher MLR pursuant to state law. If the insurer fails to meet these standards, the insurer will be required to provide a rebate to policyholders starting in 2012 on premium earned in 2011. The purpose of the SHCE is to assist state and federal regulators in identifying and defining elements that make up the MLR as described in Section 2718(b) of the PHSA and for purposes of submitting a report to the HHS Secretary required by Section 2718(a) of the PHSA. During the review of the Preliminary MLR, the analyst should also consider how the individual state’s Preliminary MLR compares to the grand total. (Refer to the Financial Profile Report)

For some procedures, particularly in Procedure 2 and Procedure 3, it may be more useful to use the Preliminary MLR that is calculated by totaling the data from all SHCEs submitted by a company to the states where it has business. This national Preliminary MLR will reduce the impact of potential issues with statistical credibility of claims experience and allocation of various expenses over states and lines of business.

For lines of business in a given state with exposures of less than 1,000 life-years looking at a five-year trend is of very limited usefulness since in such cases, claims experience is not considered credible and is subject to greater variability. More than 1,000 life years, the experience is considered credible, but is still subject to large variations until exposures are well above 1,000 life years.

The MLR will not be calculated in the traditional sense where medical expenses are simply divided by premiums. Premiums are adjusted for certain taxes and expenses. The numerator in the calculation will include health improvement expenses and fraud in addition to medical expenses.
The MLR calculated on the SHCE is a preliminary calculation and will not be used in determining rebates. Insurers will report information concerning rebate calculations directly to the HHS. The numbers that will be utilized for rebate purposes include revisions for claim reserve run-off subsequent to year end, statistical credibility concerns and other defined adjustments.

The state’s responsibility regarding the analysis of the SHCE relates to the financial solvency of the plan. The SHCE gives regulators pertinent information by state and by line of business in more detail than was available previously. A significant amount of detail is provided on health improvement and administrative expenses by line of business. The SHCE also includes an allocation report to assess the reasonableness of a company’s allocations by line of business and across expense categories. Detailed information on the nature of quality improvement expenses is provided for analyst consideration.

The analyst should review completeness or consistency validation exceptions on I-SITE that may indicate if the SHCE has not been prepared and submitted for each jurisdiction in which the company has written direct comprehensive major medical business in accordance with the Annual Statement Instructions.

The aggregation of data reported on the SHCE is by state, by market (individual, small group, large group), and by licensed entity. In other words, each health insurance issuer needs to meet the minimum loss ratio targets in each state and market.

The NAIC I-SITE Financial Profile Report for the SHCE should be reviewed and significant fluctuations investigated. For example, how does the percentage change from the prior year in incurred claims (Line 2.1) compare to total incurred claims (Line 5.0)?

The focal point for the financial analysis for all lines of business and line items should be on a per member per month (PMPM) basis. It may be difficult to identify where significant changes are occurring when analysis is not brought down to a PMPM level. For example, the percentage change in premiums, claims incurred or expenses may be significant. However membership levels may have also increased such that on a PMPM basis the change is not as significant. Similarly, if membership levels are dropping analysis on a PMPM basis may reveal significant increases in these items.

In addition, the analyst should ensure that the Supplemental filing was made providing a description of the methods utilized to allocate “Improving Healthcare Quality Expenses” to each state and to each line and column on the SHCE Part 3. When reviewing this Supplemental filing the analyst should consider whether the detailed descriptions of the Quality Improvement expenses were included, whether such descriptions conform to the definitions provided in the Annual Statement Instructions.

Procedure #2a. The national Preliminary MLR for an insurer is only one component that may be considered in the analysis of company solvency. Note, however that the Preliminary MLR is preliminary data and is not used for the final rebate calculation. Analyses of Preliminary MLRs for each state a company writes business in is potentially useful in assessing a company’s compliance and accuracy in computing Preliminary MLRs and ACA rebates. In a given state, if a line of business (individual, small group, or large group) has less than 1,000 life years of exposure, then the experience is not deemed credible and no rebate is calculated. In such cases, it is likely not useful to review Preliminary MLRs.

Procedures #2 and 3. Note that the preliminary MLR included in this supplemental health care exhibit (for any given state) is not the MLR that is used in calculating the Federal mandated rebates.

The MLR used in the rebate calculation (i.e. the ACA MLR) will differ for two reasons. First the ACA MLR will reflect the development of claims and claims reserves between Dec. 31 of the Statement Year
and March 31 of the following year. The second and far more important reason is that the ACA MLR includes a credibility adjustment that is based on the number of covered lives and certain benefit provisions of the coverages provided. The adjustment takes the form of an addition of percentage points to the calculated MLR. The ACA MLR is then used to determine if a rebate is due and to calculate the amount of the rebate. If the ACA MLR is greater than the relevant MLR standard no rebate is due. If the ACA MLR is less than the relevant MLR standard the rebate is calculated by multiplying the difference between the ACA MLR and the standard MLR by earned premium. Except for very large blocks of business (75,000 lives or more), the ACA MLR will always be larger than the Preliminary MLR. Conversely, for very small blocks of business (under 1,000 lives) the ACA MLR is not calculated since no rebate is due.

Despite the differences, the validity and reasonableness of the ACA MLR calculation, and therefore of the rebate calculation can be assessed using the data from the SHCE. The following elements from the SHCE and the rebate calculation can be used for such an assessment.

For the following items there should be little or no difference between the amounts in the SHCE and the rebate calculation.

- Earned premium.
- Federal and state taxes and licensing or regulatory fees.
- Expenses to improve health care quality.

For other items, there are expected to be differences between the SHCE and the rebate calculation due to the difference in the time of reporting between the two.

- Paid claims, unpaid claim reserve, and incurred claims
- Experience rating refunds and reserves for experience rating refunds
- Change in contract reserves
- Incurred medical pool incentives and bonuses
- Net healthcare receivables

For the Contingent Benefit Reserve, the expected relationship between the SHCE and the rebate calculation is unknown as yet.

Procedure #3 assists the analyst in reviewing the underwriting gain or loss by line of business and assessing the impact of each line to the insurer’s total operating results and financial solvency.

Procedure #4 assists the analyst in a review of the insurer’s rebate liability. (Also refer to the guidance above.)

The analyst may consider performing a comparison of the components of the MLR as reported in the SHCE and the HHS Medical Loss Ratio Reporting Form to identify any material differences in the line items. If, in the analyst’s judgment, any material differences require explanation, consider requesting such explanation from the insurer.

The MLR rebates are mandated by the PHSA to be returned to the policyholders if the ratio of medical losses and various other items paid to the ratio premiums paid (with various adjustments) is below
specified thresholds (80 percent for individuals or small group employers or greater than 85 percent for large group employers, or a threshold established in state law).

As stated above, the analysts should be aware that the preliminary MLR is not the MLR to be used for federal rebate calculations and payment purposes. For example, for federal rebate purposes issuers that have blocks of business less than a given size can make a credibility adjustment to their MLR on the federal MLR reporting form. A credibility adjustment refers to the adjustment to account for random statistical fluctuations in claims experience for smaller plans. Blocks of business with less than 1,000 life years are considered non-credible and will not be required to pay rebates in most cases. Blocks of business with greater than 1,000 but less than 75,000 life years may add a credibility adjustment to the calculated MLR. Blocks of business with greater than 75,000 life years are considered fully credible and cannot use a credibility adjustment. (Refer to the Federal Interim Final Rule 45 CFR 158.230, 158:231 and 158:232 for specific details of the credibility adjustment calculation.)

Procedure #5 assists the analyst in identifying any risks or concerns with recent rate reviews. As stated above, the rate review process may be performed by HHS or by the state department of insurance (DOI), depending on the states’ authority. The analyst should review any recent rate reviews performed (or if a different department, communicate with the rate review staff) and assess if any concerns exist. An analyst should also consider how the increase in the PMPM premiums compares with approved rate increases. Consider that there may have been different rate increases for different plans. Also consider the overall increase in premium PMPM for reasonableness compared to the approved rate increase.

In 2010, the NAIC adopted a form used to meet the requirements of Section 2794 of the PPACA that specifies insurers must provide justifications for any rate filing request that meets an “unreasonable” threshold. The form is not an endorsement of any definition of “unreasonable” that HHS may develop. The form does not apply to large group business.

The analyst should have a general understanding of the states’ rate regulation laws and practices. Currently, states have a number of ways to regulate rates. In the individual market, the majority of states rely on actuarially justified ratings, while some states rely on community ratings, adjusted community ratings and rating bands. In the small group market, rating bands are more prevalent, while a small number of states utilize community ratings and adjusted community ratings. Rating bands limit the variation in premiums attributable to health status and other characteristics. Community ratings prohibit the use of any case characteristics besides geography to vary premium. Adjusted community ratings prohibit the use of health status or claims experience in setting premiums. Actuarial justification requires the insurer to demonstrate a correlation between the case characteristics and the increased medical claims costs. The NAIC has adopted safe harbors for case characteristics commonly used for setting premiums without providing justification. For further guidance, refer to the applicable state law or regulation.

Discussion of Level 2 Quarterly Procedures

Due to uncertainties created by the ACA, state insurance departments may perform Level 2 quarterly reviews in 2015 for all insurers. Insurance regulators should take special measures to identify carriers that have deteriorating solvency strength due to misestimating the market. The 2014 risks are likely to be as much or more liquidity risks as they are solvency risk.

The ACA imposes fees and premium stabilization provisions on insurance companies offering commercial health insurance. This includes imposing an assessment on insurers that issue health insurance for each calendar year beginning on or after Jan. 1, 2014. An insurance company’s portion of the assessment is paid no later than Sept. 30 of the applicable calendar year (the fee year) beginning in
2014 and is not tax deductible. The amount of the assessment for the insurer is based on the ratio of the amount of an insurer’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 insurer will be somewhat dependent on its concentration in those markets.

Each of the premium stabilization programs is designed to provide protection to the insurer by mitigating adverse financial outcomes; however, these programs could have a negative impact as well. Moreover, each program includes a retrospective settlement process. As such, the insurance company’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.

A description of each of the programs is as follows:

**Risk Adjustment Program**

The risk adjustment program is a permanent risk-spreading program and is effective beginning in the 2014 benefit year. All risk adjustment covered plans are required to participate in the risk adjustment program. This includes all health plans in the individual or small group markets both on and off the exchange that are compliant with the ACA market reforms. Grandfathered plans and non-compliant plans that have been granted extensions are not subject to risk adjustment. Additionally, there is a carve-out for student plans.

The purpose of the risk adjustment program is to transfer funds from lower risk plans to higher risk plans within the same market in the same state in order to adjust premiums for adverse selection among carriers caused by membership shifts due to guarantee issue and community rating mandates.

States may set up their own risk-adjustment programs, or they may permit HHS to develop and manage this program in the state. HHS will determine a user fee. In states operating their own risk-adjustment program, the state will determine the fee.

**Program payments** – Each state shall assess health plan issuers if the actuarial risk score of all of their enrollees in a state is lower than the average risk score of all enrollees in full-insured plans in that state. Payments will be made to health plan issuers whose enrollees have an actuarial risk score that is greater than the average actuarial risk scores in that state.

**Program contributions** – An issuer that offers risk adjustment covered plans and that has a net balance of risk adjustment charges payable will be notified and payment to the state or HHS on behalf of the state will be required by June 30 of the calendar year following the benefit year. Payments will be computed based on the insurer’s risk score versus the overall market risk score after applying adjustments. The reinsurance program is not considered in the computation.

**Program administration** – HHS intends to collect a user fee to support the administration of HHS-operated risk adjustment. This fee would apply to issuers of risk adjustment covered plans in states in which HHS
is operating the risk adjustment program. HHS projects that the per capita risk adjustment user fee 2014 will approximate $1 per enrollee per year. HHS will invoice risk adjustment program charges and payments. The same terms will apply for the user fee.

Timing of payments – All payments made to issuers must be completely funded through the charges assessed to other issuers within the same market in the same state to ensure proper balancing between payments and charges. Consequently, charges will be invoiced prior to processing issuer payments. Once all applicable charges are received by HHS or the state, funds will be redistributed to the higher risk plans. Each issuer will be notified of risk adjustment payments owed to, or charges owed by, the issuer by June 30 of the year following the benefit year to align the payments and charges processing. Charges owned by an issuer to HHS or the state must be remitted within 30 days of notification of the risk adjustment payments. Once all applicable charges are received by HHS or the state, funds will be redistributed to the higher risks.

The ACA risk-adjustment mechanism has several elements that may lead to increased uncertainty in an issuer’s reported financial statements, particularly with respect to 2014 financial reporting. These include the following:

• **Uncertainty as to the issuer’s risk score.** With the risk-adjustment mechanism being based on concurrent analysis, as of year-end, the issuer does not possess all of the data that ultimately will be relevant to calculating its own risk score.

• **Uncertainty as to other issuers’ risk score.** This is perhaps the largest uncertainty. Even if an issuer had perfect knowledge of its own aggregate risk score for a particular risk-adjustment cell, the ultimate payment it makes or receives for that cell is dependent not on its absolute aggregate risk score, but on the relative relationship between its aggregate risk score and those of all issuers participating in that risk-adjustment cell.

This uncertainty will be greater in 2014 than in subsequent periods because after 2014, carriers will have an understanding of what the aggregate risk score is for each risk-adjustment cell based on the prior year’s reported data.

• **Uncertainty as to member exposure.** There has always been some uncertainty at year-end around the issuer’s membership, due to premium grace period provisions that customers may exercise after year-end that keeps their coverage inforce. However, the ACA could increase the uncertainty around estimating the issuer’s member exposure, since it requires that issuers extend the grace period from 30 days to 90 days for any member receiving a premium subsidy via the exchanges.

• **Granularity of the calculation.** The commercial risk-adjustment mechanism, as contrasted with the existing Medicare Advantage risk-adjustment mechanism, is not a single national calculation but rather a series of separate calculations for each risk-adjustment cell. Even an issuer operating in only one state likely will have no more than three risk-adjustment cells to evaluate, namely individual catastrophic, other individual, and small group.

• **Implications of data review.** Although the data supporting the risk scores is maintained by each issuer, the regulations call for a data validation review that could lead to payment adjustments. The current regulations are proposing that no payment adjustments be made in 2014 or 2015.
Regulations specify no interaction between the risk-adjustment mechanism and the reinsurance mechanism. The risk-adjustment mechanism will be settled prior to the risk corridors and the calculation of any minimum loss ratio liability. These other programs will not contribute to the uncertainty related to the risk-adjustment program.

Reinsurance Program

Transitional reinsurance is effective for plan years 2014 through 2016 as a temporary transitional reinsurance program.

Starting in 2014, issuers offering products in the individual market can no longer deny coverage based on pre-existing conditions. As a result, in 2014 the individual risk pool is expected to include a greater proportion of people with chronic conditions, resulting in increased incidence of large claims. The transitional reinsurance mechanism is designed to protect issuers in the individual market from this expected increase in large claims. The reinsurance protection is funded by assessments from the commercial health insurance market and from sponsors of self-funded health benefit plans.

All issuers of major medical commercial products and third party administrators (TPAs) on behalf of uninsured group health plans are required to contribute funding at the national contribution rate to HHS. States establishing reinsurance programs may collect additional funding. Non-grandfathered individual plans are eligible to receive benefit program distributions via an excess-of-loss reinsurance system. Grandfathered plans are ineligible. All group plans are required to contribute funding, but they are not eligible to receive reinsurance program distributions.

This transitional reinsurance program provides funding to issuers in the individual market that incur high claims costs for enrollees. The program requires assessments from all issuers and TPAs on behalf of group health plans based on a per member annual fee established by HHS. The reinsurance assessment will fund reinsurance program distributions plus disbursements to the U.S. Department of the Treasury, in addition to covering administrative expenses of the program.

Program Contributions – The national contribution rate for all issuers and TPAs was established by HHS and is designed to collect more than $12.0 billion in 2014 to cover the required $10 billion in reinsurance payments, the $2.0 billion contribution to the U.S. Treasury, and additional amounts to cover the administrative costs of the Federal and applicable reinsurance entities. States electing to operate their own reinsurance program have the option to increase the contribution rate to provide additional funding for reinsurance payments or to fund the administrative expenses of the applicable reinsurance entity. Contributions for the reinsurance program must fund reinsurance payments of $10.0 billion in 2014, $6.0 billion in 2015 and $4.0 billion in 2016, plus disbursements to the U.S. Treasury of $2.0 billion, $2.0 billion and $1.0 billion, respectively in those years, in addition to covering administrative expenses of the applicable reinsurance entity or HHS.

Program Payments – Reinsurance payments will be processed either by the applicable reinsurance entity or by HHS and will be made to issuers of non-grandfathered individual market plans for high claim costs of enrollees. Payments from the applicable reinsurance entity to insurers providing individual coverage will be calculated as a coinsurance rate multiplied by the eligible claims submitted for an individual enrollee’s covered benefits between an attachment point and the reinsurance cap for each benefit year. The coinsurance rate, attachment point and reinsurance cap are initially determined by HHS, but they may be modified by the state, if the state chooses to establish its own reinsurance program.

Program Administration – Each state is eligible to establish a reinsurance program, regardless of whether the state establishes a Marketplace Exchange. If a state establishes a reinsurance program, the state must
enter into a contract with an applicable reinsurance entity or entities or establish a reinsurance entity to carry out the program. If a state does not elect to establish its own reinsurance program, HHS will administer the reinsurance program on behalf of that state. HHS has established that the administrative portion of the 2014 will be $0.11 per-member per-year resulting in $20.3 million of administrative expense funding.

**Timing of Contributions/Payments** – Contributions to fund the program are made on an annual basis beginning Dec. 15, 2014. An insurer may submit claims for reimbursement when an enrollee of the reinsurance-eligible plans has met the applicable criteria as determined by either the state or HHS. Claims may be submitted through April 30 of the year following the benefit year. HHS will distribute reinsurance payments among issuers nationally based on submitted claims. Issuers will be notified of pending reinsurance payment amounts by June 30 following the benefit year. If the requests for payments exceed actual contribution amounts, HHS will reduce reinsurers’ payments on a pro rata basis. In 2014, if the request for payments is less than actual contributions, reinsurance parameters would be adjusted to achieve full payout without a carry forward.

There are a number of aspects of the reinsurance program that can increase uncertainty and/or impair comparability in the 2014 financial statements for an issuer. These include the following:

- **Accrual for reinsurance on unpaid claims.** With respect to excess-of-loss reinsurance, many issuers historically have accrued for reinsurance receivables on specifically identified claims only. However, the magnitude of the expected ACA reinsurance benefit in relationship to premium will motivate issuers to consider estimating the potential reinsurance recovery on unpaid claims for which no specific information is available.

- **Magnitude of the reinsurance recovery accrual.** Since the regulations do not require interim settlements, an issuer will be recording an accrual at Dec. 31 for the full year’s reinsurance recovery.

- **Potential valuation allowance on reinsurance recoverable.** Since reinsurance benefits are limited to available funds in the reinsurance pool, there is potential for reinsurance benefits to be reduced due to availability of funds.

- **Potential for denied reinsurance claims.** The review process for reinsurance claims may lead to some denial of filed claims. Since this review process will not occur until after the year-end financial statements are filed, the issuer either will have to estimate a probability of claim denial or accept the possibility that future income could be affected adversely by any claim denial. Since there is no prior history for the ACA-specific reinsurance program, any estimates of the probability of a claim denial likely will vary significantly by issuers. Some issuers may conclude that they are unable to make such an estimate.

**Risk Corridors Program**

This program is effective for benefit years beginning in 2014 through 2016. The risk corridors program applies to qualified health plans (QHPs) in the individual and small group markets whether sold on or outside of an exchange.

The purpose of the risk corridors program is to provide limitations on issuer losses and gains for QHPs through additional protection against initial pricing risk. The risk corridors program creates a mechanism for sharing risk for allowable costs between the federal government and QHP issuers. The ACA establishes the risk corridors program as a federal program; consequently, HHS will operate the risk...
corridors program under federal rules without state variations. The risk corridors program is intended to protect against inaccurate rate setting in the early years of the exchanges by limiting the extent of issuer losses and gains. Although the ACA implies a level of governmental responsibility to fund the program, current rules and statements from HHS, indicate that the program will be budget-neutral, and the HHS has further indicated that program rules will be changed as needed and program distributions delayed until the subsequent year in order to achieve budget neutrality. However, HHS has indicated it will make risk corridor payments regardless of budget neutrality, subject to sufficiency of funds appropriated.

The risk-corridor program was designed to provide some aggregate protection against variability for issuers in the individual and small-group markets during the period 2014 through 2016. In many cases, the risk corridor will lessen much of the potential volatility and uncertainty in ultimate earnings that may be driven by the other two premium stabilization programs.

The risk-corridor calculation is to be performed after considering any amounts transferred to or from the issuer as a result of the risk-adjustment or reinsurance programs. Although the risk-corridor mechanism provides protection against extreme bounds of experience, there is a substantial corridor in which all variance in experience directly affects the financial return to the insurer. In estimating the risk-corridor receivable or liability, it will be important that the insurer fully consider the expected impact of the risk-adjustment and reinsurance mechanism.

The final risk corridors settlement calculation will be communicated by HHS after the end of the benefit year and after premium and loss adjustments related to the reinsurance and risk adjustment programs have been determined.

Due to the uncertain future of health insurer solvency, it is recommended to consider the following procedures in reviewing insurers who write health insurance as they pertain to the ACA. The procedures are more in line with Level 2 procedures as they are presented in the Handbook as opposed to Level 1.

Procedure #1 recommends the analyst 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. This procedure also recommends 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 and assess Note 22 – Events Subsequent of the Notes to Financial Statement, Type II – Nonrecognized Subsequent Events, item C. Premium Written subject to ACA 9010 assessment. An insurer’s annual ACA fee is allocated to individual health insurers based on the ratio of the amount of the insurer’s net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A fluctuation in premium would generally be an indication of a reason for concern.

In an instance of excessive growth not accompanied by additional surplus, the capital and surplus may not be able to support the additional exposure. Additionally, the insurer may adjust reserves as a percentage of premiums, which can lead to additional risk.

In cases where the premium has significantly changed, the analyst should assess the level of business written by the insurer by comparing premium and risk revenue to capital and surplus. This comparison should include premium and risk revenue recorded by the insurer in its income statement since both sources of revenue represent exposure to the insurer. This type of comparison is generally considered a measure of an insurer’s operating leverage and is important in determining the potential losses to the

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insurer. The higher the writings ratio, the more likely the insurer will record a material loss when morbidity spikes.

Determine whether the insurer is excessively leveraged due to the volume of premium written. The ratios of net premiums and risk revenue to capital and surplus measures the extent to which that capacity is being utilized and the adequacy of the insurer’s capital and surplus cushion to absorb losses due to pricing errors, adverse underwriting results and underestimating market conditions.

In assessing financial condition, considerable emphasis is placed on the adequacy of an insurer’s capital and surplus. Capital and surplus provides protection for policyholders against adverse underwriting results, inadequate reserve levels and fluctuations in the value of assets. In addition, capital and surplus provides underwriting capacity and allows an insurer to expand its business.

Procedure #2 assists the analyst to determine whether there are concerns regarding the insurer’s overall operating results and financial solvency. This procedure recommends the analyst review underwriting experience including the A&H loss and total expense ratios to identify those insurers that are experiencing difficulties in covering claims and expenses based on current premium levels.

When premiums are not sufficient to cover all claims and administrative expenses, the insurer 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.

With the uncertainty of the ACA health plan, premiums are more likely to be inadequate in situations where claims are difficult to predict.

The analyst should review Note 24 – Retrospectively Rated Contracts & Contracts Subject to Redetermination item D. disclosures of the amounts for MLR rebates required pursuant to the PHSA for the current reporting period year-to-date and prior reporting year including incurred rebates, amounts paid and unpaid liabilities.

An insurer’s administrative expense ratio is a moderate indicator of financial problems for most insurers. It is an indicator of how much of an insurer’s premium is expended on general expenses, and how efficient the insurer is in its operations. It also measures the cost of acquiring and maintaining business for an insurer.

High acquisition and administrative expenses in relation to premiums can indicate current or future profitability concerns. The administrative expense ratio not only includes administrative expenses but also claims adjustment expenses. Claims adjustment expenses are the costs incurred relating to reported and unreported claims and are considered to be administrative in nature.

Procedure #3 assists the analyst in determining whether an insurer has limited access to capital or has low liquidity levels. The analyst should address the parent or holding company’s ability to provide capital to the insurer as needed.

This procedure also assists the analyst in determining an insurer’s ability to meet its current obligations with its current cash and invested assets. A significant increase in the liabilities to liquid assets ratio could indicate the insurer’s growing inability to satisfy its financial obligations without having to sell long-term investments.
On a quarterly basis, the analyst should review cash flow and liquidity ratios:

1. Are the liquid assets and receivables to current liabilities ratio less than 200 percent?
2. Is the ratio of working capital to total assets less than 30 percent?
3. Are affiliated investments and receivables greater than 20 percent of capital and surplus?

Procedure #4 recommends reviewing quarterly estimates of health RBC based on quarterly financial information to identify deteriorating RBC levels.

The RBC formula is designed to calculate a minimum threshold measure of capital and surplus adequacy based on each insurer’s unique mix of asset risk, insurance risk, and business risk.

Since it is retrospective, the current annual RBC formula will not identify any negative result of these risks until the end of 2014. As such, the solvency of a company could be negatively affected by mispricing due to these factors.

Procedure #4 directs the analyst to identify an insurer that may have deteriorating solvency strength due to misestimating the current year market. The procedure recommends that the analyst perform an RBC quarterly estimation based on underwriting and business risk. Underwriting risk represents the risk associated with unexpected fluctuation of incurred claims while business risk includes the risk associated with excessive growth levels of the insurer’s premiums. The analyst should utilize the Quarterly RBC Estimation tool within I-SITE. This procedure assists the analyst in determining whether the overall amount of total adjusted capital and surplus is adequate to support growth.

For the annual reporting period ending Dec. 31, 2013 and thereafter, an insurer subject to the ACA assessment will provide a disclosure in Note 22 – Subsequent Events of the Notes to Financial Statements of the annual financial statement of the assessment payable in the upcoming year and an estimate of its financial impact, including the impact on its RBC position as if it had occurred on the balance sheet date. Additionally, for annual reporting periods ending on or after Dec. 31, 2014, the disclosure has been expanded to include information on the amounts reflected in special surplus in the data year.

The disclosure provides information regarding the nature of the assessment, estimated amount of the assessment payable for the upcoming year (current 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 based on net assessable premium.

The disclosure also provides the Total Adjusted Capital (TAC) and Authorized Control Level (ACL) before and after adjustment to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The disclosure also provides a statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

Procedure #5 recommends the analyst review Note 24 – Retrospectively Rated Contracts & Contracts Subject to Redetermination Item E. disclosures to assess the impact of the Risk Sharing Provisions of the ACA on admitted assets, liabilities and revenue for the current year.
III. Annual Procedures – C.7. Level 2 Risk-Based Capital (Life/A&H)

1. Determine whether concerns exist regarding the insurer’s Risk-Based Capital (RBC) position.
   a. Review the Annual Financial Statement, Five-Year Historical Data Schedule, RBC Analysis and/or the RBC filing, and consider the following:
      i. Is the ratio of Total Adjusted Capital divided by Authorized Control Level (RBC Ratio) less than or equal to 250 percent?
      ii. If the current RBC Ratio is less than or equal to 300 percent, has there been a significant change (+30 points/–20 points) in the RBC Ratio from the prior year?
      iii. Has the RBC Ratio declined each of the past two years? If so, show the percentage point decline over the two years and the current-year RBC Ratio.
      iv. Has the Total Adjusted Capital declined by 15 percent or greater from the prior year?
      v. Has the Authorized Control Level increased by 15 percent or greater from the prior year? If so, review the five RBC risk factors for material changes from the prior year and document the leading underlying causes for the changes.

2. Did the insurer fail the RBC Trend Test? If so, discuss the plans to address the RBC Trend Test failure.

3. If the insurer has triggered an action level RBC event and if authorized by statute:
   a. Obtain and review a copy of the insurer’s RBC plan.
   b. Monitor the insurer’s RBC plan and overall progress in implementing plan initiatives and improving the RBC level.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding RBC. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating RBC.

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 examination section for targeted 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

Beginning with the 1993 Annual Financial Statement, life and health insurers became subject to a new Annual Financial Statement requirement that they calculate and report an estimated level of capital that is dependent upon the insurer’s risk profile. An insurer’s risk-based capital (RBC) requirement is calculated by applying risk factors to various asset, premium and reserve items, where the factor is higher for those items with greater underlying risk and lower for those items with lower underlying risk. The RBC ratio is defined as the ratio of Total Adjusted Capital (i.e., actual capital) divided by Authorized Control Level RBC (i.e., required capital). States that enact the Risk-Based Capital (RBC) for Insurers Model Act can take regulatory action based upon this ratio. Historically, minimal capital requirements were imposed on insurers by various state laws. Those minimums frequently were arbitrary, generally low, varied widely from state to state, and generally did not consider the risk profile of the insurer. The RBC Model Act supplements the system of absolute minimums and considers the risk profile of each individual insurer.

The RBC formula and Model Act were the result of several years of work by insurance regulators, actuaries and other industry representatives. The formula is detailed and lengthy, but in concept is quite simple. There are five major categories of risk requirements: 1) asset risk – affiliates; 2) asset risk – other; 3) insurance risk; 4) interest rate risk and health credit risk; and 5) business risk. Each is summarized below.

1. **Asset Risk – Affiliates**
   
   This is the risk of assets’ default for certain affiliated investments. This represents the RBC requirement of the downstream insurance subsidiaries owned by the insurer. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the carrying value. There are thirteen categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items are included in this risk component, such as non-controlled assets, guarantees for affiliates, contingent liabilities, etc.

2. **Asset Risk – Other**
   
   Asset risk attempts to measure the risk that an insurer’s assets will default or will decline in fair value. Each category of assets is assigned a risk requirement factor that increases with the perceived risk level of the asset. For example, high quality bond investments are assigned a low factor and noninvestment-grade bonds are assigned a high factor. Similar factors are assigned to other asset categories.

3. **Insurance Risk**
   
   Insurance risk represents the risk associated with unfavorable and/or improper assumptions used by an insurer in the mortality, morbidity, persistency and investment income components of insurance underwriting. The risk factors target the net amount of insurance at risk, net of reinsurance. The higher the level of insurance in-force, the lower the relative factor. Health insurance premiums and reserves are also targeted in the insurance risk factor.

4. **Interest Rate Risk and Health Credit Risk**
   
   Interest rate risk represents the risk that may arise under changing interest rate environments associated with asset and liability mismatches. This area especially impacts annuity writers. Annuity products that are not subject to discretionary withdrawal, or are subject to discretionary withdrawal with a market value adjustment, are assigned a lower risk factor. Annuity products
subject to discretionary withdrawal with nominal surrender charges receive a higher risk factor. Thus, those insurers that have written large volumes of high yielding annuities, and invested in high-risk assets to earn a spread, are required by both the asset risk and interest rate risk formula to maintain higher capital levels to reflect the increased risk. Health credit risk is the risk that health benefits prepaid to providers become the obligation of the health insurer once again.

5. **Business Risk**

Business risk represents other potential risks that are not effectively covered by the previous three categories. The key area addressed here is premium income subject to guaranty fund assessments.

The Model Act requires a comparison between Total Adjusted Capital and Authorized Control Level RBC. The Model Act then defines several levels of RBC. The description of each level includes a brief summary of what happens if an insurer’s Total Adjusted Capital is below that level. For example, one of the levels is called the “Company Action Level,” because an insurer must take action if its Total Adjusted Capital falls below that level. The various levels are related to one another by fixed percentages as follows:

\[
\begin{align*}
\geq 250\% \text{ (or} 300\% \text{)} & \quad \text{No action level} \\
\geq 200\% \text{ to} < 250\% \text{ (or} 300\% \text{)} & \quad \text{Trend test level} \\
\geq 150\% \text{ to} < 200\% & \quad \text{Company action level} \\
\geq 100\% \text{ to} < 150\% & \quad \text{Regulatory action level} \\
\geq 70\% \text{ to} < 100\% & \quad \text{Authorized control level} \\
< 70\% & \quad \text{Mandatory control level}
\end{align*}
\]

Most insurers are required to file a “RBC report.” The report shows the calculation of the Total Adjusted Capital and the calculation of the RBC levels. An insurer whose Total Adjusted Capital is greater than 250 percent of the Authorized Control Level is not within an action level. Other than filing the RBC report, no further action is required by the insurer. An insurer may trigger a Company Action Level event if the RBC Trend Test is triggered and the domiciliary state has adopted the trend test. An insurer that falls within or below the trend test level may trigger an action level if the insurer reports a declining RBC ratio. An insurer that falls within or below the Company Action Level is required to file a RBC plan with the domiciliary state. The plan must include proposals for corrective steps by the insurer. Model #312 provides that the plan is confidential. If an insurer’s Total Adjusted Capital is within the Regulatory Action Level, the insurance commissioner must perform whatever examination of the insurer is deemed necessary, and issue an order specifying the corrective steps to be taken by the insurer. If an insurer’s Total Adjusted Capital is within the Authorized Control Level, the commissioner may seize the insurer if that step is deemed to be in the best interests of the policyholders and creditors of the insurer and of the public. If an insurer’s Total Adjusted Capital is within the Mandatory Control Level, the commissioner must seize the insurer; however, that step may be forgone if there is a reasonable expectation that the circumstances causing the insurer to be within that level will be eliminated within 90 days.

**Discussion of the Level 2 Annual Procedures**

The Level 2 Annual Procedures are designed to identify potential areas of concern regarding RBC.

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. The analyst should also consider the insurer’s corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

Procedure #1 assists the analyst in understanding the insurer’s RBC position. Some examples that may cause the RBC Ratio to fall into an RBC Action Level include, but are not limited to, increased writings, heightened investment risk, catastrophic loss events, or an unexpected surplus decline. The procedure also identifies insurers with an RBC Ratio below 300 percent that have recorded significant increases or decreases from the prior year. Additionally, the procedure identifies insurers that have recorded RBC Ratio declines over two successive years. The procedure also identifies significant changes in the RBC Ratio components compared to the prior year. The analyst should document the leading underlying causes for the changes in the Authorized Control Level and Total Adjusted Capital.

Procedure #2 determines for the analyst whether the insurer failed the RBC Trend Test. The RBC Trend Test is triggered when an insurer has an RBC ratio between 200 and 250 (or 300) percent, and the insurer has had a negative RBC trend for three years. The trend test calculates the greater of the decrease in the margin between the current year and the prior year and the average of the past three years. Any insurer that trends below 190 percent could potentially place the insurer in a Company Action Level if the domiciliary state has adopted the trend test. The Capital Adequacy (E) Task Force amended the RBC Model Act in 2011 to increase the upper threshold for the trend test to 300 percent. The percentage to be utilized for a domestic insurer is dependent on individual state law.

Procedure #3a directs the analyst to obtain and review a copy of the insurer’s RBC plan if the insurer has triggered an action level RBC event. If applicable in your state, the analyst may participate in the review and approval process of the RBC plan. The RBC plan is a comprehensive financial plan which: 1) identifies the conditions in the insurer which contribute to the Company Action Level Event; 2) contains proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the Company Action Level Event; 3) provides projections of the insurer’s financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and/or surplus (the projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component); 4) identifies the key assumptions impacting the insurer’s projections and the sensitivity of the projections to the assumptions; and 5) identifies the quality of, and problems associated with, the insurer’s business including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance in each case, if any.

Procedure #3b directs the analyst to monitor, on a periodic basis, the insurer’s progress in achieving the initiatives included in the RBC plan and the impact of those initiatives on Total Adjusted Capital and the risk factors in the Authorized Control Level RBC. The goal of any RBC plan is the improvement of the underlying causes that led to an RBC Action Level, and an improvement in subsequent RBC Ratio results that will remove the insurer from Action Level status.
III. Annual Procedures – C.8. Level 2 Cash Flow and Liquidity (Life/A&H)

1. Determine whether concerns exist regarding the insurer’s cash flow from operations. Review the Cash Flow.
   a. Is net cash from operations negative? If “yes,” calculate:
      i. Net cash from operations to premium income.
      ii. Net cash from operations to capital and surplus.
   b. Review the trend in cash flow from operations for the past five years and note any unusual fluctuations or negative trends between years.
   c. Are net transfers to or from separate accounts greater than 20 percent of capital and surplus?
   d. Has the line item other cash provided (applied) changed by more than +/- 10 percent of capital and surplus?
   e. Is the line item other cash provided (applied) greater than 10 percent of capital and surplus?
   f. Is the line item other cash provided (applied) greater than +/- 150 percent of net cash from operations?

   Additional procedures and prospective risk considerations if further concerns exist:
   g. Review the trend in line items within cash flow for the past five years and note any unusual fluctuations or negative trends between years.
   h. Review the trend in net transfers to or from separate accounts for the past five years for unusual fluctuations, such as:
      i. Significant reliance on cash provided from separate accounts.
      ii. Significant trends in providing cash to separate accounts.
   i. Describe any material commitments for capital expenditures as of the end of the reporting period indicating the purpose, source of funds, changes in equity and debt, and any off-balance sheet financing arrangements.
   j. Compare cash flow from operations with the industry and peer group (Peer Financial Report) in order to identify significant deviations.

2. Review Schedule E – Part 3 and determine whether concerns exist regarding the insurer’s special deposits.
   a. Is the book/adjusted carrying value of all other special deposits (not for the benefit of all policyholders) greater than 50 percent of total special deposits?
   b. Is the difference between the book/adjusted carrying value of total special deposits to the fair value of total special deposits greater than 5 percent?

   Additional procedures and prospective risk considerations if further concerns exist:
   c. Review the listing of special deposits held by the insurer not for the benefit of all policyholders and consider:
      i. The number of states in which the insurer has these types of deposits. The greater the number, the more difficult it could be for the domiciliary state to call on these deposits in a rehabilitation.
III. Annual Procedures – C.8. Level 2 Cash Flow and Liquidity (Life/A&H)

ii. The amount of concentration in any one particular state.

3. Determine whether concerns exist regarding the insurer’s overall level of liquidity.
   a. Is the change in liquid assets less than negative 15 percent or greater than 80 percent?
   b. Is the ratio of surrender benefits and withdrawals on deposit-type contracts to net premiums and deposits on deposit-type contracts greater than 50 percent?
   c. Are surrender benefits and withdrawals on deposit-type contracts greater than 20 percent of capital and surplus?

Additional procedures and prospective risk considerations if further concerns exist:
   d. Compare the insurer’s cash flow and liquidity results to industry and peers in the Peer Financial Profile in order to identify significant deviations.
   e. Review Schedule D – Part 1 and determine the extent to which the fair value of bonds varies from the amortized cost (III.C.1. Investments Procedure #54 and assess the impact of such variance on the insurer’s overall liquidity.
   f. Communicate with the examiner to determine if the insurer has recently provided responses to the stress liquidity inquiries and templates included in the NAIC Financial Condition Examiners Handbook. If such has occurred, review this information to ascertain whether the analyst’s liquidity concerns have been alleviated. If not, request the insurer to submit responses to these inquiries.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding cash flow and liquidity. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating cash flow and liquidity 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 examination section for targeted 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 ________
III. Quarterly Procedures – C.8. Level 2 Cash Flow and Liquidity (Life/A&H)

1. Determine whether concerns exist regarding the insurer’s cash flow from operations. Review the Cash Flow for the current quarter and prior year, same quarter.
   a. Is net cash from operations negative?
      If “yes,” calculate and consider the following ratios:
      i. Net cash from operations to premium income.
      ii. Net cash from operations to capital and surplus.
   b. Has net cash from operations changed by greater than +/-10 percent of capital and surplus?
   c. Has net transfers to separate accounts changed by greater than +/-10 percent from the prior quarter-to-date?
   d. Is net transfers to separate accounts greater than 20 percent of capital and surplus?
   e. Has other cash provided (applied) changed by greater than +/-10 percent of capital and surplus?
   f. Is other cash provided (applied) greater than 10 percent of capital and surplus?
   g. Is other cash provided (applied) greater than +/-150 percent of net cash from operations?
   h. Have surrender benefits (from the Summary of Operations) changed by greater than +/- 5 percent of capital and surplus?

2. Determine whether concerns exist regarding the insurer’s overall level of liquidity.
   a. Is the change in liquid assets from the prior year quarter-to-date or from the prior year-end less than negative 15 percent or more than 80 percent?
   b. Are surrender benefits (from the Summary of Operations) greater than 20 percent of capital and surplus?

Summary and Conclusion

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

Does the analyst recommend that the Priority designation of the insurer be changed as a result of the procedures performed? Justify the recommended priority designation.

   Analyst ________________ Date ________

Comments as a result of supervisory review.

   Reviewer ________________ Date ________

Overview
The Cash Flow is one of several core financial statements presented in the Annual Financial Statement of life/health insurers. It provides information about the primary sources of cash (inflow) and applications of cash (outflow). The Cash Flow is organized to readily identify the net cash flow from operations separately from the net cash flow from investments sold or acquired. Other important sources and applications of cash are also shown such as net transfers to or from separate accounts and dividends to stockholders. The net change in cash and short-term investments as reflected on the Cash Flow reconciles to the change in the balance sheet accounts cash and short-term investments for the year.

While the Cash Flow provides information about historical sources and applications of cash, the analyst should analyze the liquidity of the balance sheet in order to evaluate the insurer’s ability to fund policyholder benefits and other demands for cash in the future. One common way of accomplishing this is to compare the total liabilities of the insurer in relation to its liquid assets available to fund the liabilities.

Discussion of Level 2 Annual Procedures
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. The analyst should also consider the insurer’s corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. One concern relates to identifying situations where negative cash flow is being generated, in large amounts in the current year, or less amounts sustained over a longer period of time. Another concern relates to evaluating the liquidity of the insurer’s balance sheet in terms of its ability to fund future liabilities. Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst.

Procedure #1 assists the analysts in identifying situations where the insurer’s operations are generating negative cash flow. It is important for the analyst to focus on specific components of the insurer’s operation. The analyst should evaluate negative cash flow from operations closely, as well as any negative trends. The analyst should also closely evaluate significant net transfers to or from separate accounts since this could provide insights regarding potential financial problems.

Additional steps the analyst may perform if there are concerns regarding the insurer’s cash flow from operations include an evaluation of line items within cash flows, including transfers to or from separate accounts.

Procedure #2 assists the analyst in determining if the insurer is exposed to greater than normal liquidity risk with respect to special deposits. Special deposits are segregated into two sections: 1) for the benefit of all policyholders and 2) not for the benefit of all policyholders. Deposits for the benefit of all policyholders are deposits held by individual states but are aggregated on one summary line. Deposits not held for the benefit of all policyholders must be itemized by security. The assets comprising these deposits are held on the various investment schedules in the financial statement. However, the assets are not held in custody of the insurer and restrictions are placed on their disposal. In a situation of a
rehabilitating or troubled insurer, these restrictions on assets may cause concerns, particularly those not held for the benefit of all policyholders.

Additional steps the analyst may perform are intended to assist the analyst in determining if the domiciliary state may have difficulty in calling deposits that are deemed “not for the benefit of all policyholders.” These procedures specifically apply when the level of deposits not for the benefit of all policyholders as a percentage of total assets is high, or in cases when the insurer has been determined to be troubled. The analyst may consider this assessment necessary in either of those cases because once the insurer is moved into rehabilitation, the cash flow position of the insurer may deteriorate rapidly.

Procedure #3 assists the analyst in evaluating concerns relating to liquidity. The primary method of accomplishing this is to review changes in the insurer’s liquid assets.

Additional steps the analyst may perform if there are concerns regarding the insurer’s liquidity include reviewing the insurer’s cash flow and liquidity results against industry averages, or peer insurers in the Peer Financial Profile report.

Procedure #3f advises that analysts should be aware that stress liquidity inquiries and templates are included in the NAIC Financial Condition Examiners Handbook. Information captured in these templates is considered confidential; therefore, is not captured within the annual financial statements. In order to obtain this information, regulators must request that reporting entities complete the forms. As noted in the Examiners Handbook, requests for reporting entities to complete these templates may occur at any time and are not limited to instances of comprehensive statutory examinations. The analyst should communicate with the examiner to determine if the insurer has recently submitted responses to the stress liquidity inquiries and templates or if a request should be made to the insurer for the information.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for cash flow and liquidity are intended to identify significant changes in cash flow and liquidity that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.
III. Annual Procedures – C.9. Level 2 Reinsurance (Life/A&H)

1. Determine whether the insurer’s accounting treatment for reinsurance is proper and in accordance with the *Annual Statement Instructions*.
   a. Briefly scan the individual reinsurers listed in Schedule S – Part 3 – Section 1 (Reinsurance Ceded Life and Annuities) and Schedule S – Part 3 – Section 2 (Reinsurance Ceded Accident and Health). Do any of the reinsurers classified as authorized appear to be improperly classified as such?
   b. Review Schedule S – Part 4 (Reinsurance Ceded to Unauthorized Companies). Is the liability for reinsurance in unauthorized companies to the sum of reserve credits taken, paid and unpaid losses, and other debits greater than 25 percent?
   c. Review Schedule S – Part 4 (Reinsurance Ceded to Unauthorized Companies). Are there any concerns about the appropriateness of reinsurance credits taken?
   d. Are there any concerns in the Statement of Actuarial Opinion regarding the insurer failing to properly establish a reserve relating to reinsurance assumed from another reinsurer for accident and health?
   e. Briefly scan the Annual Financial Statement pages relating to Assets; Liabilities, Surplus and Other Funds; and Summary of Operations. Are any unusual items noted relating to write-ins or significant changes or inconsistencies from prior years regarding reinsurance activities?

Additional procedures and prospective risk considerations if further concerns exist:

   f. Further investigate whether specific reinsurers classified as authorized throughout Schedule S – Part 3 – Section 1 (Reinsurance Ceded Life and Annuities), Schedule S – Part 3 – Section 2 (Reinsurance Ceded Accident and Health), and Schedule S – Part 4 (Reinsurance Ceded to Unauthorized Companies) are, in fact, authorized.
      i. Select the five largest individual reinsurers based on the total reinsurance recoverables amount and determine whether those reinsurers are authorized.
      ii. On a test basis, as considered necessary, select a sample from among the remaining reinsurers and determine whether those reinsurers are authorized.
   g. Generate Examination Jumpstart analysis to determine whether ceding company credits are appropriately “mirrored” by the reinsurer, after considering the impact of normal timing delays.
   h. If the insurer holds a material letter of credit (LOC) securing unauthorized reinsurance recoverables, identify the amount of the LOC and the issuing bank. If so, then provide the rating of the bank and summarize any concerns.
   i. Review General Interrogatories, Part 1, #15.1 and 15.2.
      i. Is the reporting entity the beneficiary of a LOC that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List?
      ii. If the answer to 1.i.i. is “yes,” list the name of the issuing or confirming bank, the circumstances that can trigger the LOC and the amount.

2. Determine whether amounts recoverable (both paid and unpaid losses on claims and reserve credits) or amounts receivable from reinsurers are significant and collectable.
   a. Are reinsurance amounts recoverable on paid and unpaid losses on claims greater than 10 percent of capital and surplus?
b. Are reserve credits (Life, A&H, and Annuities) greater than 25 percent of surplus?

c. Review Schedule S – Part 3 – Section 1 (Reinsurance Ceded Life and Annuities) and Schedule S – Part 3 – Section 2 (Reinsurance Ceded Accident and Health). Are any unusual items noted regarding the types of reinsurance and their relative significance, or the specific reinsurers involved?

d. Are other amounts receivable under reinsurance contracts greater than 10 percent of capital and surplus?

Additional procedures and prospective risk considerations if further concerns exist:

e. Determine the current ratings of the reinsurer from the major rating agencies and investigate significant changes during the past 12 months.

f. Review the reinsurer’s current and prior year Analyst Team priority designations for any reinsurer that has received a Validated Level “A” or “B,” request a copy of the reinsurance agreement[s], and confirm amounts included on Schedule S – Part 4 (Reinsurance Ceded to Unauthorized Companies).

g. Review information about the reinsurer available from industry analysts and benchmark capital adequacy with top performers and peer groups.

h. Request a copy of the insurer’s A.M. Best Supplemental Ratings Questionnaire, and review the reinsurance section for unusual items.


j. Discuss any significant write-offs of reinsurance collectables during the period.

k. Review U.S. Securities and Exchange Commission (SEC) filings of the reinsurer, if applicable, for insight regarding collectability.

l. Obtain and review the Statement of Actuarial Opinion of the reinsurer for additional insight regarding collectability.

m. Determine whether adequate levels of collateral (letters of credit, etc.) are being maintained to secure outstanding losses.

n. Contact the domiciliary state to determine whether any regulatory actions are pending against the reinsurer.

o. Review the reinsurer’s history of payments of recoverables and determine compliance with the NAIC Life and Health Reinsurance Agreements Model Regulation (#791) regarding quarterly settlements of payments due from reinsurers.

p. Using the Global Receivership Information Database (GRID) within I-SITE, review the status of any relevant multi-state, single-state, or alien reinsurance company departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).

q. Determine whether the reinsurance transactions involved going “in and out” of treaties in such a manner that, in substance, the transactions are for financial reinsurance purposes.
III. Annual Procedures – C.9. Level 2 Reinsurance (Life/A&H)

3. Determine whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another.
   a. Review Schedule S – Part 1 – Section 1 (Reinsurance Assumed Life and Annuities) and Schedule S – Part 1 – Section 2 (Reinsurance Assumed Accident and Health).
      i. Are assumed premiums from affiliates to gross premiums greater than 25 percent?
      ii. Is there a significant change in the above ratio from the prior year (+/− 25 percent) or over the past five years (+/− 50 percent)?
   b. Review Schedule S – Part 3 – Section 1 (Reinsurance Ceded Life and Annuities) and Schedule S – Part 3 – Section 2 (Reinsurance Ceded Accident and Health).
      i. Are affiliated ceded premiums written greater than 25 percent of gross premiums written?
      ii. Is there a significant change in the above ratio from the prior year (+/− 25 percent) or over the past five years (+/− 50 percent)?
   c. Review Schedule S – Part 2 (Reinsurance Recoverable on Paid and Unpaid Losses), Schedule S – Part 3 – Section 1 (Reinsurance Ceded Life and Annuities), and Schedule S – Part 3 – Section 2 (Reinsurance Ceded Accident and Health). Are reinsurance recoverables from affiliates to capital and surplus greater than 15 percent?
   d. Is there a significant increase in the above ratio from the prior year (15 percent) or over the past five years (25 percent)?
   e. Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10 percent or controlled, either directly or indirectly, by the insurer or any representative, officer, trustee, or director of the insurer (Notes to Financial Statement, Note #22A – Events Subsequent, Ceded Reinsurance Report – Section 1 – General Interrogatories, Part 2)? If the answer is “yes,” proceed with the following questions; otherwise, proceed to Procedure #3f.
      i. Review Schedule S – Part 2 (Reinsurance Recoverable on Paid and Unpaid Losses). Are any unusual items noted regarding the nature or magnitude of non-affiliated relationships?
      ii. Review Schedule S – Part 3 – Section 1 (Reinsurance Ceded Life and Annuities). Are any unusual items noted regarding the nature or magnitude of non-affiliated relationships?
      iii. Review Schedule S – Part 3 – Section 2 (Reinsurance Ceded Accident and Health). Are any unusual items noted regarding the nature or magnitude of non-affiliated relationships?
   f. Have any policies issued by the insurer been reinsured with an alien insurer owned or controlled, directly or indirectly, by the insured, a beneficiary, a creditor of the insured, or any other person not primarily engaged in the insurance business (Note to Financial Statements, Note #22A – Events Subsequent, Ceded Reinsurance Report – Section 1 – General Interrogatories, Part 2)?

Additional procedures and prospective risk considerations if further concerns exist:

   g. Obtain and review the underlying agreements that support the transaction(s) in question.
III. Annual Procedures – C.9. Level 2 Reinsurance (Life/A&H)

h. Critically assess the substance of the transaction in terms of the following criteria:
   i. The transaction must be economic-based and at arm’s length.
   ii. The transaction must result in the transfer of risk and represent a consummated or permanent act.
   iii. Any assets transferred to an affiliate must be transferred at fair value, if an economic-based transaction.
   iv. In the case of a portfolio transfer involving an affiliate, the transaction might not be allowable under state law or might require prior regulatory approvals.

4. Determine whether reinsurance is being used for fronting purposes and, if so, whether any potential abuses exist.
   a. Is the ratio of ceded premiums written to gross premiums written greater than 50 percent?
   b. Is the ratio of ceded premiums to gross premiums for any significant line of business (defined as a line of business where gross premium is greater than 25 percent of total gross premiums) greater than 50 percent?

Additional procedures and prospective risk considerations if further concerns exist:
   c. Determine whether the requirements of the state’s statutes and regulations regarding fronting disclosure have been met, if applicable.
   d. Review the types of reinsurance being used and the specific products involved, and assess whether such reinsurance is being used for fronting purposes.
   e. Perform procedures to evaluate collectability (see Level 2 Additional Procedures, Procedure #2) and summarize any concerns.

5. Determine whether any significant and/or unusual reinsurance intermediary or reinsurance assumed agreements exist.
   a. Is the ratio of assumed premiums written to gross premiums written greater than 50 percent?
   b. Is the ratio of assumed premiums written to gross premiums written for any significant line of business (defined as a line of business where gross premium is greater than 25 percent of total gross premiums) greater than 50 percent?
   c. Does any agent, general agent, or broker control a substantial part of new or renewal business (General Interrogatories, Part 1, # 4.11 and 4.12)?

Additional procedures and prospective risk considerations if further concerns exist:
   d. Obtain and review underlying documents relating to the use of the reinsurance intermediary or reinsurance assumed.
   e. Determine whether the agreement is at arm’s length and has economic substance.
   f. Verify by direct contact or confirmation that funds withheld for payment are valid and adequately segregated for payment of losses.
   g. Determine whether the requirements of the NAIC Reinsurance Intermediary Model Act (#790) have been met. If not, list the requirements that the insurer has not met.
h. Determine whether the requirements of the NAIC Managing General Agents Act (#225) have been met. If not, list the requirements that the insurer has not met.

6. Determine whether any significant and/or unusual reinsurance transactions were completed during the year.
   a. Did the insurer enter into any assumption reinsurance agreements whereby the responsibility for the insurer’s policyholder obligations passes to an assuming insurer?
   b. Is Surplus Relief (IRIS Ratio 8) greater than 10 percent?
   c. Briefly scan the individual reinsurers listed in Schedule S – Part 4 (Reinsurance Ceded to Unauthorized Companies). Are there any unusual items noted, such as significant amounts of reinsurance with alien or “offshore” reinsurers?
   d. Are there any concerns expressed in the actuarial opinion relating to surplus relief reinsurance?
   e. Did the insurer report during the year, in accordance with the NAIC Disclosure of Material Transactions Model Act (#285), any material nonrenewals, cancellations, or revisions of ceded reinsurance agreements?
   f. Were there any changes to the primary reinsurers during the year compared to the prior year?

Additional procedures and prospective risk considerations if further concerns exist:

   g. Are there any significant new reinsurers generally known to engage in surplus relief transactions that may trigger concerns as to transfer of risk with respect to this specific insurer?
   h. Are there any specific situations noted, or overall trends, that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies?
   i. Obtain and review significant bulk reinsurance and surplus relief agreements.
      i. Determine whether transfer of risk criteria have been met.
      ii. Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly “mirrored.”
   j. Obtain and review assumption reinsurance agreements.
      i. Were proper policyholder consents received before the assumption reinsurance transfer was consummated?
      ii. Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.
   k. Review any disclosures made by the insurer, in accordance with Model #285, regarding material nonrenewals, cancellations, or revisions of ceded reinsurance agreements.
      i. Obtain and review supporting documentation of such material transactions.
      ii. Determine if, in the analyst’s opinion, additional procedures are considered necessary.

7. Review the “Supplemental XXX/AXXX Reinsurance Exhibit” to determine if the insurer has any in force reinsurance transactions reported. The analyst may wish to refer to the guidance under “Form D – Captive Reinsurance Transactions” in chapter IV.E.3. Form D Supplemental
Procedure #16; although Supplemental Procedure #16 applies only to affiliate transactions filed for review on Form D, the concepts and regulatory review goals are the same.

Although the analyst should perform a general review of Part 1 to obtain an overview of the insurer’s use of reinsurance with respect to XXX/AXXX reserves, the analyst’s primary focus should be on the transactions identified in Part 2, as those are the transactions that do not qualify for any of the exemptions identified in Part 1. If there are reinsurance transactions reported in Part 2, complete the following:

a.  For all transactions listed in Part 2 and entered into prior to Jan. 1, 2015 and exempt from Actuarial Guideline 48, the following analysis should be performed:
   i.  Obtain information from the insurer to review the actual experience on the ceded business in order to assess how the transaction is tracking relative to the initial or most recently provided projections and underlying assumptions. Although the actual experience data should be updated annually, the analyst should review three to five years of actual experience, if available, as some level of annual deviation is expected and should be viewed in a broader context.
   ii. If the information contained within item 7.a.i above shows material adverse deviations from the initial or most recently provided projections and/or expected experience and the reinsurer is an affiliate of the ceding insurer, require the insurer to submit five years of pro forma financial statements of the affiliate (assets, liabilities, equity and income) including specifically projected statutorily required reserves as well as any capital requirements imposed by the external finance provider on the reinsurer.
   iii. Review the investments of the reinsurer, as reflected in the statutory financial statements and any additional information filed by the reinsurer with the reinsurer’s domestic regulator, and consider the extent to which they comply with the state’s investment laws for non-captive insurers and are admitted assets under the NAIC Accounting Practices and Procedures Manual, as well as whether the overall investment portfolio would be disadvantaged if held directly by a domestic insurer. Review any funds held by or on behalf of the ceding insurer as security for the reinsurance contract to determine that, at a minimum, they comply with state’s investment laws for non-captive insurers and are admitted assets under the NAIC Accounting Practices and Procedures Manual. Specifically determine that none of the capital requirements imposed by an external financial provider are supported by any type of letter of credit which would not meet the definition of an admitted asset under statutory accounting principles.
   iv.  Involve a department actuary or consulting actuary wherever necessary.

b.  For all transactions listed in Part 2 and entered into on or after Jan. 1, 2015 or otherwise subject to Actuarial Guideline 48 and using the definitions set forth in Actuarial Guideline 48, the following analysis should be performed:
   i.  Obtain information from the insurer to review the actual experience on the ceded business in order to assess how the transaction is tracking relative to the initial or most recently provided projections and underlying assumptions. Although the actual experience data should be updated annually, the analyst should review three to five years of actual experience, if available, as some level of annual deviation is expected and should be viewed in a broader context.
III. Annual Procedures – C.9. Level 2 Reinsurance (Life/A&H)

ii. Review Parts 2 and 3 of the “Supplemental XXX/AXXX Reinsurance Exhibit” to determine if 1) funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis and 2) funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (1) above, are held by or on behalf of the ceding insurer as security under the reinsurance contract. If not, request a detailed explanation from the insurer.

iii. Involve a department actuary or consulting actuary wherever necessary.

iv. At least once every five years:

1. If the reinsurer is an affiliate of the ceding insurer, require the insurer to submit five years of pro forma financial statements of the affiliate (assets, liabilities, equity and income).
2. Require the insurer to submit current and five-year projected calculations, and support therefor, of (a) the statutory reserves with respect to the cession and (b) the Required Level of Primary Security.
3. Review the funds held by or on behalf of the ceding insurer to determine whether such funds are properly classified as a Primary Security or Other Security.
4. Have a department actuary, or consulting actuary engaged by the department, review the Actuarial Opinion to determine if the insurer has followed the Actuarial Method for this business consistent with the requirements of Actuarial Guideline 48.

Summary and Conclusion

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

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

- Contact insurer seeking explanations or additional information
- Obtain the insurer’s business plan
- Require additional interim reporting from the insurer
- Refer concerns to 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 ________
III. Quarterly Procedures – C.9. Level 2 Reinsurance (Life/A&H)

1. Determine whether amounts recoverable from reinsurers are significant.
   a. Is the balance sheet asset, reinsurance ceded, greater than 10 percent of capital and surplus?
   b. Has the balance sheet asset, reinsurance ceded, changed by more than +/-25 percent from the prior year-end?

2. Determine whether the liability for reinsurance in unauthorized and certified companies is significant. Review the Quarterly Financial Statement pages related to Liabilities, Surplus and Other Funds and Summary of Operations.
   a. Is there a balance sheet liability for reinsurance in unauthorized and certified companies?
   b. Has the balance sheet liability, reinsurance in unauthorized and certified companies, changed by more than +/-10 percent from the prior quarter or +/-20 percent from the prior year-end?
   c. Has the Summary of Operations, capital and surplus account line item relating to the change in liability for reinsurance in unauthorized and certified companies changed by more than +/-10 percent from the prior quarter or +/-20 percent from the prior year-end?

3. Determine whether any unusual reinsurance transactions were completed during the quarter.
   a. Review Schedule S – Ceded Reinsurance. Were any new reinsurers added since the prior quarter?
   b. Did the insurer report, during the quarter, in accordance with the Disclosure of Material Transactions Model Act (General Interrogatories, Part 1, #1.1), any material nonrenewals, cancellations or revisions of ceded reinsurance agreements?
   c. If the answer to 3.b. is “yes,” did the insurer fail to make the appropriate filing with its state of domicile in accordance with the Disclosure of Material Transactions Model Act (General Interrogatories, Part 1, #1.2)?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the Annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

   Analyst ________________ Date ________

Comments as a result of supervisory review.

   Reviewer ________________ Date ________
Overview

Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the primary insurer transfers or “cedes” to another insurer (the “reinsurer”) all or part of the financial risk of loss for claims incurred under insurance policies sold to the policyholder. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding insurer for all or part of the loss that the ceding insurer may sustain from claims. Reinsurers may, in turn, transfer or “retrocede” some of the risk assumed under reinsurance contracts. This form of reinsurance is known as “retrocession,” and the reinsurer of reinsurance is known as the “retrocessionaire.” Retrocessions are simply reinsurance for reinsurers.

Reinsurance commonly is undertaken in ordinary life insurance (with accompanying disability and accidental death benefits), in credit insurance, in individual health insurance, in annuities, and in group insurance in its various forms. In most ways, reinsurance is in the same position as direct insurance, with several exceptions. There is no direct relationship between the reinsurer and the ceding company’s policyholder. In the event of the ceding insurer’s insolvency, the policyholder or beneficiary under a contract that is reinsured has the same status as a policyholder or beneficiary with a policy that was not reinsured. Insurers may be required to file copies and receive approval of reinsurance treaties. An insurer may not need to be licensed in a state in order to act as a reinsurer of a domestic insurer. The domestic insurer may not receive full reinsurance credit on business ceded to such reinsurers. Some states require that, to be “authorized,” a reinsurer must meet certain criteria, but these may not be the same as those demanded of companies doing direct business in the state. Reinsurance premiums usually are not subject to premium taxes.

In formulating its rules for accepting applications for insurance, an insurer must decide upon three areas of action: retaining, reinsuring or declining the risks presented. Insurers of various sizes have different capacities to write insurance on a single life. An insurer must determine the maximum exposure it is able to accept and retain as its own insurance business. Having made this determination, the insurer must then decide what to do with any risks presented that exceed the maximum amount it is willing to retain. It has two choices: 1) accept the additional risk and reinsure it or 2) decline the extra risk. Once an insurer has decided to reinsure amounts in excess of its desired retention, it may proceed on one of several basic modes.

1. **Coinsurance**

   Under this mode, the excess face amount is reinsured on the same plan as that of the original policy. The direct writer and the reinsurer share in the risk in the same manner. The ceding insurer pays the reinsurer a proportional part of the premiums collected from the insured. In return, the reinsurer reimburses the ceding insurer for the proportional part of the death claim payments and other benefits provided by the policy, including nonforfeiture values, policy dividends, commissions, premium taxes, and other direct expense agreed to in the contract. The reinsurer must also establish the required reserves for the portion of the policy it has assumed. In coinsurance of participating policies, the reinsurer reimburses the ceding insurer for its portion of the dividends paid to the policyholder. In determining its schedule of dividends, the ceding insurer takes into account the experience on the business as written and the reinsurer generally is required to accept or match this schedule. Coinsurance also is used for nonparticipating policies, particularly in situations where a severe strain is on the direct writing insurer’s surplus in the first policy year. For example, the premium received by the direct writer during the first policy year usually is insufficient to pay the high first-year commissions and other costs of issue, to establish the initial reserve, and to avoid a surplus loss. In such an example, coinsurance relieves some of
the surplus strain of adding large amounts of new insurance and commissions, and expense allowances on the reinsurance provide direct surplus relief to the ceding insurer.

2. **Modified Coinsurance**
   A number of companies reinsure on the “modified coinsurance” mode, which is a variation of coinsurance whereby the reserves for the original policies may be maintained by the ceding insurer instead of the reinsurer. Under modified coinsurance, the assuming company transfers to the ceding insurer, usually on an annual basis as of Dec. 31, the increase in the mean reserve on the reinsured portion. From this is deducted interest at a rate stated in the reinsurance contract on the prior year’s total mean reserves. The resulting net transfer is called the modified coinsurance reserve adjustment. The modified coinsurance agreement may provide surplus relief through reinsurance commissions and allowances. In some cases, a policy may be reinsured partially on a coinsurance mode and partially on a modified coinsurance mode.

3. **Yearly Renewable Term (YRT)**
   Under this mode of reinsurance, the primary insurer transfers the net amount at risk to the reinsurer and pays a one-year term premium. The “net amount at risk,” as defined in the treaty, is usually the amount of insurance provided by the policy in excess of the reserve on it. In certain term insurance, reserves generally are disregarded. The ceding insurer’s liability is the reserve held in the event of death and the cash value held in the event of withdrawal.

4. **Other**
   Other forms of reinsurance are also available, such as catastrophe and stop loss coverage. The terms of such reinsurance vary considerably, so no general rules can be made.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the insurer’s corporate governance, which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. Reinsurance is a complicated and potentially high-risk area for the insurer. While there are many legitimate business uses for reinsurance, it can be used to mask an insurer’s financial problems or expose the insurer to significant collectability, or credit risk.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst.

*Procedure #1* assists the analyst in determining whether significant errors exist relating to the accounting for reinsurance. Generally, the major concern will relate to the manner in which the insurer accounts for credits, or reductions in, the liability for reserves relating to recognition of estimated reinsurance recoverables. SSAP No 61—*Life, Deposit-Type & Accident and Health Reinsurance*, defines the specific circumstances when the insurer can record such a credit, or reduction in, the liability for loss reserves. In summary, a credit for reinsurance can be recorded when the assuming insurer is authorized (i.e., licensed or approved by the ceding insurer’s state of domicile, or accredited). When the assuming insurer is
unauthorized (i.e., neither licensed or approved by the ceding insurer’s state of domicile, nor accredited), then a credit for reinsurance may only be recorded when adequate security exists in the form of trust accounts, letters of credit, etc. A second important accounting issue relates to the liability for reinsurance in unauthorized companies. Under SSAP No. 61, the insurer must establish a liability by formula that considers the amount of reinsurance recoverable on paid losses due and credits from unauthorized companies.

Procedure #2 assists the analyst in determining whether reinsurance recoverables and receivables are significant and if so, whether the amounts involved are collectable. Under a reinsurance contract, the primary insurer transfers or “cedes” to another insurer (the “reinsurer”) all or part of the financial risk of loss for claims incurred under insurance policies sold to the policyholder. Reinsurance does not modify in any way the obligation of the primary insurer to pay policyholder claims. Only after loss claims have been paid can the primary company seek reimbursement from a reinsurer for its share of paid losses. As a result, evaluating the collectability of the recoverables and receivables, as well as the overall creditworthiness of the reinsurers, is a key concern. Evaluating the collectability of reinsurance recoverables and receivables requires an understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained.

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

1. Professional Reinsurers – The main business of professional reinsurers is assuming reinsurance from non-affiliated insurers. In general, the large and well-capitalized professional reinsurers will not pose a serious collectability concern.
2. Reinsurance Departments of Primary Insurers – Many insurers assume reinsurance from non-affiliates, but also write significant business on a direct basis. These types of insurers may pose a larger collectability concern than professional reinsurers since the specialized reinsurance expertise may not be as strong.
3. Alien Insurers – Reinsurers domiciled in another country may pose a significant collectability concern.

Additional procedures are suggested if collectability concerns exist. The fundamental issue involved with evaluating collectability is an assessment of the financial stability of the underlying reinsurers, and, if applicable, specific retrocessionaires involved throughout the chain of reinsurance. To evaluate the collectability of reinsurance recoverables, the analyst should consider the need to collect as much financial information as possible about the reinsurers, including various regulatory and governmental filings, rating agency reports, and financial analyses available from industry analysts.

The I-SITE application, Global Receivership Information Database (GRID), allows the regulator to review the status of a receivership (i.e., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post-receivership data, creditor class/claim data, legal, financial and reporting data. Receivables and recoverables due from companies in liquidation proceedings may be partially collected; however, collection will likely be delayed. It is practically certain that balances due at the time a liquidation is closed (the last action date that may be entered in GRID) will never be collected. Evaluating the collectability of reinsurance recoverables requires understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented toward the type of reinsurer from whom the reinsurance was obtained.

Procedure #3 assists the analyst in identifying whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another. A group of affiliated insurance companies may use
reinsurance as a mechanism to diversify the portfolios of individual companies and to allocate premiums, assets, liabilities, and surplus among affiliates. From an economic standpoint, reinsurance transactions between affiliated insurance companies do not reduce risk for the group, but instead shift risk among affiliates. Reinsurance between affiliated companies presents opportunities for manipulation and potential abuse. In a group of affiliated insurers, intercompany reinsurance may serve to obscure one insurer’s financial condition by shifting loss reserves from one affiliate to another. 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.

Procedure #4 assists the analyst in determining whether reinsurance is being used for fronting purposes and, if so whether any potential abuses exist. Fronting also can be subject to potential abuse by either the ceding company or the reinsurer. For example, where fronting commissions received by the ceding company from the reinsurer exceed the ceding company’s costs of selling policies, the insurer has incentive to write additional business to generate commissions and profits. An insurer may underwrite poor risks at underpriced rates because it believes it will not have to pay all the resulting losses. In fact, the ceding insurer may not have adequate details about the business being written by its representatives to assess its potential losses. This practice may be used to circumvent state licensing requirements and thus avoid regulatory oversight. Although an insurance company must first be licensed in a state to sell insurance directly to the public, a reinsurer may assume reinsurance without a license in that state. Through a fronting arrangement, a company not licensed in a state may reinsure all or nearly all of the liabilities for policies that it cannot directly write.

Procedure #5 assists the analyst in determining whether any significant and/or unusual reinsurance intermediary or reinsurance assumed agreements exist. While some major professional reinsurers are direct marketers, intermediaries (brokers, managers, or managing general agents) may arrange reinsurance agreements between a ceding insurer and a reinsurer in exchange for commissions or fees. A reinsurance broker negotiates agreements for a ceding insurer but does not have the authority to bind the insurer to a reinsurance agreement. On the other hand, a reinsurance manager acts as the agent for a reinsurer and has the authority to bind a reinsurer to an agreement. Finally, a managing general agent may have authority both to underwrite primary insurance and to bind reinsurance agreements on that business for the ceding insurer. An intermediary, either a broker, manager, or managing general agent, has an incentive to place reinsurance with sound reinsurers when its commission is tied to the success of the business being reinsured. However, when commissions are based on volume of business, reinsurance placed through an intermediary may be subject to conflicts of interest and potential abuse. To generate more income, a managing general agent may cede business to reinsurers who later are unable or unwilling to pay losses, or a reinsurance manager may assume poor, underpriced risks. The intermediary bears no financial risk in the event of underpriced or poor underwriting or placement with a troubled reinsurer. But poor performance by an intermediary can affect both ceding insurers and reinsurers.

Procedure #6 assists the analyst in identifying unusual reinsurance transactions where a review of the transfer of risk criteria may be important. The essential ingredient of a reinsurance contract is the shifting of risk. The reinsurer must indemnify the ceding insurer in form and in fact, against loss or liability relating to the original policy. Unless the contract contains this essential element of risk transfer, the ceding insurer may not account for it as a reinsurance recoverable. Determining whether a contract involves the transfer of risk requires a complete understanding of the contract between the ceding insurer and the reinsurer. All contractual features that limit the amount of insurance risk to the reinsurer (such as through experience refunds, cancellation provisions, adjustable features, or additions of profitable lines of business to the reinsurance contract) or delay the timely reimbursement of claims by the reinsurer (such as through payment schedules or accumulating retentions from multiple years) should be thoroughly understood by either the analyst or a reinsurance expert. A transfer of risk requires that the reinsurer
assume significant insurance risk under the reinsured portions of the underlying insurance contracts, and
that it is reasonably possible that the reinsurer may realize a significant loss from the transaction.

The analyst should be particularly alert to three unusual types of transactions such as bulk reinsurance,
surplus relief and assumption reinsurance. Bulk reinsurance is when an insurer cedes all or part of a block
of insurance business. Such bulk cessions may or may not be in the ordinary course of business and may
or may not require prior regulatory approval. Under an indemnity reinsurance arrangement, the ceding
insurer remains liable to the policyholders and the reinsurer has no obligations to them. Typically, the
ceding insurer will continue to perform all functions in connection with claims and other policyholder
services. Under an assumption reinsurance arrangement, the liability to policyholders is assumed by the
reinsurer, although in some cases, the ceding insurer retains a contingent liability. Assumption
reinsurance requires that the reinsurer issue assumption certificates to the existing policyholders and take
over responsibility for policyholder services. On occasion, the reinsurer will contract with the original
insurer to continue to provide such services on a fee basis. Regulatory approval of all assumption
reinsurance arrangements is normally required. Typically, because a block of in-force business has value,
the sale transaction will result in a gain to the ceding insurer. If the policies are somewhat mature and
have reasonably large reserves, the transaction probably will result in a transfer of cash or other assets by
the ceding insurer. In this case, the reserves released by the ceding insurer will be greater than the value
of the assets transferred, with the resulting credit being a gain and an increase in surplus. If the policies
are young and have very small reserves, the assuming insurer may pay some amount in the purchase. If
the ceding insurer has an obligation to buy back the block of insurance or to repay the reinsurer’s losses,
the intent of the transaction has usually been to create surplus in the ceding insurer and a transfer of risk
has not occurred. In these situations, the accounting for the transaction must look beyond the intent and
record the obligation. Therefore, there is no gain or surplus increase to be recognized, but the credit would
be recorded as a liability to reflect the obligation to repay the difference to the reinsurer.

Surplus relief, or financial reinsurance, is a method of accelerating future profits on a block of insurance
business. With conventional reinsurance agreements, the ceding insurer receives a ceding fee that covers
the acquisition costs plus a profit. A transfer of risk is completed and the reinsurer retains all future profits
on the block of business reinsured. In surplus relief reinsurance, however, the reinsurer normally returns
the majority of the profits, less a fee, to the ceding insurer through an experience refund. Since surplus
relief transactions merely represent a financing arrangement, SSAP No. 61 does not allow a credit to
surplus until the risk has been transferred.

Assumption reinsurance agreements occur when the insurer transfers, with the consent of the
policyholder, responsibility for policyholder obligations to another insurer. These types of transactions are
of concern to the policyholder, particularly where the assuming company has a weaker financial position
than the ceding insurer. They may also indicate financial difficulties of the ceding insurer and may be
motivated by pressure to generate surplus.

Additional procedures assist the analyst in evaluating significant or unusual reinsurance transactions, such
as bulk reinsurance, surplus relief, and assumption reinsurance. Material transactions involving the sales
of blocks of business are becoming more commonplace in the life/health insurance industry. The analyst
should analyze these types of transactions closely to determine whether a transfer of risk has been
consummated. Even when transfer of risk has been consummated, the analyst should evaluate the impact
of the transaction on future financial performance of the insurer.

Procedure #7 assists the analyst in annual review of reinsurance transactions that pertain to either term
life or universal life with secondary guarantees (ULSG), commonly referred to as XXX or AXXX. Refer
to the guidance in chapter IV.E.3. Form D supplemental procedure 16.
Discussion of the Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are intended to identify significant changes in reinsurance that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.
III. Annual Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

1. Determine whether the insurer is a member of a holding company system and, if so, whether the corporate structure, or any changes in the corporate structure, elevate concerns about affiliated transactions.
   
a. Review General Interrogatories, Part 1, #1.1
   i. Is the insurer a member of an insurance holding company system consisting of two or more affiliates, one or more of which is an insurer? If so, what is the name of the ultimate controlling person or entity as reported on the holding company system registration statement?
   ii. Is the answer for 1.a.i. different from the prior year?
   iii. Review Schedule Y – Parts 1 and 2 along with the General Interrogatories and Notes to Financial Statements. Is there any information noted that contradicts the response in 1.a.i.?
   iv. Is the company required to file a holding company system registration statement with the insurance department?

If 1.a.i. through 1.a.iv. are all “no,” do not proceed with the remaining Affiliated Transactions procedures.

b. Review General Interrogatories, Part 1, #1.2. Did the insurer fail to file a registration statement in accordance with the NAIC Insurance Holding Company System Regulatory Act (#440)?

c. Review Schedule Y – Part 1 – Organizational Chart for the current and prior years.
   i. Were there any significant changes to the corporate structure during the year (e.g., acquisitions, divestitures, and/or mergers)?
   ii. If the answer to 1.c.i. is “yes,” and the change involved ownership of the insurer or a transaction with an affiliate, did the insurer fail to receive proper regulatory approvals?
   iii. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?
   iv. Does the insurer have an agency or brokerage subsidiary?

d. Review Schedule Y – Parts 1 and 1A – Detail of Insurance Holding Company System for the current year.
   i. Identify the ultimate controlling party(ies)/person(s) and summarize any financial concerns.
   ii. If there is more than one group listed on Part 1A, summarize the interrelationship and understand the rationale for the distinct groups.
   iii. Summarize any concerns that the analyst has with regard to non-insurance entities.

Additional procedures and prospective risk considerations if further concerns exist:

e. Obtain and review the financial statements of the parent holding company (available with Form B filing) in order to understand its debt and equity structure.

f. Determine the level of debt service required by the holding company and gain an understanding of its primary sources of revenue.
III. Annual Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

g. If the primary sources of revenue are dividends and fees from the insurer, evaluate these sources to determine their validity and reasonableness.

h. Obtain and review U.S. Securities and Exchange Commission filings, if available.

2. Identify whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.
      i. Were any unusual items noted, such as significant new affiliated transactions or modified intercompany agreements from the prior year, or significant increases in transaction amounts?
      ii. Does it appear that a different schedule is included for the other affiliates?
      iii. Has the insurer forwarded to any one affiliate funds greater than 15 percent of the insurer’s surplus?
      iv. Were management fees paid to affiliates, as identified in footnote (a) to Exhibit 2, greater than 15 percent of the total incurred general expenses?
   b. Review the Notes to Financial Statements, Note #10 – Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties.
      i. Were any unusual items noted, such as significant new affiliated transactions from the prior year, or significant increases in transaction amounts?
      ii. Do any transactions described appear to conflict with the transactions disclosed in Schedule Y – Part 2?
      iii. Are any transactions disclosed with an affiliate that is not listed on Schedule Y – Part 2?
      iv. Do affiliated business ventures resulting in a contingent liability to the insurer involve financial exposure greater than 25 percent of surplus?
      v. Review the description of management and services agreements. Is an allocation basis involved other than one designed to estimate actual cost?
      vi. Was the amount of the shareholder dividend at a level that required prior regulatory approval or notification?
      vii. If the response to 2.b.vi. is “yes,” did the insurer fail to obtain proper prior regulatory approvals?
      viii. Does the amount of the dividend paid differ from the amount reflected on the Cash Flow?
   c. Review the Notes to Financial Statements, Note #13 – Capital and Surplus, Shareholders’ Dividend Restrictions and Quasi-Reorganizations. Are any unusual items noted?

Additional procedures and prospective risk considerations if further concerns exist:
   d. Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
   e. If the concern relates to the economic substance of the transaction, obtain and review supporting documents.
f. If the concern relates to the fair value used to record the transaction:
   i. Obtain and review an appraisal of the asset transferred.
   ii. Consider consulting an independent appraiser.

g. If the concern involves a Management Agreement or Service Contract:
   i. Determine that appropriate regulatory approvals were received and that the insurer is complying with the terms as approved.
   ii. Obtain and review the supporting contract.
   iii. Determine whether the amounts involved are reasonable approximations of actual costs.
   iv. Determine whether actual amounts paid are in agreement with the supporting contract.
   v. For any agreement based on a cost plus formula or percentage of premiums formula, request justification from the insurer for amounts in excess of the actual cost of providing the service.
   vi. For those services being performed by/or for an affiliate, and which are also provided by unrelated third-party vendors (i.e., data processing, actuarial, investment management), contact such vendors or review vendor pricing schedules in order to determine the reasonableness of the intercompany transfer pricing level.
   vii. Evaluate whether any portion of such fees is, in substance, dividends that should be evaluated in the context of dividend regulations.

3. Determine whether investments in affiliates are significant.
   a. Is the total of all investments in affiliates (Five-Year Historical Data) greater than 20 percent of capital and surplus?
   b. Has the total of all investments in affiliates changed by more than +/- 20 percent from the prior year-end?
   c. Has there been any change in any category of affiliated investments more than +/- 10 percent from the prior year-end?
   d. Are affiliated investments in violation of state statutes?

4. Determine whether investments in affiliates are properly valued in accordance with statutory accounting practices.
   a. If investments in common stocks of parents, subsidiaries, and affiliates involve publicly-traded securities, is the investment valued on a basis other than market valuation?
   b. If investments in common stocks of parents, subsidiaries, and affiliates do not involve publicly-traded securities, is the investment valued on a basis other than the Statutory Equity or GAAP Equity methods?

Additional procedures and prospective risk considerations if further concerns exist:
   c. Review details of affiliated investments as reported in Schedules A, B, BA, and D, and compare with prior years.

III. Annual Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

d. Obtain an understanding of the primary business activity of the affiliate and determine that such an investment complies with regulatory requirements.

e. Review the components of investment income reflected on the Exhibit of Net Investment Income and the Exhibit of Capital Gains (Losses).
   i. Calculate the return on investment for current and prior years.
   ii. Review the components of investment income and determine whether the source is cash or merely an increase in accrued interest income.
   iii. If a substantial portion of investment income relates to an increase in the accrual, determine whether such revenue recognition is legitimate and reasonable.
   iv. Determine whether accrued interest on investments in affiliates have grown to a significant level.

f. Obtain and review the Audited Financial Statement and Annual Financial Statement of the affiliate, if available.

g. Determine the current ratings of the affiliate from the major rating agencies, if available.

h. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.

i. Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.

j. Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.

k. Using the Global Receivership Information Database (GRID) within I-SITE, review the status of any relevant multi-state, single-state, or alien-affiliated company under departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).

5. Determine whether other affiliated transactions are legitimate and properly accounted for.

a. Review the balance sheet asset receivable from parent, subsidiaries and affiliates, as well as the liability payable to parent, subsidiaries and affiliates. Is either of these items greater than 10 percent of capital and surplus?

b. Review Schedule E:
   i. Were any open depositories a parent, subsidiary, or affiliate?
   ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the insurer?

c. Review the Notes to Financial Statements, Note #9 – Income Taxes.
   i. Is the insurer included in a consolidated federal income tax return?
   ii. If the answer to 5.c.i. is “yes,” are there any concerns about the manner in which federal income taxes are allocated to the insurer?
   iii. Are Federal Income Tax Recoverables greater than 5 percent of capital and surplus?
   iv. If the answer to 5.c.iii. is “yes,” are Federal Income Tax Recoverables due from an affiliate?

III. Annual Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

d. Review General Interrogatories, Part 1, #7.1. Does any foreign entity control 10 percent or more of the insurer, either directly or indirectly, through a holding company system?
   i. If the response to 5.d. is “yes,” did the insurer fail to properly disclose the investment on Schedule Y – Part 1?

e. Review General Interrogatories, Part 1, #20.11 and #20.12, as well as #20.21 and #20.22.
   i. Was the total amount loaned during the year to directors, other officers, or stockholders greater than 10 percent of statutory net income?
   ii. Was the total amount of loans outstanding at the end of the year to directors, other officers, or stockholders greater than 5 percent of capital and surplus?

f. Review General Interrogatories, Part 1, #18. Has the insurer failed to establish a conflict of interest disclosure policy?

g. Is there any evidence that activities of directors, officers or shareholders were in violation of state statutes?

h. Review Schedule SIS (Stockholder Information Supplement). Are any unusual items noted regarding transactions with, or compensation to, directors and officers?

Additional procedures and prospective risk considerations if further concerns exist:

i. If the concern relates to federal tax recoverables from a parent or affiliate:
   i. Obtain and review the financial statements of the parent or affiliate, and evaluate any collectability risk to the insurer.
   ii. Review the tax-sharing agreement and verify that terms of the tax-sharing agreement are being followed.
   iii. Verify that the amount recoverable from the prior year-end has been paid.

j. Assemble a list of all affiliates and other related parties.
   i. Summarize the financial impact of each transaction.
   ii. Identify any other unusual transactions and investigate for reasonableness.
   iii. Determine whether any required regulatory approvals were obtained.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding affiliated transactions. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating affiliated transactions 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
- Request consolidating holding company schedules
- Require additional interim reporting from the insurer
- Refer concerns to examination section for targeted examination
- Consult an independent appraiser to evaluate specific transactions involving significant transfers of assets
III. Annual Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

- Meet with the insurer’s management
- Recommend that a cease and desist order and/or fines be issued for holding company violations that were detected during the review
- Obtain a corrective plan from the insurer
- Recommend that action be taken to reverse or modify contracts that are harmful to insurer
- Other (explain)

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
III. Quarterly Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

1. Determine whether the insurer is a member of a holding company system and, if so, whether the corporate structure, or any changes in the corporate structure, elevate concerns about affiliated transactions.
   
a. Was the insurer a member of an insurance Holding Company System as of the prior year-end?

b. Has the department directed the insurer to file a Holding Company System registration statement?

c. Did the insurer fail to file a registration statement in accordance with the Insurance Holding Company System Regulatory Act?

d. Briefly scan Schedule Y along with the General Interrogatories. Is there any information noted that contradicts the response to 1.a.?

e. Review Schedule Y, Parts 1 – Organizational Chart and 1A – Detail of Insurance Holding Company System for the current quarter.
   
i. Identify the ultimate controlling party(ies)/person(s) and summarize any financial concerns.

   ii. If there is more than one group listed on Part 1A, summarize the interrelationship and understand the rationale for the distinct groups.

   iii. Summarize any concerns that the analyst has with regard to non-insurance entities.

If the answers to 1.a. – 1.d. are “no,” do not proceed with the remaining Affiliated Transactions procedures.

f. Review Notes to Financial Statements. Did the insurer report a change in its capital structure?

g. Review General Interrogatories, Part 1, #3.1-3.3. Have there been any substantial changes in the organizational chart since the prior quarter-end?

h. If the answer to 1.g. is “yes,” and the change involved ownership of the insurer or a transaction with an affiliate, did the insurer fail to receive proper regulatory approvals?

i. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?

j. Does the insurer have an agency or brokerage subsidiary?

k. Review General Interrogatories, Part 1, #5. Have there been any significant changes to any management agreement in terms of the agreement or principals involved?

2. Determine whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.
   
a. Review the Summary of Operations, capital and surplus account line item dividends to stockholders.

   i. Is the amount of the stockholder dividend at a level that required prior regulatory approval or notification?

   ii. If the answer to 2.a.i. is “yes,” did the insurer fail to obtain proper prior regulatory approvals?
III. Quarterly Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

b. Review Schedule A – Part 2 (Real Estate Acquired and Additions Made During the Current Quarter) and Schedule BA – Part 2 (Other Long-Term Invested Assets Acquired and Additions Made During the Current Quarter).
   i. Did any such acquisitions involve an affiliate or other related party?
   ii. If the answer to 2.b.i. is “yes,” is the amount of the acquisition greater than 5 percent of capital and surplus?
   iii. If either the answer to 2.b.i. or 2.b.ii. is “yes,” is there any reason to believe the sale was recorded on a basis other than fair market value?

c. Review Schedule A – Part 3 (Real Estate Disposed During the Current Quarter) and Schedule BA – Part 3 (Other Long-Term Invested Assets Disposed, Transferred or Repaid During the Current Quarter).
   i. Did any such dispositions involve an affiliate or other related party?
   ii. If the answer to 2.c.i. is “yes,” is the amount of the disposition greater than 5 percent of capital and surplus?
   iii. If either the answer to 2.c.i. or 2.c.ii. is “yes,” is there any reason to believe the sale was recorded on a basis other than fair market value?

   a. Is the total of all investments in affiliates greater than 20 percent of capital and surplus?
   b. Has the total of all investments in affiliates changed by more than +/−20 percent from the prior year-end?
   c. Has there been any change in any category of affiliated investments more than +/−10 percent from the prior year-end?

4. Determine whether other affiliated transactions are legitimate and properly accounted for.
   a. If federal and foreign income tax recoverables exceed 3 percent of total assets (excluding separate accounts), have such recoverables changed by more than +/−10 percent from the prior quarter or +/−20 percent from the prior year-end?
   b. Is the receivable from parent, subsidiaries and affiliates greater than 10 percent of capital and surplus?
   c. Has the receivable from parent, subsidiaries and affiliates changed by more than +/−25 percent from the prior year-end?
   d. Is the payable to parent, subsidiaries and affiliates greater than 10 percent of capital and surplus?
   e. Has the payable to parent, subsidiaries and affiliates changed by more than +/−25 percent from the prior year-end?
      i. Were any open depositories a parent, subsidiary or affiliate?
      ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the insurer?
III. Quarterly Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

5. Are there any indications that significant or unusual transactions involve an affiliate or other related party?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the Annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

SSAP No. 25 – *Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties*, defines an affiliate as an entity that is within the holding company system that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. Control is defined as the possession, directly or indirectly, of the power to direct or cause the direction of management and policies of a person or entity through the ownership of voting securities. Control should be presumed to exist if a reporting entity and its affiliates, directly or indirectly, own, control, hold with the power to vote, or hold proxies, representing 10 percent or more of the voting securities.

Transactions between affiliates and other companies within the same holding company system shall be fair and reasonable. The accounting for assets transferred between affiliates is generally determined by an analysis of the economic substance of the transaction. An economic transaction is an arms-length transaction, which results in the transfer of risks and rewards of ownership and represents a consummated act. An arms-length transaction is defined as one in which willing parties, each being reasonably aware of all relevant facts and neither under compulsion to buy, sell or loan, would be willing to participate. Such a transaction must represent a bonafide business purpose demonstrable in measurable terms, such as the creation of a tax benefit, an improvement in cash flow position, etc. A transaction which results in the mere inflation of surplus without any other demonstrable and measurable improvement is not an economic transaction.

Determining that the risks and rewards of ownership have been transferred to the buyer requires an examination of the underlying facts and circumstances. The following circumstances from SSAP No. 25 may raise questions about the transfer of risks:

1. A continuing involvement by the seller in the transaction or in the assets transferred, such as through the exercise of managerial authority to a degree usually associated with the ownership, perhaps in the form of a re-marketing agreement or a commitment to operate the property.
2. Absence of significant financial investment by the buyer in the asset transferred, as evidenced, for example, by a token down payment or by a concurrent loan to the buyer.
3. Repayment of debt that constitutes the principal consideration in the transaction dependent on the generation of sufficient funds from the asset transferred.
4. Limitations or restrictions on the purchaser’s use of the asset transferred or on the profits from it.
5. Retention of effective control of the asset by the seller.

Security swaps of similar issues between or among affiliated companies are considered non-economic transactions. Swaps of dissimilar issues accompanied by exchanges of liabilities between or among affiliates are considered non-economic transactions. The appearance of permanence is also an important criterion in establishing the economic substance of a transaction. If subsequent events or transactions reverse the effect of an earlier transaction, the question is raised as to whether economic substance existed in the case of the original transaction. In order for a transaction to have economic substance and thus warrant revenue (loss) recognition, it must appear unlikely to be reversed.

A bona fide business purpose would exist, for example, if an asset were transferred in order to create a specific advantage or benefit. The advantage or benefit must be to the benefit of the insurer. A bona fide business purpose would not exist if the transaction were initiated for the purpose of inflating (or deflating) a particular insurer’s financial statement, including effects on the balance sheet or income statement.

When accounting for a specific affiliated transaction, the following valuation methods should be used, according to SSAP No. 25:

1. Economic-based transactions between affiliates should be recorded at prevailing fair values at the date of the transaction.

2. Non-economic based transactions between affiliated insurers should be recorded at the lower of existing book values or prevailing fair values at the date of the transaction.

3. Non-economic based transactions between an insurer and an entity that has no significant ongoing operations other than to hold assets that are primarily for the direct or indirect benefit or use of the insurer or its affiliates should be recorded at the prevailing fair value at the date of the transaction. However, to the extent that the transaction results in a gain, that gain should be deferred until such time as permanence can be verified.

4. Transactions that are designed to avoid statutory accounting practices shall be included as if the insurer continued to own the assets or to be obligated for a liability directly instead of through a subsidiary.

Assets may be valued on a different basis if held by a life insurer versus a property/casualty insurer. Therefore, the regulator must take this into consideration when using the general guidelines. In the absence of specific guidelines or where doubt exists as to the propriety of a special accounting method, the domiciliary state should be consulted.

Discussion of Level 2 Annual Procedures

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. The analyst should also consider the insurer’s corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The challenge to the analyst in this area is to understand, in substance, the various transactions between affiliates and recognize those transactions that are intended to circumvent existing regulations. Many of the procedures may require a prior knowledge of the insurer or a past knowledge of the holding company structure. A review of the insurer’s holding company files may assist in this regard. Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst.

Procedure #1 assists the analyst in understanding the insurer’s corporate structure. Significant changes in corporate structure may materially impact the insurer’s future financial condition and generally require prior regulatory approval. The analyst should closely analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure in which the insurer operates, the analyst may be able to foresee future problems and take appropriate action. For example, a common corporate structure the analyst may encounter involves a holding company whose only significant asset is the stock of the insurer. The holding company may have financed the acquisition of the insurer through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the insurer. This type of corporate structure warrants close attention by the analyst to ensure that dividends are valid and in compliance with the applicable dividend restrictions,
and that any other payments by the insurer to the holding company are legitimate, rather than dividends in disguise. The analyst should also be alert to a corporate structure that includes affiliated brokers or intermediaries that may be recording unusual or significant levels of commissions and fees. When a corporate structure is involved that includes multiple tiers of affiliates where significant levels of surplus are comprised of investments in affiliates, the analyst should focus on the level of real surplus that exists on a consolidated basis.

The analyst may perform additional steps if the insurer’s corporate structure elevates concerns about affiliated transactions. The primary objective is to understand the financial position of the parent company. By understanding the financial commitments of the Parent, the analyst will be able to better understand the Parent’s motivation for entering into transactions with the insurer or other affiliates. Financial statements of affiliates may reveal unauthorized transactions in progress.

Procedure #2 assists the analyst in understanding and evaluating the summary of transactions reported in Schedule Y – Part 2. Several types of affiliated transactions are reported in Schedule Y – Part 2 and explanatory comments are provided in Notes to Financial Statements, Note #10 – Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties. The analyst should refer to both sources of information in order to develop an understanding of the underlying affiliated transactions.

The following briefly describes the key concerns to the analyst for several of the major affiliated transactions. For shareholder dividends, the major concern relates to whether the level of dividend is within the regulatory guidelines, and whether the dividend should be considered extraordinary, and therefore require prior regulatory approval. For capital contributions from the insurer to another affiliate, the analyst should determine that such contribution does not substantially impact the financial condition of the insurer. For non-cash capital contributions into the insurer, the analyst should determine that the infusion is recorded at fair value so as to not arbitrarily inflate surplus. In the case of purchases, sales or exchanges of loans, securities, real estate, mortgage loans or other investments, the concern to the analyst is primarily one of valuation. These types of transfers should be at arms-length and recorded at fair value. The analyst should also be alert to possible abuses regarding the transfer of assets between property/casualty and life/health affiliates merely to impact the Risk-Based Capital calculation of the affiliates. For management agreements and service contracts, the main concerns to the analyst relate to the type of service being performed and the reasonableness of the cost. This is a common area for abuse when parent companies desire to withdraw funds from the insurer, but do not want to, or would not be permitted to, classify it as a shareholder dividend. The analyst should understand why the parties were motivated to enter into such contracts, and particularly, the benefit to the insurer.

Procedures #3 and #4 assist the analyst in determining whether investments in affiliates are significant 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 investment may be substantially overvalued.

The analyst may perform additional steps when there are concerns that transactions with affiliates may not be economic-based or at arms-length. For those services provided by an affiliate where a market already exists (such as data processing, actuarial, or investment management), an effective way for the analyst to determine whether an arms-length transaction exists is to contact one of the vendors and request a proposal or fee estimate for a similar service.

When investments in affiliates are significant and the valuation of such investments is a concern, the analyst should review the level of return on the investment in affiliate, including the source of the investment income (e.g., cash or merely an increase in the accrual). The analyst should not only be alert to
the level of investments in affiliate, but also the level of accrued interest relating to investments in affiliate.

The I-SITE application, Global Receivership Information Database (GRID), allows the regulator to review the status of a receivership (i.e., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post-receivership data, creditor class/claim data, legal, financial, and reporting data. Receivables and recoverables due from companies in liquidation proceedings may be partially collected; however, collection will likely be delayed. It is practically certain that balances due at the time a liquidation is closed (the last action date that may be entered in GRID) will never be collected. Evaluating the collectability of reinsurance recoverables requires understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented toward the type of reinsurer from whom the reinsurance was obtained.

Procedure #5 assists the analyst in evaluating all other affiliated transactions. The analyst’s primary objective in this area is to understand the substance of the transactions and to determine whether they are economic-based. The analyst should review the extent of transactions with officers and directors to ensure that the transactions are at arms-length and are not detrimental to the financial condition of the insurer. The analyst should closely monitor other affiliated transactions to ensure that the insurer is not exposed to significant collectability risk. For example, if the insurer is included in a consolidated federal income tax return and a significant asset for Federal Income Tax Recoverable is recorded on the financial statements of the insurer, the analyst should closely review the financial statements of the parent to determine the parent’s ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectability risk to the insurer. When the amounts of structured settlements are significant, the analyst should review and understand the financial statements of the life insurance affiliate.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for affiliated transactions are intended to identify: 1) significant changes in the corporate structure; 2) whether affiliated transactions that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement are economic-based; 3) whether the transactions are significant, legitimate and properly accounted for; or 4) other significant or unusual transactions with affiliates.
III. Annual Procedures – C.11. Level 2 MGAs and TPAs (Life/A&H)

1. Determine whether concerns exist due to a significant amount of the insurer's direct premiums being written through managing general agents (MGAs) and third-party administrators (TPAs).
   a. Review General Interrogatories, Part 1, #4.1 and #4.2. Did any agent, broker, sales representative, non-affiliated sales/service organization, or any combination thereof under common control (other than salaried employees of the insurer) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of either the sale of new business or renewals?
   b. Review the Notes to Financial Statements, Note #19 – Direct Premium Written/Produced by Managing General Agents/Third-Party Administrators. Was the aggregate amount of direct premiums written through MGAs and TPAs greater than 10 percent of total direct premiums written?

Additional procedures and prospective risk considerations if further concerns exist:
   c. Review the Notes to Financial Statements, Note #19 – Direct Premium Written/Produced by Managing General Agents/Third-Party Administrators, which lists individual MGAs and TPAs whose direct writings are greater than 5 percent of capital and surplus. Determine the following: 1) which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the insurer); 2) the types and amount of direct business written by the MGAs and TPAs; and 3) the types of authority granted to the MGAs and TPAs by the insurer.
   d. For the more significant MGAs and TPAs, request information from the insurer regarding commission rates and any other amounts paid to the MGAs and TPAs, review the information for reasonableness and compare the commission rates to those paid by the insurer to other agents.
   e. For the more significant MGAs and TPAs, request information from the insurer to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether that reinsurance was arranged for by the MGA or TPA. If the MGA or TPA arranged for the reinsurance, determine whether the MGA or TPA is affiliated with the reinsurer and consider reviewing the reinsurance agreements to determine whether the terms are reasonable.
   f. Determine whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid certificates of authority. (In some states, an insurer may utilize an MGA who is not licensed if biographical questionnaires have been submitted for each individual owning more than 10 percent of the MGA. If this provision is applicable and the MGA is not licensed, verify that the required biographical questionnaires have been submitted.)
   g. Request copies of the contracts between the insurer and its more significant MGAs and review to determine that the contracts include the minimum required provisions per Section 4 of the NAIC Managing General Agents Act (#225) and/or the applicable sections of the insurance code.
   h. Request copies of the contracts between the insurer and its more significant TPAs and review to determine whether the contracts include the minimum required provisions per Sections 2, 4, 6, 7 and 8 of the NAIC Registration and Regulation of Third-Party Administrators (Guideline #1090) and/or the applicable sections of the insurance code.
   i. For the more significant MGAs utilized by the insurer, request and review the following:
      i. The most recent Audited Financial Statement of the MGA.
III. Annual Procedures – C.11. Level 2 MGAs and TPAs (Life/A&H)

ii. If the MGA establishes loss reserves, the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA.

iii. Documentation supporting the insurer’s periodic (at least semi-annual) on-site review of the MGA’s underwriting and claims processing operations.

j. For the more significant TPAs utilized by the insurer, request and review the following:

i. The most recent annual report of the TPA.

ii. Documentation supporting the insurer’s periodic (at least semi-annual) review of the operations of the TPA. (At least one of the semi-annual reviews is required to be an on-site audit of the operations of the TPA).

k. If there are concerns regarding the business placed with the insurer by an MGA or TPA, consider determining whether other insurers are utilizing the same MGA or TPA, and perform the following:

i. Compare the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates).

ii. Compare the insurer’s loss and loss adjustment expense (LAE) ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer might be receiving a disproportionate amount of “bad” business from the MGA or TPA.

Summary and Conclusion

Develop and document a summary and conclusion regarding whether concerns exist due to a significant amount of the insurer’s direct premiums being written through MGAs and TPAs. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the insurer’s use of MGAs and TPAs under the specific circumstances involved.

Recommendations for further action, if any, based on the 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
- Refer concerns regarding a particular MGA or TPA to the examination section for examination of the MGA or TPA
- 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 ________
III. Quarterly Procedures – C.11. Level 2 MGAs and TPAs (Life/A&H)

1. Review General Interrogatories, Part 1, #5. Have there been any significant changes regarding the terms of any agreements with MGAs or TPAs?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding whether concerns exist due to the insurer’s use of MGAs and TPAs. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the insurer’s use of MGAs and TPAs under the specific circumstances involved.

Does the analyst recommend that one or more of the Additional Procedures in the Annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview
Managing general agents (MGAs) and third party administrators (TPAs) produce or solicit business for an insurer and also provide one or more of the following services: underwriting, premium collection, claims adjustment, claims payment and reinsurance negotiation. (See Analyst Reference Guide Section III.C.9. for a detailed discussion of reinsurance including reinsurance intermediaries, fronting, etc.) Insurers are required to have written contracts with MGAs and TPAs which set forth the specific responsibilities of each party. MGAs and TPAs have been used by insurers to increase the volume of business written without having to expand internal staffing and to facilitate entry into new lines of business or geographical locations. However, the more authority that is delegated to MGAs and TPAs, the greater the opportunity for abuse. If the insurer relinquishes too much control, management may not be able to effectively guide and monitor the insurer’s operations. MGAs and TPAs may have priorities or needs that conflict with those of the insurer. For example, there is an inherent conflict for MGAs and TPAs between writing quality business and being compensated by commissions based on the volume of business written. When MGAs and TPAs are compensated based on the volume of business written, their incentive is to write as much business as possible which may result in bad risks being written. These types of conflicts have played a significant part in the failure of several insurers. It is important that the insurer actively supervise, control and monitor the performance of MGAs and TPAs on an ongoing basis to help avoid abuses.

To effectively monitor MGAs and TPAs, insurers should obtain and review annual independent financial examinations and financial reports of the MGAs and TPAs utilized. In addition, the NAIC model acts regarding MGAs and TPAs require insurers to periodically perform on-site reviews of the underwriting and claims processing operations of each MGA and TPA utilized.

The NAIC Managing General Agents Act (#225) (MGA Act) defines an MGA as any person who: 1) manages all or part of the insurance business of an insurer (including the management of a separate division, department or underwriting office) and 2) acts as an agent for such insurer, who, with or without the authority, produces, directly or indirectly, and underwrites an amount of gross direct written premiums equal to or more than five percent of the insurer’s surplus in any one quarter or year and either adjusts or pays claims or negotiates reinsurance on behalf of the insurer. However, the MGA Act exempts certain persons from being considered MGAs for purposes of the Act, including employees of the insurer, underwriting managers under common control with the insurer whose compensation is not based on the volume of premiums written, and attorneys-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

The NAIC Registration and Regulation of Third-Party Administrators (Guideline #1090) is a revision of the former TPA Statute. Guideline #1090 defines a TPA as a person who directly or indirectly underwrites, collects charges, collateral or premiums from, or adjusts or settles claims, in connection with life, annuity, health, stop-loss or workers’ compensation coverage. However, the TPA Guideline exempts certain persons from being considered TPAs, including, among others: insurers, licensed agents whose activities are limited exclusively to the sale of insurance, licensed adjusters whose activities are limited to the adjustment of claims, and MGAs.

Discussion of Level 2 Annual Procedures
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. The analyst should also consider the insurer’s corporate governance which includes the
assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

The Annual Financial Statement contains information regarding the MGAs and TPAs utilized by the types and amount of direct premiums written by each, and the types of authority granted to each by the insurer. The Level 2 Annual Procedures are designed to assist the analyst in identifying those insurers which may have problems due to significant reliance on MGAs and TPAs.

Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst.

Procedure #1 assists the analyst in determining whether a significant amount of the insurer’s direct premiums are being written through MGAs and TPAs. While the amount of direct premiums written by MGAs and TPAs is not necessarily an indication of a problem or concern, this procedure provides an indication to the analyst of the insurer’s exposure to potential abuse by MGAs and TPAs. MGAs and TPAs who had been delegated significant authority without insurer oversight have played a major role in the insolvency of several large insurers.

The analyst may perform additional steps if there are concerns regarding the insurer’s use of MGAs and TPAs. The analyst should consider reviewing the information in the Notes to Financial Statements, Note #19 – Direct Premium Written/Produced by Managing General Agents/Third-Party Administrators in more detail than was done as a part of the Level 2 Annual Procedures review to determine which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the insurer), the types and amount of direct premium written by each, and the types of authority granted to each by the insurer.

For the more significant MGAs and TPAs, the analyst should consider requesting information from the insurer to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether the MGA or TPA arranged for that reinsurance. If the MGA or TPA arranged for the reinsurance, the analyst might consider determining whether the MGA or TPA is affiliated with the reinsurer. In addition, the analyst should consider reviewing the reinsurance agreements to determine whether the terms are reasonable. For the more significant MGAs and TPAs, the analyst should also consider requesting information from the insurer regarding commission rates and any other amounts paid to the MGAs and TPAs, reviewing that information for reasonableness and comparing the commission rates to those paid by the insurer to other agents. Any arrangement involving sliding-scale commissions based on loss ratios or a sharing of interim profits on business, where the MGA or TPA establishes claim liabilities or controls claim payments, should be reviewed closely to determine if there is potential for abuse by the MGA or TPA. In addition, the analyst might also consider determining whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid Certificates of Authority.

The more authority that is delegated to an MGA or TPA, the more important it is for the insurer to provide active, ongoing oversight into the MGA’s or TPA’s operations. To evaluate the insurer’s oversight of significant MGAs and TPAs, the analyst should consider requesting from the insurer copies of its contracts with the MGAs and TPAs to determine compliance with the minimum contract provisions per the MGA Act and the TPA Guideline and/or the applicable provisions of the insurance code. The analyst should also consider requesting from the insurer copies of financial statements for the significant MGAs and TPAs and documentation supporting the insurer’s periodic (at least semi-annual) review of the underwriting and claims processing systems. If there are concerns regarding the business placed with the insurer by an MGA or TPA, the analyst should consider determining if other insurers are utilizing the
same MGA or TPA and comparing the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates).

**Discussion of Level 2 Quarterly Procedures**

The procedure included in the MGAs and TPAs section of the Level 2 Quarterly Procedures is intended to identify any significant changes regarding the terms of any agreements with MGAs or TPAs that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.
III. Annual Procedures – C.12. Level 2 Separate Accounts (Life/A&H)

1. Determine whether the insurer maintains Separate Accounts.
   a. Review General Interrogatories, Part 2, #3.1. Does the insurer have separate accounts?
   b. Review the balance sheet asset and liability items relating to separate accounts business. Are there balances in either of these categories?

   If the answers to both 1.a. and 1.b. are “no,” do not proceed with the remaining Separate Accounts procedures.

2. Review Separate Accounts General Interrogatories #8.2 and #8.3.
   a. Did the insurer report any separate account products that do not meet separate account GAAP classification? If so, review in detail the products and conditions listed in General Interrogatory #8.3.
   b. Did the insurer file a non-insulated separate accounts statement? If “yes,” list the total non-insulated separate account assets and the percentage of non-insulated assets to total separate account assets. Identify and document any concerns regarding the inclusion of non-insulated products in the separate account.
   c. Were any non-variable (non-unit linked) products reported in the Separate Account? If “yes:”
      i. Review the specific product information to determine and understand the reasons for including non-variable products in the separate accounts.
      ii. Identify and document any concerns regarding the non-variable products’ inclusion in the separate accounts.

   Additional procedures and prospective risk considerations if further concerns exist:
   d. Request additional information from the insurer of any unusual or non-variable (non-unit linked) products included in the separate accounts.
   e. Review the Assessments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (filed April 1). Are separate account products being properly accounted for in the Exhibit?

3. Review the Notes to the Financial Statement and the Separate Accounts General Interrogatories to determine whether there are separate account products with general account guarantees.
   a. What is the maximum guarantee the general account would provide to the separate account (S.A. Gen. Int. #2.2)? List the maximum guarantee amount, percentage of capital and surplus, and percentage of total admitted assets. Document any concerns.
   b. Have any separate accounts collected amounts from the general account within the past five years related to separate account guarantees (S.A. Gen. Int. #2.4)? If so, list the total of amounts paid in each of the past five years. If “yes:”
      i.. Does the department have any concerns regarding the amounts or trend of guarantees paid?
      ii. Were the guarantees appropriately reserved for in the general account?
   c. Have there been any risk charges paid to the general account related to separate account guarantees (S.A. Gen. Int. #2.7)? If so, list the total of amounts paid in each of the past five years. If “yes,” do they appear appropriate?
d. Did the insurer report maximum guarantees that the general account would provide or pay amounts on guarantees in the current year, and report no risk charges to the general account? Document any concerns.

e. Review the Notes to Financial Statements, Note #34 – Separate Accounts.
   i. Do any of the separate accounts have guarantees that are designed to mirror an established index?
   ii. Do any of the separate accounts have non-indexed guarantees greater than 4 percent?

f. Review the results of the Actuarial Opinion Supplemental Procedures.
   i. Was there any indication of contingent liabilities created by the separate accounts for the general account?
   ii. Were separate account assets and liabilities subject to asset adequacy analysis?
   iii. If the response to 3.f.ii. is “no,” did the actuarial opinion explain why?

g. Based upon an overall understanding of the insurer’s separate accounts products, is there evidence that such products may be creating contingent liabilities to the general account with product features such as minimum guaranteed death benefits, minimum guaranteed interest rates, etc?

Additional procedures and prospective risk considerations if further concerns exist:

h. Contact the qualified actuary to discuss the nature and scope of the valuation procedures performed relating to guarantees included with separate accounts products.

i. Review the insurer’s separate accounts plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits, particularly minimum guarantees.

j. Contact the policy forms section of the insurance department and inquire as to whether the insurer filed any new and unusual separate account policy forms during the past 12 months.

k. Specifically, determine whether the insurer writes any modified guaranteed annuities and, if so, the overall materiality and potential negative impact on the insurer’s general account.

l. If material guarantees exist, or if non-insulated products exist, determine whether the assets associated with these products are being invested in accordance with statutory guidelines.

m. Request that the field examination staff request a valuation listing by plan and issue year and test a sample of the individual policy reserves for accuracy.

n. Review the results of the Life/A&H Cash Flow and Liquidity chapter of the Handbook. Determine whether any potential liquidity concerns of the general account could adversely impact the financial condition of the separate accounts.

o. Determine whether growth in separate accounts appears to be financed through borrowings of the general account and, if so, whether any concerns exist regarding the terms of repayment or collateralization.
III. Annual Procedures – C.12. Level 2 Separate Accounts (Life/A&H)

p. Perform a comparison review of the total maximum guarantee and the guarantee amounts paid by the general account on a company-by-company basis to determine if the amounts appear reasonable.

4. Determine whether the accounting for activity between the general account and the separate accounts is proper.
   a. Is the portion of capital and surplus funds of the insurer covered by assets in the Separate Accounts Financial Statement greater than 5 percent of capital and surplus?
   b. Review General Interrogatories, Part 2, #3.3. Is the portion of such capital and surplus not distributable from the separate accounts to the general account for use by the general account greater than 5 percent?
   c. Compare the amounts recorded on page 4, line 20 of the Separate Accounts Financial Statement, contributed surplus, to Page 4, line 46 of the General Account Financial Statement, surplus (contributed to) withdrawn from separate accounts during period. Do the amounts fail to reconcile?
   d. Are other changes in surplus in the Separate Accounts Financial Statement greater than 5 percent of capital and surplus?
   e. Review the Notes to Financial Statements, Note #34 – Separate Accounts.
      i. Do the amounts transferred between the general account and separate accounts statement(s) reconcile?
      ii. Are any reconciling adjustments noted?
      iii. Is the net amount of all reconciling items greater than 10 percent of statutory net income?

Additional procedures and prospective risk considerations if further concerns exist:

f. Review the Separate Accounts Annual Financial Statement and the General Account Annual Financial Statement and:
   i. Verify that the separate accounts gain from operations is properly recorded in the capital and surplus section of the General Account Summary of Operations.
   ii. Verify that all other premium and benefits activity is properly recorded on the net transfers to or (from) separate accounts line of the General Account Summary of Operations.

g. Review the Separate Accounts Summary of Operations and surplus account in order to identify potential misclassifications as to “above the line” and “below the line” classifications.

h. Review the level of investment management fees charged to the separate accounts to determine that they are in the generally accepted range of 125 to 140 basis points on separate accounts assets.

i. Review the insurer’s response to General Interrogatories, Part 2, #3.3. Develop and document an overall conclusion regarding the portion of capital and surplus funds of the insurer covered by assets in the Separate Accounts Financial Statements that are not currently distributable from the separate accounts to the general account for use by the general account.
III. Annual Procedures – C.12. Level 2 Separate Accounts (Life/A&H)

5. Determine whether concerns exist regarding securities lending transactions within the separate accounts.
   a. Does the reporting entity engage in securities lending transactions with separate account assets? If so, list the aggregate amount and the percentage of total separate account invested assets.
   b. If the insurer reported securities lending transactions within its separate account(s), list the aggregate total collateral received, if any.

Additional procedures and prospective risk considerations if further concerns exist:
   c. Obtain and review a copy of the insurer’s investment strategy as well as separate accounts plan descriptions and/or policy forms as they relate to its securities lending program.

6. Does the reporting entity report Federal Home Loan Bank (FHLB) funding agreements within the separate account(s)?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding separate accounts. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating the insurer’s separate accounts under the 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
- Conduct additional asset adequacy analysis
- 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 ________
III. Quarterly Procedures – C.12. Level 2 Separate Accounts (Life/A&H)

1. Determine whether the insurer maintains Separate Accounts. Review the Balance Sheet asset and liability items relating to separate accounts business. Are there balances in either of these categories?

   If the answer above is “no,” do not proceed with the remaining Separate Accounts procedures.

2. Have the Balance Sheet items assets from separate accounts or liabilities from separate accounts changed by more than +/-10 percent from the prior year-end?

3. Review the Capital and Surplus Account Statement page.
   a. Is the line item, other changes in surplus in the Separate Accounts Statement, greater than 5 percent of capital and surplus?
   b. Did the line item, other changes in surplus in the Separate Accounts Statement, change by more than +/-10 percent from the prior year, same quarter?

   a. Did the line item, net transfers to or (from) separate accounts, change by more than +/-20 percent from the prior year, same quarter?
   b. Did the insurer report a net loss in the line item, separate accounts net gain from operations excluding unrealized gains or losses, whose absolute value is greater than 5 percent of general account capital and surplus?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the Annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

   Analyst ________________  Date ________

Comments as a result of supervisory review.

   Reviewer ________________  Date ________
Overview

Separate accounts are segregated pools of assets owned by a life/health insurer in which the investment experience is credited directly to the participating policies. Separate accounts are not a separate legal entity, but rather a segregated line of business where the assets and related investment gains and losses are insulated from general account creditors and liquidation claims. The insurer is not a trustee by reason of the separate accounts and state statutes provide that separate account assets may be invested and reinvested without regard to any requirements or limitations imposed upon an insurer by the investment statutes, which apply to insurers. Separate accounts were historically used for pension accounts. More recently they have been used to market unique investment options and guaranteed investment returns. The flexibility they offer policyholders has been the driving force behind their greatly expanded use. Separate accounts may be used to fund a variety of products including individual and group, fixed and variable, guaranteed and non-guaranteed, life insurance and annuities.

Accounting for separate account business involves both the general account of the insurer and the separate accounts. The Separate Accounts Annual Financial Statement is concerned primarily with the investment activities of the separate accounts and with the flow of funds from and to the general account. Only direct investment transactions (purchase, sale including profit and loss thereon, income, and direct expenses and taxes relative to specific investments) are recorded as direct transactions in the Separate Accounts Annual Financial Statement. All other transactions are reported as transfers between the general account of the insurer and the separate accounts statements. In general, the separate accounts do not maintain surplus since gain or loss from separate accounts is transferred to the general account each year.

This chapter focuses primarily on the impact on the general account of separate accounts activities. With many of the separate accounts products, the entire investment risk is absorbed by the policyholder. However, other types of separate accounts products include guarantees in the form of minimum death benefits, minimum interest rates and bailout surrender charge provisions. Any minimum guaranteed obligation must be recorded on the general account of the insurer since, by definition, the entire asset transferred to the separate accounts is at risk. The following is a brief summary of the types of separate accounts products that may create contingent liabilities to the general account:

1. **Variable Annuities**
   
   These products may have implications for the general account by virtue of transfer rights, enhanced death benefits, and minimum interest rate guarantees. Excess reserves required by these provisions are normally carried in the general account of the insurer.

2. **Modified Guaranteed Annuities**
   
   Modified Guaranteed Annuities were developed in the 1980s and are a hybrid between a book/adjusted carrying value deferred annuity and a variable annuity. This product provides interest rate guarantees for a period of time and is patterned after the group Guaranteed Interest Contract. If the policy is surrendered before maturity, then appropriate adjustments are made to the value. However, the insurer bears default risk and additional risk if the insurer’s investment return does not match product guarantees.

   Modified guaranteed annuities in general are not insulated or “walled off” from the general account. These liabilities are, in effect, guaranteed by the general account. The general account must fund any shortfalls in the separate account related to these products. Whether this product is insulated from the general account is determined by the product’s contract wording. If not specifically addressed in the contract, certain states have taken the position that the product is not
insulated. The lack of insulation would result in the assets and liabilities associated with the product being transferred to the general account in the event of liquidation.

3. **Indexed Products**
   With an indexed product, an insurer guarantees that the portfolio will show returns, which will exceed a certain index by a specified number of basis points. An insurer generally requires a large commitment of deposits before issuing such a product, so that the portfolio can achieve the diversification necessary to support the product structure. The risk to the insurer is a mismatch risk between the index and the rate of return recognized. In addition, the product may also contain expense guarantees.

There are generally restrictions upon withdrawals for the accounts. Certain states have required excess reserves for these products based on the remaining guaranty period. However, there is not consistency within the industry as to whether excess reserves are required, how they are calculated, or where they are recorded.

4. **Experience Rated Guaranteed Interest Contracts**
   These products are true group products, with three-party involvement. This is a fully guaranteed product from the plan participant’s point of view. Interest rate guarantees are generally for interest credited to date. Future interest guarantees typically are 0 percent. Termination of the contract is generally at true fair value, or paid out over time.

5. **Fully Guaranteed Interest Contracts**
   These are traditional guaranteed interest contracts written in a separate account. Although many insurers carry non-par guaranteed interest contracts in the general account, insurers will write them in the separate account to better control duration matching. Assets and liabilities are generally valued at book, so reserve accounting and asset valuation is the same as for the general account. The product may or may not be insulated from the general account.

6. **Funded, Experienced Rated Group Annuity**
   These products tend to be immediate annuities, where the plan sponsor participates in the earnings of a segregated investment portfolio. The plan sponsor provides a “margin” in order to participate in the preferred investment portfolio. Nearly all reserves are carried at fair value. If asset value falls below total liabilities plus a margin, then additional deposits are required or a company has the right to invest the assets more conservatively to better hedge its risk. Reserves may be placed in either the general account or the separate account.

7. **Synthetic Guaranteed Interest Contracts**
   This product creates an investment management vehicle for a benefit plan that does not require the plan to transfer ownership of plan assets. Therefore, the insurer selling these products provides investment management services but does not own the assets. The assets and liabilities from these products are not carried on the insurer’s financial statements. These products were developed to provide an extra layer of insulation from general account liabilities. There are two types of synthetic guaranteed interest contracts: 1) participating and 2) non-participating. Non-participating products generally have a portfolio of high quality assets that is not actively traded. The issuer (insurer) agrees to purchase plan assets at book value if needed to make plan benefit payments. If any plan assets associated with the product go into default, the insurer’s purchase obligation is terminated to those securities. The insurer receives a fee for these services.
In participating products, plan assets are normally set aside in a separate custodial account and are actively managed, under agreed upon diversity and credit rating requirements. The portfolio is managed to provide for a return of principal plus a crediting rate. Generally, a floor is established which sets a minimum crediting rate. At the end of the contract term, the insurer is obligated to pay the plan the excess, if any, of the book value of the investment portfolio over its fair value (i.e., the insurer bears the risk of default). Current practices aimed at financial statement disclosure appear to include no disclosure, disclosure through footnotes, or disclosure through inclusion of liabilities on the Exhibit of Deposit-Type Contracts of the general account Annual Financial Statement as both a liability and a negative liability. Some insurers may carry excess reserves for the guaranty of performance, although current practices vary widely.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the insurer’s corporate governance which includes the assessment of the risk environment facing the insurer in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board.

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. Separate accounts, while segregated from the general account of the insurer, can have a significant impact on the financial condition of the insurer. Additional procedures, including prospective risk, are also available if the level of concern warrants further review, as determined by the analyst.

**Procedure #1** assists the analyst in determining whether the insurer maintains separate accounts. Many life/health insurers do not maintain separate accounts. In these situations, the entire separate accounts section of the Handbook is not applicable and the analyst should proceed with the next financial analysis topic.

**Procedure #2** assists the analyst in determining if the insurer has any products in the separate account that have not met the criteria for receiving separate account classification under GAAP per SSAP No. 56—Separate Accounts. A separate account product must meet four conditions as defined in Separate Accounts General Interrogatory #8.2 in order to receive separate account classification: 1) legal recognition; 2) legal insulation; 3) investment directive; and 4) investment performance. If an insurer reports any products that do not meet these criteria, the analyst should review the conditions listed in Separate Accounts General Interrogatory #8.3 and further review the details of the separate account disclosures, as this is an indication the insurer includes products in its separate account that are not true separate account products.

Some insurers may include non-variable (non-unit linked) products in the separate account. Separate Accounts General Interrogatory #8.3 may assist the analyst in determining if such products are included. The analyst should gain an understanding of the reasons why non-variable products are included in the separate account. The analyst may need to contact the policy form unit within the insurance department to obtain information about the policy form application and approval to help gain such understanding of the products included in the separate account. The analyst may need to contact the insurer to request additional information about the policies included in the separate account. Considerations may include: What investment guidelines apply to these products? Outside of product guarantees, does the general account have any responsibilities for funding the reserve liabilities?
If the insurer filed a non-insulated separate accounts statement, Procedure #2b assists the analyst in gaining an understanding of the insurer’s non-insulated products.

Procedure #3 assists the analyst in identifying situations where separate accounts products may be creating contingent liabilities to the general account. This is largely a function of the types of separate accounts products offered by the insurer, and the analyst should rely on general knowledge of the insurer’s products at this stage of the analysis.

The analyst should review disclosures in Separate Accounts General Interrogatory #2 and the Notes to the Financial Statements of the general account to gain an understanding of general account guarantees on separate account products. The analyst should gain an understanding of any products in the separate account that contain guarantees that are held in the separate account instead of the general account and the types of guarantees (GMDB, GMIB, etc).

Procedures #3c and 3d. The analyst should note that, if the insurer reports a maximum guarantee exposure amount in Separate Accounts General Interrogatory #2.2 and guarantees paid in Separate Accounts General Interrogatory #2.3, but does not report risk charges paid in Separate Accounts General Interrogatory #2.7, the insurer is providing guarantees and may not be receiving a risk fee in return for that guarantee. Note that, while group products require risk charges, there may be no requirements for risk charges on individual products. Also note that in some instances, risk fees may be imbedded in the management fees paid to the general account. The analyst should gain an understanding of how risk fees are reported by the insurer and if concerns exist regarding the risk fees, the analyst should consider requesting additional details from the insurer. Additional procedures assist the analyst in determining that contingent liabilities to the general account of the insurer created by separate accounts assets are properly recorded. Guarantees included with separate accounts products must be recorded as a liability of the general account. The analyst may consider comparing the maximum guarantee and the guarantees paid over five years on a company-by-company basis in a review of separate accounts for reasonableness of the exposure to guarantees.

Procedure #4 assists the analyst in determining whether accounting activity between the general account and the separate accounts is proper. All separate accounts activity reaches the Separate Accounts Annual Financial Statement through the General Account Annual Financial Statement. Premiums are recorded in the general account and then “transferred to” the Separate Accounts Financial Statement through the item Net Transfers to or from Separate Accounts (referred to as “above the line” activity). Once the premiums have been moved to the separate accounts, all direct investment activity and reserve changes are recorded on the Separate Accounts Annual Financial Statement. Seed money is “contributed to or withdrawn from” the Separate Accounts Financial Statement through the item Surplus (contributed to) withdrawn from Separate Accounts during the period (referred to as “below the line” activity).

Additional procedures assist the analyst in determining that the accounting for activity between the separate accounts and the general accounts is proper. The primary concern here is to properly classify such activity as to “above the line” (i.e., recorded on the Net Transfers to or (from) Separate Accounts line on the general account) or “below the line” activity (i.e., recorded on the Change in Surplus in Separate Accounts Statement on the general account). An additional area the analyst should investigate in this regard is the level of investment management fees charged to the separate accounts. The U.S. Securities and Exchange Commission has set maximums for the level of such fees. Common industry practice is for this fee to range between 125 and 140 basis points on separate accounts assets.

Procedure #5 assists the analyst in determining if securities lending transactions exist within the separate accounts and the amount of securities lending activity in relation to total separate account invested assets.
If there are concerns regarding this activity, the analyst may consider requesting and reviewing the insurer’s investment plans as they relate to securities lending, as well as separate account plan descriptions and/or policy forms to gain a better understanding of the insurer’s separate account securities lending program.

*Procedure #6* assists the analyst in identifying if the insurer engages in Federal Home Loan Bank (FHLB) funding agreements within the separate account. The analyst should also review the general account Notes to the Financials for more information regarding related general account FHLB agreements. If there are concerns regarding this activity, the analyst may need to obtain additional information from the insurer about their FHLB agreements.

FHLB agreements have become more widely used in recent years and may carry some risk to insurers in a residential mortgage market downturn. While the FHLB requires high-quality assets to be pledged as part of the collateral agreements, the investments purchased by the insurer for funding agreements must be mortgage-related investments under the FHLB loan arrangement. Consider this possible situation. Typically, the insurer could purchase from the FLHB a fixed-rate loan or the insurer may purchase on a floating rate basis, as the spread an insurer could earn is much greater on a floating rate basis. In order to do an appropriate investment match, an insurer would purchase floating rate mortgage securities to match the floating rate loan it has with the FHLB. In a residential mortgage market downturn, the floating rate mortgage securities become depressed in value. As such, the investments that are posted as collateral for the FHLB floating rate loans often do not mirror that in which the insurer invested. If the insurer finds itself in a situation where it is forced to pay off the funding agreement, it could potentially have to sell other higher-quality, non-depressed assets, possibly leaving lower-quality assets in the insurer’s portfolio.

**Discussion of Level 2 Quarterly Procedures**

The procedures described in the Level 2 Quarterly Procedures for separate accounts are intended to identify significant changes in separate accounts that have occurred since the prior year Annual Financial Statement, or the prior Quarterly Financial Statement.
III. Annual Procedures – D.1. Level 2 Investments (Health)

1. Determine whether the health entity’s investment portfolio appears to be adequately diversified to avoid concentration of investments by type or issue.
   a. Are the total of industrial and miscellaneous bonds owned greater than 25 percent of total net admitted assets?
   b. Are residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS) or other loan-backed and structured securities (LBaSS) owned greater than 20 percent of total net admitted assets?
   c. Are foreign bonds owned greater than 5 percent of total net admitted assets?
   d. Are preferred stocks owned greater than 3 percent of total net admitted assets?
   e. Are common stocks owned greater than 20 percent of total net admitted assets?
   f. Are mortgage loans and real estate, including home office real estate, owned greater than 5 percent of total net admitted assets?
   g. Are other invested assets (Schedule BA) greater than 5 percent of total net admitted assets?
   h. Are aggregate write-ins for invested assets greater than 5 percent of total net admitted assets?
   i. Are investments in affiliates greater than 5 percent of total net admitted assets?
   j. Is any one single investment greater than 3 percent of total net admitted assets (excluding federal issues and affiliated investments)?
   k. Has the health entity failed to comply with state-specific investment laws, regulations or guidelines for diversity and limitations?

Additional procedures and prospective risk considerations if further concerns exist:

l. Determine whether the health entity’s investment portfolio is in compliance with the investment limitations and diversification requirements per the state’s insurance laws.
   m. Review the Percentage Distribution of Total Assets for significant shifts in the mix of investments owned during the past five years.
   n. Compare the health entity’s distribution of invested assets per the Percentage Distribution of Total Assets with the industry and peer groups in order to identify significant deviations.
   o. Request a copy of the health entity’s investment plan which discusses investment objectives and strategy, with specific guidelines as to quality, maturity, and diversification of investments and:
      i. Evaluate whether the investment plan appears to result in investments and practices that are appropriate for the health entity based on the types of business written and its liquidity and cash flow needs.
      ii. Determine whether the health entity appears to be adhering to the investment plan.
   p. Review the maturity distribution of bonds in Schedule D - Part 1A - Section 1 (Quality and Maturity Distribution of all Bonds Owned) and consider the liquidity of the health entity’s investments to determine whether the health entity’s investment portfolio appears reasonable based on the types of business written.
III. Annual Procedures – D.1. Level 2 Investments (Health)

q. If the health entity’s investments include a significant amount of foreign bonds, consider the health entity’s potential foreign currency exposure from holding bonds denominated in a foreign currency.

r. If there are concerns regarding liquidity or cash flows, consider having a cash flow analysis performed by an actuary.

2. Determine whether there are concerns due to the level of investment in certain types of securities, which tend to be riskier and/or less liquid than publicly traded investment grade bonds and cash and short-term investments.

a. Determine whether there are concerns due to the level of investment in non-investment grade securities.

   i. Is the ratio of non-investment grade securities to capital and surplus greater than 15 percent?

   ii. If investments in non-investment grade bonds exceed 3.5 percent of capital and surplus, have such investments increased by greater than 15 percent over the prior year?

Additional procedures and prospective risk considerations if further concerns exist:

iii. Review Schedule D - Part 1A - Section 1 (Quality and Maturity Distribution of all Bonds Owned) and compare the health entity’s holdings of non-investment grade bonds to the limitations included in the NAIC’s *Investments in Medium Grade and Lower Grade Obligations Model Regulation* (#340):

   a. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 3, 4, 5, or 6 is less than 20 percent of total net admitted assets.

   b. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 4, 5, or 6 is less than 10 percent of total net admitted assets.

   c. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 5 or 6 is less than 3 percent of total net admitted assets.

   d. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 6 is less than 1 percent of total net admitted assets.

iv. Request a copy of the health entity’s plan for investing in non-investment grade bonds and review the guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity and geographic location.

v. Determine whether the health entity appears to be adhering to its plan for investing in non-investment grade bonds.

vi. For the more significant non-investment grade bonds, request the following current information regarding the issuer from the health entity to determine the issuer’s financial position and ability to repay its debt:

   a. Audited financial statements.
b. Report from an NAIC credit rating provider (CRP) (Moody’s Investors Service, Standard & Poor’s, A.M. Best, Dominion Bond Rating Service (DBRS), Fitch Ratings, Real Point, LLC (CMBS only) or Kroll Bond Rating Agency).

b. Review Schedule D, Part 1A, Section 2 to determine whether there are concerns due to the level of investment in RMBS, CMBS and LBaSS.
   i. Is the ratio of all RMBS, CMBS and LBaSS owned to capital and surplus greater than 25 percent?
   ii. If investments in all RMBS, CMBS and LBaSS currently exceed 15 percent of capital and surplus, have these investments increased by greater than 20 percent over the prior year?
   iii. Is the ratio of RMBS to capital and surplus greater than 5 percent?

Additional procedures and prospective risk considerations if further concerns exist:

iv. Review the RMBS, CMBS and LBaSS categories in Schedule D - Part 1 (Bonds) for bonds with a book-adjusted carrying value significantly in excess of par value, which could result in a loss being realized if bond prepayments occur faster than anticipated.

v. Review the RMBS, CMBS and LBaSS categories in Schedule D - Part 1 for bonds with an unusually high effective yield.

vi. Request information from the health entity regarding the percentage distribution of the amounts of each type of RMBS, CMBS and LBaSS held, as well as planned amortization class (PAC), support bonds, interest only (IO) tranches, principle only (PO) tranches to evaluate the level of prepayment risk in the portfolio.

vii. Request and examine information from the health entity regarding the estimated prepayment speeds on its RMBS.

viii. Request information from the health entity regarding the background and expertise in structured securities of its investment advisors (in-house and/or contractual) and its analytical systems capabilities. Determine whether the advisors and systems are adequate to allow the health entity to continuously monitor its structured securities investments.

ix. Consider having the collateralized mortgage obligations CMOs modeled by an independent actuary as part of an independent cash flow analysis.

c. Determine whether there are concerns due to the level of investment in private placement bonds.
   i. Is the ratio of private placement bonds owned to capital and surplus greater than 15 percent?
   ii. If private placement bonds owned exceed 5 percent of capital and surplus, have such investments increased by greater than 15 percent over the prior year?
Additional procedures and prospective risk considerations if further concerns exist:

iii. Review Schedule D - Part 1A - Section 1 & 2 (Quality and Maturity Distribution of all Bonds Owned) and Schedule D - Part 1A - Section 2 (Maturity Distribution of All Bonds Owned December 31 by Major Type and Subtype) and determine the following:
   a. The total amount of privately placed bonds owned.
   b. The types of issues with privately placed bonds.
   c. The NAIC designations of the privately placed bonds.
   d. The maturity distribution of the privately placed bonds.
   e. The amount of total privately placed bonds that are freely tradable under U.S. Securities and Exchange Commission (SEC) Rule 144 or qualified for resale under SEC Rule 144A.

iv. For the more significant privately placed bonds, request current audited financial information regarding the issuer from the health entity and evaluate the issuer’s financial position and ability to repay its debt.

d. Determine whether there are concerns due to the level of investment in structured notes.
i. Are investments in structured notes greater than 10% of capital and surplus?

Additional procedures and prospective risk considerations if further concerns exist:

ii. Review the Notes to Financial Statements, Note #5 – Investments and Schedule D, Part 1, to identify the types of structured notes and the interest rate reported.

iii. Review the most recent financial examination for any risks noted.

iv. Inquire of the insurer:
   a. Has management adequately reviewed the structured note portfolio and does it understand the underlying yields, cash flows and their volatility?
   b. Gain an understanding of the concentration by collateral type, subordination in the overall structure of the structured note transactions, and any trend analysis that management has performed on the underlying assets to ensure appropriate valuation of the structured note.
   c. Gain an understanding of management’s process for valuing the structured notes so as to assess if the notes are valued appropriately.
   d. What is the insurer’s intended use of these structured notes and purpose within the insurer’s portfolio?
   e. Does management have an appropriate level of expertise with this type of security?
   f. Does the insurer have controls implemented to mitigate the risks associated with this investment type?

III. Annual Procedures – D.1. Level 2 Investments (Health)

e. Determine whether there are concerns due to the level of investment in total real estate and mortgage loans.

i. Is the ratio of total real estate and mortgage loans to capital and surplus greater than 15 percent?

ii. If total real estate and mortgage loans exceed 10 percent of capital and surplus, have such investments increased by greater than 15 percent over the prior year?

Additional procedures and prospective risk considerations if further concerns exist:

iii. Review Schedule A - Part 1 (Real Estate Owned) to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the book-adjusted carrying value (BACV) and reported fair value of the property and the year of last appraisal.

iv. Review Schedule A - Part 1 (Real Estate Owned) and:

a. Investigate any instances where a property has a BACV in excess of its cost.

b. Request information from the health entity regarding any increases by adjustment in BACV during the year.

v. Review Schedule A - Part 1 (Real Estate Owned) for any properties owned which have a book-adjusted carrying value in excess of fair value and determine whether the asset should be written down.

vi. Review Schedule B - Part 1 (Mortgage Loans Owned) and:

a. Compare the book value of each loan to the value of the land and buildings mortgaged to determine whether the mortgage loans are adequately collateralized.

b. Request information from the health entity regarding any increases by adjustment in BACV during the year.

c. Determine whether any of the mortgage loans are to an officer, director, parent, subsidiary, or affiliate.

f. Determine whether there are concerns due to the level of investment in Schedule BA assets.

i. Is the ratio of Schedule BA assets to capital and surplus greater than 10 percent?

ii. If total Schedule BA assets exceed 5 percent of capital and surplus, have such investments increased by greater than 10 percent over the prior year?

Additional procedures and prospective risk considerations if further concerns exist:

iii. Review Schedule BA - Part 1 (Other Long-Term Invested Assets Owned) to determine the amount and types of other invested assets owned and to determine whether they are properly categorized as other invested assets.

iv. Request information from the health entity to support significant increases by adjustment in BACV during the year.
v. Request current audited financial statements and other documents (partnership agreements, etc.) necessary to support the BACV of the health entity’s investment in partnerships, joint ventures and limited liability companies.

vi. Request information necessary to support the BACV of significant other invested assets other than partnerships, joint ventures and limited liability companies.

vii. Request information necessary to determine the fair value of collateral to the amount loaned to ensure the loan is adequately collateralized.

3. Determine whether the board of directors approves purchases and sales of all investments and whether all securities owned as of Dec. 31 of the current year are under the exclusive control of the health entity and in the health entity’s possession.

a. Review General Interrogatories, Part 1, #16. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof?

b. Review General Interrogatories, Part 1, #24.01 and #24.02. Were any stocks, bonds and other securities owned, over which the health entity has exclusive control, not in the actual possession of the health entity, except as shown on Schedule E Part 2 - Special Deposits?

c. Review General Interrogatories, Part 1, #25.1 and #25.2. Were any stocks, bonds or other assets owned by the health entity not exclusively under the control of the health entity?

d. Review General Interrogatories, Part 1, #21.1. Were there any assets reported subject to a contractual obligation to transfer to another party without the liability for such obligation being reported?

e. Review the summary detail on restricted assets provided in the Notes to Financial Statements, Note #5H - Investments. Were there any restricted assets that are greater than 10 percent of invested assets? If “Yes,” provide details.

Additional procedures and prospective risk considerations if further concerns exist:

f. Request a copy of the health entity’s investment plan to determine who is authorized to purchase and sell investments and what approvals are required for investment transactions.

g. If the health entity has securities under its exclusive control that are not in its actual possession, review General Interrogatories, Part 1, #24.01 to determine the reason the securities are not in the health entity’s possession, who holds the securities, and whether they qualify as admitted assets of the health entity.

h. If the health entity owns assets that are not under its exclusive control, review General Interrogatories, Part 1, #25.1, #25.2 and #25.3 to determine the reason the assets are not under the health entity’s exclusive control, who holds the assets and whether they qualify as admitted assets of the health entity.

4. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Investment Analysis Office.


i. Has the health entity failed to follow the filing requirements of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*?
III. Annual Procedures – D.1. Level 2 Investments (Health)

ii. If the answer to 4.a.i is “yes,” document the exceptions listed in General Interrogatories, Part 1, #32.2.

b. Review Schedule D - Part 1 (Bonds) and Schedule D - Part 2 (Preferred Stocks and Common Stocks). Does it appear that the health entity is not complying with the requirement to submit securities that are not filing exempt to the SVO for a valuation (i.e., there are securities that were acquired prior to the current year with a “Z” suffix after the NAIC designation and there is a significant number of securities that were acquired during the current year with a “Z” suffix after the NAIC designation)?

Additional procedures and prospective risk considerations if further concerns exist:

c. Review Schedule D - Part 1 (Long-Term Bonds Owned) to determine whether all bonds with an NAIC designation of 3, 4, 5, or 6 (non-investment grade bonds) have been valued at the lesser of BACV or fair value and all other bonds have been valued at their book-adjusted carrying value BACV.

d. Review Schedule D - Part 2 (Preferred Stocks and Common Stocks Owned) to determine whether sinking fund preferred stocks have been valued at their cost and all other stocks have been valued at their fair value.

e. If securities are listed in Schedule D - Part 1 (Long-Term Bonds Owned) or Schedule D - Part 2 (Preferred Stocks and Common Stocks Owned) with a “Z” suffix after the NAIC designation:

i. Request verification from the health entity that the securities, if not filing exempt, have been submitted to, and subsequently valued by, the SVO.

ii. If the securities do not qualify as filing exempt, compare the price or designation actually received from the SVO to that included in the Annual Financial Statement for significant securities.

5. Determine whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value.

a. Review General Interrogatories, Part 1, #30 (which shows the aggregate statement value and the aggregate fair value of bonds and preferred stocks owned). Is the aggregate excess of the statement value over the fair value of bonds and preferred stocks owned greater than 5 percent of the statement value of bonds and preferred stocks owned?

b. Is the aggregate excess of the statement value over the fair value of bonds and preferred stocks owned greater than 5 percent of capital and surplus?

Additional procedures and prospective risk considerations if further concerns exist:

c. Review Schedule D - Part 1 (Long-Term Bonds Owned) and Schedule D - Part 2 (Preferred Stocks and Common Stocks Owned) or request additional information from the health entity to determine which individual securities have a book-adjusted carrying value significantly in excess of their fair value. For those securities:

i. Verify the NAIC designation assigned and, if not filing exempt, determine whether they have been updated recently by the SVO.
III. Annual Procedures – D.1. Level 2 Investments (Health)

ii. If filing exempt, determine the current rating by an NAIC CRP (e.g. Moody’s Investors Service, Standard & Poor’s, A.M. Best, Dominion Bond Rating Service (DBRS), Fitch Ratings, Real Point (CMBS only) or Kroll Bond Rating Agency).

iii. Determine whether there has been any other than temporary impairment in fair value.

d. Request information from the health entity regarding investment strategies and short-term cash flow needs to determine whether investments with a BACV significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

6. Determine whether the fair value of common stock is significantly greater than or less than the cost.

a. Review Schedule D - Part 2 - Section 2 (Common Stocks). Is the aggregate fair value of common stock below the actual cost?

i. If 6.a. is “yes,” is the difference greater than 5 percent of capital and surplus?

b. Review Schedule D - Part 2 - Section 2, (Common Stocks). Is the aggregate actual cost of common stock below the fair value?

i. If 6.b. is “yes,” is the difference greater than 5 percent of capital and surplus?

c. If an investment in one issue of common stock exceeds 5 percent of invested assets, does the fair value of the common stock exceed the actual cost by greater than 30 percent or is the fair value less than the actual cost by greater than -20 percent?

Additional procedures and prospective risk considerations if further concerns exist:

d. Review Schedule D - Part 2 - Section 2, (Common Stocks Owned) or request additional information from the health entity to determine which individual common stocks have a cost significantly in excess of their fair value. For those securities:

i. If the stock is listed on a market or exchange, (designated by the symbol L or U), such as the New York Stock Exchange, the American Stock Exchange, the NASDAQ National Market system, or a foreign exchange, verify the price and total fair value.

ii. If the stock is designated “A” (Unit Price of the share has been analytically determined by the SVO) determine whether the rating has been updated recently by the SVO.

iii. Determine whether there has been another temporary impairment in the fair value of the common stock.

e. Request information from the health entity regarding investment strategies and short-term cash flow needs to determine whether common stock with a cost significantly in excess of its fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

f. Is the health entity aware of any market conditions that could threaten the value of the health entity’s investment portfolio?

7. Determine whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year.
a. Review Schedule D - Part 3 (Long-Term Bonds and Stocks Acquired During Current Year). Were significant amounts of bonds or stocks purchased near the beginning or the end of the year? If so, determine the types of securities purchased and the vendors used for those purchases. Refer to the “Financial Summary Investment Activity” section of the insurer’s “Financial Profile” for information regarding long-term bonds and stocks acquired near the beginning or the end of the year.

b. Review the Annual Financial Statement Liabilities. Is payable for securities greater than 3 percent of invested assets?

c. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed of During Current Year). Were significant amounts of bonds or stocks disposed of near the beginning or the end of the year? If so, determine the types of securities sold and the purchasers of those securities. Refer to the “Financial Summary Investment Activity” section of the insurer’s “Financial Profile” for information regarding long-term bonds and stocks sold, redeemed or otherwise disposed of near the end of the year.

d. Review the Annual Financial Statement Assets. Is receivable for securities greater than 3 percent of invested assets?

e. Review Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed Of During Current Year). Were significant amounts of bonds or stocks acquired near the beginning of the year and disposed of near the end of the year? If so, determine the types of securities purchased, the vendors used for those purchases and the purchasers of those securities. Refer to the “Financial Summary Investment Activity” section of the insurer’s “Financial Profile” for information regarding long-term bonds and stocks acquired near the beginning of the year and disposed of near the end of the year.

Additional procedures and prospective risk considerations if further concerns exist:

f. Review Schedule D - Part 3 (Long-Term Bonds and Stocks Acquired During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the types of securities purchased at or near the beginning and the end of the year and the vendors used for those purchases. Refer to the “Financial Summary Investment Activity” section of the insurer’s “Financial Profile” for information regarding long-term bonds and stocks acquired near the beginning or the end of the year.

g. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the types of securities sold at or near the beginning and the end of the year, and the purchasers of those securities. Refer to the “Financial Summary Investment Activity” section of the insurer’s “Financial Profile” for information regarding long-term bonds and stocks sold, redeemed or otherwise disposed of near the end of the year.

h. Based on the results of a. and b. above, determine whether the health entity might have engaged in "window dressing" of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end).
8. Determine whether concerns exist due to significant turnover of long-term bonds, preferred stocks, or common stocks during the year.

   a. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired During Current Year and Disposed of During Current Year). Is the long-term bond turnover ratio greater than 50 percent?

   b. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired During Current Year and Disposed of During Current Year). Is the stock turnover ratio greater than 50 percent?

   c. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired During Current Year and Disposed of During Current Year). Is the total long-term bond and stock turnover ratio greater than 50 percent?

Additional procedures and prospective risk considerations if further concerns exist:

   d. Determine that all brokers used by the company for investment transactions are licensed and in good standing with the SEC.

   e. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During the Current Year) to determine the amount of bonds and stocks disposed of during the current year.

      i. Review Schedule D - Part 3 (Long-Term Bonds and Stocks Acquired During Current Year) to determine the quality of bonds acquired, noting any “Z” rated (not filing exempt or not rated by the SVO) securities. Also, note any NAIC designations of 3, 4, 5, or 6 (non-investment grade bonds).

      ii. Review Schedule D - Part 3 (Long-Term Bonds and Stocks Acquired During Current Year) to determine the quality of preferred and common stocks acquired. Evaluate any “U” (unlisted) or “A” (analytically determined) rated stocks.

   f. High turnover of investments can result in realized capital gains. Review the Exhibit of Capital Gains (Losses) to determine the degree of reliance on capital gains to increase surplus or to offset underwriting losses.

9. Determine whether there are concerns due to investments in derivative instruments. Review the Notes to Financial Statements #1 and #8; General Interrogatories, Part 1, #26; the write-ins for assets and liabilities; Exhibit of Net Investment Income, Line 7; Exhibit of Capital Gains and Losses Line 7; Schedule DB - all parts; the MD&A; and the Audited Financial Report. Is the health entity engaging in derivative activity?

Additional procedures and prospective risk considerations if further concerns exist:

   a. Request and review a comprehensive description of the health entity’s hedge program in order to obtain an understanding of the health entity’s use of derivative instruments to hedge against the risk of a change in value, yield, price, cash flow, quantity or degree of exposure with respect to assets, liabilities, or future cash flows that the health entity has acquired or incurred, or anticipates acquiring or incurring and:
III. Annual Procedures – D.1. Level 2 Investments (Health)

i. Evaluate whether the hedge program appears to result in hedges, which are appropriate for the health entity based on its assets, liabilities, and cash flow risks.

ii. Determine whether the health entity appears to be adhering to the description of the hedge program.

b. Review Schedule DB (Derivative Instruments). For significant derivative instruments, which are open at year-end, request the following information from the health entity:

i. A description of the methodology used to verify the continued effectiveness of the hedge provided.

ii. A description of the methodology to determine the fair value.

iii. A description of the determination of the BACV.

c. Consider having the health entity’s derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. 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 health entity’s investments under the specific circumstances involved.

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

☐ Contact the health entity seeking explanations or additional information
☐ Obtain the health entity’s business plan
☐ Require additional interim reporting from the health entity
☐ Refer concerns to examination section for targeted examination
☐ Engage an independent appraiser to value particular investments
☐ Engage an independent actuary to perform cash flow analysis
☐ Meet with the health entity’s management
☐ Obtain a corrective plan from the health entity
☐ Other (explain)

Analyst ________________ Date ________

Comment as a result of supervisory review.

Reviewer ________________ Date ________
III. Quarterly Procedures – D.1. Level 2 Investments (Health)

1. Determine whether the health entity’s investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue.
   a. Are preferred stocks owned greater than 3 percent of total net admitted assets?
   b. Are common stocks owned greater than 10 percent of total net admitted assets?
   c. Are non-investment grade bonds owned greater than 3.5 percent of total net admitted assets?
   d. Are mortgage loans and real estate, including home office real estate, owned greater than 5 percent of total net admitted assets?
   e. Are other invested assets (Schedule BA) greater than 3 percent of total net admitted assets?
   f. Are aggregate write-ins for invested assets greater than 3 percent of total net admitted assets?
   g. Are investments in affiliates greater than 5 percent of total net admitted assets?

2. Determine whether the health entity has significantly increased its holdings since the prior year-end in certain types of investments, which tend to be riskier and/or less liquid than publicly traded investment grade bonds and stocks and cash and short-term investments.
   a. If non-investment grade bonds exceed 3.5 percent of capital and surplus, have such investments increased by greater than 15 percent over the prior year-end?
   b. If total real estate and mortgage loans exceed 5 percent of capital and surplus, have such investments increased by greater than 15 percent over the prior year-end?
   c. If other invested assets (Schedule BA) exceed 5 percent of capital and surplus, have such investments increased by greater than 10 percent over the prior year-end?
   d. If aggregate write-ins for invested assets exceed 2 percent of capital and surplus, have such investments increased by greater than 20 percent over the prior year-end?
   e. If affiliated investments exceed 10 percent of capital and surplus, have such investments increased by greater than 20 percent over the prior year-end?

3. Determine whether the health entity invests in derivatives, which tend to be riskier and/or less liquid than publicly traded investment grade bonds, stocks, cash, and short-term investments. Review Schedule DB, all Parts, the write-ins for assets and liabilities, General Interrogatory #15.1 and #15.2, Notes to the Financial Statements #1 and #8 (if reported). Does the health entity engage in derivative activity?

4. Determine whether all securities owned are under the control of the health entity and in the health entity’s possession. Review General Interrogatory, Part 1, #11.1. Were any of the assets of the health entity loaned, placed under option agreement or otherwise made available for use by another person (excluding securities under securities lending agreements)?

5. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office.
   a. Review General Interrogatory for Investments Part 1, #18.1. Has the Company failed to follow the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office?
III. Quarterly Procedures – D.1. Level 2 Investments (Health)

b. If the answer to 5.a above is “yes,” document the exceptions listed in General Interrogatory Part 1, #18.2.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. 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 health entity’s investments under the specific circumstances involved.

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comment as a result of supervisory review.

Reviewer ________________ Date ________
Overview

Health entities receive premiums from policyholders today in exchange for a promise to pay covered claims in the future. These premiums, net of operating expenses paid, along with capital and surplus funds, are invested in a variety of different types of investments until needed to pay claims. Although most health entities tend to operate with a fairly liquid investment philosophy compared to other insurers, state insurance laws are still in place to regulate a health entity’s investments and prescribe the types of investments that may be acquired by health entities. These laws also generally provide limitations on investments by type and issue. However, in most states, a large amount of the health entity’s assets may be invested at the discretion of management or the board of directors within the statutory limits. A health entity may become financially troubled if it invests heavily in speculative or high-risk investments that later result in losses or if it invests in securities with maturities that are inappropriately matched with its liabilities.

As previously mentioned, most health entities typically maintain a fairly conservative investment philosophy. Some of this conservatism can be driven by the health entity’s need to maintain liquidity in order to match the generally short-term benefits cycle. The liquidity philosophy may be driven by their size and level of capital and surplus. In some cases, a small or thinly capitalized health entity may need to maintain additional liquidity and therefore hold mostly cash or cash equivalents. Other health entities, such as Hospital, Medical and Dental Services or Indemnities (HMDIs), may be able to maintain sufficient liquidity while holding some long-term investments. A significant portion of most health entities’ invested assets is maintained in cash and short-term investments. Most health entities also hold the majority of remaining invested assets in investment grade bonds with somewhat short-term maturities. Although most health entities will maintain a fairly liquid asset mix, the analyst should be aware that an improper matching of assets with liabilities can occur with health entities and can lead to forced liquidations of long-term investments. In some of these cases, it is possible that the health entity may not be able to liquidate its portfolio fast enough when benefits obligations come due. In other cases, the liquidation may result in capital losses, leading to deterioration in the financial solvency of the health entity.

Because of the somewhat conservative investment philosophy used by many health entities, investment yields for most health entities are generally low compared to life or property/casualty insurers. However, some health entities may also write small amounts of life insurance, long-term care (LTC), or other long-tail lines of business. For those health entities, investment income can be a key component in the pricing of these longer-tail lines of business. In some cases, management may use strategies to maximize investment yields when losses are higher than anticipated at the time the products were priced. Higher investment yields generally involve higher risk. A shift to higher yield investments may result in the ownership of investments with questionable quality or value.

Investment risk may also involve a failure to adequately diversify an investment portfolio. A concentration of assets in one type of investment may not adequately spread the investment risk and may result in more volatile investment returns. A high concentration of investments that are not readily marketable may also indicate increased investment risk and may raise concerns as to the value of the investments.

The principal areas of concern to the analyst in reviewing a health entity’s investment portfolio are these: 1) diversification; 2) liquidity; 3) quality; and 4) valuation. First, under most circumstances, a health entity's investment portfolio should be adequately diversified to prevent an undue concentration of investments by type or issue. In order to determine whether diversification is in order, the analyst should take into account both the amount of concentration and the quality of the various types of investments in
the portfolio. Second, the investment portfolio should be structured in such a way that it is appropriately liquid to allow for the cash flows necessary to cover the health entity’s benefit commitments as they become due. Generally, cash holdings and scheduled investment maturities should be adequate to fund anticipated net cash outflows. To accommodate unanticipated outflows, sufficient assets should be readily convertible to cash and the sale of necessary assets should not involve significant losses caused by changes in the market. Third, default or credit risk is a function of investment quality. As the quality of an investment decreases, the probability that principal will be returned and that the expected yield will be realized tends to decrease. Fourth, invested assets are generally valued at cost or amortized cost, except for common stocks and perpetual preferred stocks, which are valued at fair value. However, the analyst should track investments that may need to be written down to fair value due to impairments in the market.

**Discussion of Level 2 Annual Procedures**

The Level 2 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of concern regarding a health entity’s investment portfolio are diversification, liquidity, quality, valuation and asset/liability matching. Most of the procedures are designed to assist the analyst in identifying undue concentrations of investments by type or issue and investments that have been improperly valued in the Annual Financial Statement. As stated in the discussion above, health entities generally hold cash, short-term securities and investment grade bonds. However, a review of all types of potential investments should be performed for health entities. Health entities that also write long-tail business may hold other riskier and/or less liquid securities.

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary (IPS) 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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.

*Procedure #1* assists the analyst in determining whether the health entity’s investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue. The ratios within the procedure are a measure of diversity of the health entity’s investment portfolio by type of investment. The results of these ratios may also provide some indication of the health entity’s liquidity. Ratios are included for most types of investments except for government and agency bonds and cash and short-term investments, which are generally very liquid. In addition, the ratio of the investment in any one issue or issuer to total net admitted assets is a measure of the diversity of the health entity’s investment portfolio.

Additional steps may be performed if there are concerns regarding whether the health entity’s investment portfolio is adequately diversified to avoid concentration of investments by type or issue. The analyst should consider determining whether the health entity’s investment portfolio is in compliance with the investment limitations and diversification requirements per the state’s insurance laws. The analyst might also review the Percentage Distribution of Assets in the Financial Profile Report for significant shifts in the mix of investments owned during the past five years. The analyst should compare the health entity’s distribution of invested assets to industry averages to determine significant deviations from the industry averages. In addition, the analyst might also want to request a copy of the health entity’s formal adopted investment plan. This should be evaluated to determine if the plan appears to result in investments that are
appropriate for the health entity based on the types of business written and its liquidity and cash flow needs and to determine whether the health entity appears to be adhering to its plan. The analyst might also review Schedule D - Part 1A - Quality and Maturity Distribution of All Bonds Owned and consider the liquidity of the health entity’s investments to help determine whether the health entity’s investment portfolio appears reasonable based on the types of business written. If the analyst has concerns regarding liquidity or cash flows, he or she should consider having a cash flow analysis performed by an actuary.

Procedure #2 assists the analyst in determining whether concerns exist regarding the level of investment in certain types of investments that tend to be riskier and/or less liquid than publicly traded bonds, stocks, cash and short-term investments. Although most health entities tend to invest primarily in publicly traded bonds and stocks and short-term securities, there are some health entities that may have a significant concentration of riskier investments. In addition to the steps for the types of investments included in procedure #2, the analyst should review procedures #3 and procedure #4 in the Affiliated Transactions section of the Level 2 Annual Procedures.

Additional steps may be performed if there are concerns regarding the level of investment in certain types of investments that tend to be riskier and/or less liquid than publicly traded bonds and stocks and short-term investments.

Procedure #2a assists the analyst in determining whether concerns exist due to the level of investment in non-investment grade bonds. Bonds that have NAIC designations of 3, 4, 5 or 6 by the Investment Analysis Office (SVO), are considered non-investment grade bonds and represent a significantly higher credit or default risk to the health entity than do investments in investment grade bonds. In addition, the prices of non-investment grade bonds are frequently more volatile than the prices of investment grade bonds. The NAIC has adopted a Investments in Medium Grade and Lower Grade Obligations Model Regulation (#340). Model #340 establishes limitations on the concentration of non-investment grade bonds because of concerns that changes in economic conditions and other market variables could adversely affect health entities having a high concentration of these types of bonds. While most states have adopted this model, not all states include all health entities in the scope of the regulation.

Additional steps may be performed if there are concerns regarding the level of investment in non-investment grade bonds. The analyst should consider reviewing Schedule D - Part 1A - Section 1 - Quality and Maturity Distribution of All Bonds Owned and compare the health entity’s holdings of non-investment grade bonds to the limitations included in Model (#340) by NAIC designation. The health entity should have a plan for investing in non-investment grade bonds that has guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location. The analyst might consider requesting a copy of this plan from the health entity to determine whether the health entity appears to be adhering to its plan for investing in non-investment grade bonds. For the more significant non-investment grade bonds, the analyst might also consider requesting from the health entity audited financial statements and a rating agency report for the issuer of the bonds to assess the health entity’s current financial position and ability to repay its debt.

Procedure #2b assists the analyst in determining whether concerns exist due to the level of investment in residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS), and loan-backed and structured securities (LBaSS). Of the structured securities, RMBS are generally the most complex and volatile. RMBS convert a pool of mortgage loans into a series of securities that have expected maturities that vary significantly from the underlying pool as a result of slicing the pool into numerous tranches with different repayment characteristics. RMBS are either issued or backed by the U.S. government, carry very little credit risk, and are commonly stated at par value. As a result, many RMBS have been designated category 1 by the SVO. However, the credit rating does not consider the
prepayment or interest rate risk inherent in the RMBS investment. If the underlying mortgage loans are repaid by the borrowers faster or slower than anticipated, the RMBS repayment streams will be affected, and the expected durations will either contract or extend. Thus the cash flows on these investments are much more unpredictable than those for more traditional bonds and for mortgage pass-through certificates. If the RMBS prepayments are significantly faster than anticipated and the health entity had paid a large premium for the RMBS when it was acquired, the health entity could experience a significant loss on the investment even though the par value was received. In addition, cash flows on RMBS are harder to match with corresponding payments on policy liabilities, which leads to the risk that prepayments may not be able to be reinvested in instruments earning comparable yields in order to support the liability payment streams.

Additional steps may be performed if there are concerns regarding the level of investment in RMBS. The analyst should consider reviewing the RMBS, CMBS and LBaSS securities categories in Schedule D - Part 1 – Long-Term Bonds Owned for bonds with a book/adjusted carrying value (BACV) significantly in excess of par value, which could result in a loss being realized if bond prepayments occur faster than anticipated. The analyst should also consider reviewing a listing of the effective yield on each of the health entity’s RMBS, CMBS and LBaSS. The effective yield on most debt securities is generally linked to its credit risk and duration. However, significant prepayment risk can also increase the effective yield.

There are many different types of RMBS, each of which have different characteristics and inherent risks. Therefore, the analyst might consider requesting information from the health entity regarding the amount of each type held (e.g., Planned Amortization Class (PACs), support bonds, interest only (IO) and principal only (PO)) to help evaluate the riskiness of the portfolio.

The analyst might consider requesting information from the health entity regarding estimated prepayment speeds on its RMBS. Several standardized forms of calculating the rate of prepayments of a mortgage security exist in the market. The Constant Prepayment Rate (CPR) and the Standard Prepayment Model of the Bond Market Association (PSA curve) are the most common methods used to measure prepayments. The analyst should consider further analysis in those instances that prepayment risk appears high.

*Procedure #2c* assists the analyst in determining whether concerns exist due to the level of investment in privately placed bonds. While U.S. Securities and Exchange Commission (SEC) Rule 144 and Rule 144A securities are reasonably liquid, most private placement bonds are illiquid. Significant investments in illiquid privately placed bonds may cause the analyst to have concerns regarding the health entity’s liquidity because many of these types of investments cannot be resold, while those that can be resold frequently have restrictions as to whom they can be sold. There is no structured market for privately placed bonds like there is for publicly traded bonds. Therefore, even if the privately placed bonds can be sold, it may be difficult to find a willing buyer. Health entities commonly purchase these debt obligations in order to avoid the uncertainties of the market, to engage in private negotiations, and to avoid the SEC restrictions.

Additional steps may be performed if there are concerns regarding the level of investment in privately placed bonds. The analyst should consider reviewing Schedule D - Part 1A - Section 1 - Quality and Maturity Distribution of All Bonds Owned and Schedule D - Part 1A - Section 2 - Maturity Distribution of All Bonds Owned December 31 by Major Type and Subtype to determine the amount, issue type, NAIC designation, maturity distribution of privately-placed bonds, and the amount of privately-placed bonds which are freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A. For the more significant privately-placed bonds, the analyst should also consider requesting from the health
entity current audited financial information regarding the issuer to evaluate the issuer’s financial position and ability to repay its debt.

Procedure #2d assists the analyst in determining whether concerns exist due to the level of structured notes held by the insurer. If the amount is material as compared to the insurer’s capital and surplus plus asset valuation reserve (AVR), the analyst should consider steps to gain a better understanding of the prospective risks of these investments and the insurer’s level of investment expertise regarding these types of notes.

The analyst should refer to the FAQ guidance of the Blanks (E) Working Group at the following link, [www.naic.org/documents/committees_e_app_blanks_related_structured_notes_faq.pdf](http://www.naic.org/documents/committees_e_app_blanks_related_structured_notes_faq.pdf) for the definition of structured notes and information about different types of structured notes.

Structured notes are issuer bonds where the cash flows are based upon a referenced asset and not the issuer credit. These notes differ from structured securities in that they do not have a related trust and, as such, are not valued in accordance with Statement of Statutory Accounting Principles (SSAP No. 43R – Loan-Backed and Structured Securities, but instead are valued in accordance with SSAP No. 26 – Bonds, Excluding Loan-Backed and Structured Securities. Mortgage referenced securities are examples of these structured notes and most recently this type of security has been issued by the Federal Home Loan Mortgage Corporation (FHLMC) (e.g., Structured Agency Credit Risk or STACR) and the Federal National Mortgage Association (FNMA). These mortgage referenced securities are not filing exempt (FE) and the Structured Security Group (SSG) assigns NAIC designation based upon modeling assumptions; even though other structured securities still are FE. If an insurer has a material amount of structured notes, the analyst should, through discussion with the insurer, determine whether management has adequately reviewed the insurer’s structured note portfolio and understands the underlying yields, cash flows and volatility. The analyst should consider the following risks related to structured notes: collateral type concentration, subordination in the overall structure of the transactions, and trend analysis of underlying assets to ensure appropriate valuation. The analyst should assess if the notes are valued appropriately so as to ensure the insurer is not undercapitalized. The analyst should also refer to any recent examination findings. The procedures also instruct the analyst to inquire of the insurer on such items as the structured note’s use, valuation, the insurer’s level of expertise with this type of security and controls the insurer has implemented to mitigate this risk.

Procedure #2e assists the analyst in determining whether concerns exist due to the level or quality of investment in real estate and mortgage loans. These investments are less liquid than many other types of investments. In addition, the analyst may also have concerns regarding the fair value of the real estate, whether it is the underlying investment or the collateral for a mortgage loan. Real estate in certain parts of the country has experienced significant declines in fair values from time to time. Most states restrict mortgage loan investments to first liens on property, with some states allowing second liens in instances where the health entity also owns the first lien. Second liens are more risky because, in the event of default, the holder of the first lien would be repaid out of any proceeds from the sale of the underlying property prior to the holder of the second lien.

Additional steps may be performed if there are concerns regarding the level or quality of investment in real estate and mortgage loans. If there are concerns regarding real estate owned, the analyst should consider reviewing Schedule A - Part 1 - Real Estate Owned to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the BACV and reported fair value of the property, and the year of the last appraisal. In addition, for those properties with BACV in excess of fair value, the analyst might consider whether the asset should be written down. The analyst should also consider investigating any instances where a property has a BACV in excess of its
cost and requesting information from the health entity regarding any increases in book/adjusted carrying value during the year. If there are concerns regarding mortgage loans, the analyst should consider reviewing Schedule B - Mortgages Loans Owned to compare the book/adjusted carrying value of each loan to the value of the land and buildings mortgaged. The analyst should determine whether the mortgage loans are adequately collateralized and whether any of the mortgage loans are to officers, directors or other affiliates of the health entity. For those loans that have had an increase in book/adjusted carrying value during the year, the analyst might consider requesting information from the health entity regarding the increase to determine whether the increase should be considered an admitted asset. In addition, for those loans with interest overdue or are in process of foreclosure, the analyst should consider reviewing the year of last appraisal of the underlying land and buildings to determine whether updated appraisals should be required. For both real estate and mortgage loans, the analyst should utilize postal code and property type information along with the city and state location information in Schedule A and B to identify geographic concentrations and to identify differences in volatility based on the property type and geographic location.

Procedure #2f assists the analyst in determining whether concerns exist due to the level of investment in other invested assets (Schedule BA). The types of investments included in Schedule BA include collateral loans, limited liability companies (LLCs), joint ventures and partnerships, oil and gas production, and mineral rights. Joint ventures and partnerships typically involve real estate. These types of assets tend to be fairly illiquid and may contain significant credit risk.

In addition to the steps for the types of investments included in procedures #2a – #2e, the analyst should review procedures #3 and 4 in Level 2 Annual Procedures for Affiliated Transactions.

Additional steps may be performed if there are concerns regarding the level of investment in other invested assets. The analyst should consider reviewing Schedule BA - Part 1 – Other Long-Term Invested Assets to determine the amount and types of other invested assets owned and to determine whether they are properly categorized as other invested assets. Information might be requested from the health entity to support any increases by adjustment in BACV during the year. In addition, the analyst should consider requesting current audited financial statements and other documents (e.g., partnership agreements) necessary to support the BACV of the health entity’s investment in partnerships and joint ventures and information to support the BACV of significant other invested assets (e.g., other than partnerships and joint ventures). For investments in collateral loans the analyst may want to compare the fair value of the collateral to the amount loaned to determine whether the loan is adequately collateralized

Procedure #3 assists the analyst in determining whether the purchases and sales of investments were approved by the health entity’s board of directors and whether all securities are owned Dec. 31 of the current year, over which the health entity exclusive control, and are in the health entity’s possession. Most states require investment transactions to be approved by the health entity’s board of directors or a subordinate committee. General Interrogatory #16 indicates whether this has been done. General Interrogatories #24.01 and #24.02 indicates whether the stocks, bonds or other securities, of which the health entity has exclusive control (defined by the NAIC as the exclusive right by the health entity to dispose of an investment at will, without the necessity of making a substitution therefore) are in the actual possession of the health entity. If the health entity owns securities, which are not in its possession, the securities should be held by a custodian under a properly executed custodial agreement in order to be considered net admitted assets. General Interrogatories #25.1 and #25.2 indicates whether any of the stocks, bonds or other assets of the health entity are not exclusively under its control. Assets that are not under the health entity's control might not meet the state’s requirements to be considered net admitted assets.
Additional steps may be performed if there are concerns regarding investment approval or control and possession. If there are concerns regarding investment approval, the analyst should consider requesting a copy of the health entity’s formal adopted investment plan to determine who is authorized to purchase and sell investments and what approvals are required for investment transactions. If there are concerns regarding investments that are held by someone other than the health entity, the analyst should consider reviewing General Interrogatory #24 in more detail to determine the reason the securities are not in the health entity’s possession and who holds the securities in order to evaluate whether they qualify as net admitted assets of the health entity under the state insurance laws or whether there are concerns regarding the health entity’s ability to have access to the securities when needed. If there are concerns regarding investments that are not under the health entity’s exclusive control, the analyst should consider reviewing General Interrogatory #25 in more detail to determine the reason the assets are not under the health entity’s exclusive control (e.g., loaned to others, subject to repurchase or reverse repurchase agreements, pledged as collateral, placed under option agreements) and who holds the assets in order to evaluate whether they qualify as net admitted assets for the health entity under the state insurance laws or whether there are other concerns.

Procedure #4 assists the analyst in determining whether the securities owned by the health entity have been valued in accordance with the standards promulgated by the SVO. Beginning in 2004, the provisional exemption (PE) identifier in the NAIC Investment Analysis Office Purposes and Procedures Manual was changed to FE. This change expands the exemption to preferred stocks and all NAIC equivalent designations and removes several of the optionality requirements. In conjunction with this change, the SVO compliance certificate was changed to a general interrogatory in the investment section. According to NAIC requirements, all securities purchased that are not filing exempt per the Investment Analysis Office Purposes and Procedures Manual should be submitted to the SVO for valuation within 120 days of the purchase. In accordance with the NAIC Annual Financial Statement Instructions, if the SVO provides an NAIC designation or price, that designation or price should be utilized. Health entities are required to complete the general interrogatory on compliance filing requirements of the Investment Analysis Office Purposes and Procedures Manual and list exceptions as a component of the Annual Financial Statement. This interrogatory should indicate the following: 1) all prices or NAIC designations for the securities owned by the health entity that appear in the Valuations of Securities (VOS) publication have been obtained directly from the SVO; 2) all securities previously valued by the health entity and identified with a “Z” suffix (which indicates that the security is not FE, does not appear in the VOS publication or has not been reviewed and approved in writing by the SVO) have either been submitted to the SVO for a valuation or disposed of, and 3) all necessary information on securities that have previously been designated (not rated (NR) due to lack of current information) by the SVO have been submitted to the SVO for valuation or that the securities have been disposed of. In addition, the analyst should review Schedule D - Part 1 - Bonds and Schedule D - Part 2 - Preferred Stocks and Common Stocks to determine whether it appears that the health entity is complying with the requirement to submit securities to the SVO for valuation. There should be no securities that were acquired prior to the current year that have a “Z” suffix after the NAIC designation.

Additional steps may be performed if there are concerns regarding whether securities have been valued in accordance with the standards promulgated by the NAIC SVO. The analyst should consider reviewing Schedule D - Part 1 - Bonds to determine whether all bonds with an NAIC designation of 3, 4, 5 or 6 (non-investment grade bonds) have been valued at fair value and all other bonds have been valued at BACV in accordance with the NAIC Accounting Practices and Procedures Manual (AP&P Manual). The analyst should also consider reviewing Schedule D - Part 2 - Preferred Stocks and Common Stocks to determine whether sinking fund preferred stocks have been valued at cost and all other stocks have been valued at fair value in accordance with the NAIC AP&P Manual. For those securities listed in Schedule D - Part 1 - Bonds or Schedule D - Part 2 - Preferred Stocks and Common Stocks with a “Z” suffix after the
NAIC designation, the analyst might request verification from the health entity that the securities are FE or have been submitted to, and subsequently valued by the SVO. The analyst should compare the price or designation subsequently received from the SVO to that included in the Annual Financial Statement for significant securities. The analyst should also consider using Examination Jumpstart investment analysis (available in I-SITE) to compare the CUSIP number, NAIC designation, and fair value for each of the securities listed in Schedule D - Part 1 – Bonds, Schedule D - Part 2 – Preferred Stock and Common Stocks, and Schedule DA – Short-Term Investments to information on the SVO master file.

Procedure #5 assists the analyst in determining whether the book/adjusted carrying value of bonds and sinking fund preferred stocks is significantly greater than fair value. General Interrogatory #30 shows the aggregate BACV and the aggregate fair value of bonds and preferred stocks owned and requires the health entity to indicate how the fair values were determined. If the BACV of bonds and sinking fund preferred stocks is significantly greater than fair value, the health entity could realize significant losses if it were forced to sell these investments to cover unexpected cash flow needs due to larger than anticipated losses.

Additional steps may be performed if there are concerns regarding the significance of any excess of the BACV over the fair value of bonds and sinking fund preferred stocks. To determine which individual bonds and sinking fund preferred stocks have a BACV significantly in excess of their fair value, the analyst should consider: 1) reviewing Schedule D - Part 1 – Bonds; 2) reviewing Schedule D - Part 2 - Preferred Stocks and Common Stocks; or 3) requesting information from the health entity. The analyst should be aware that the fair value for those securities with an amortized value (AV) designation in the rate used to obtain the fair value column in Schedule D does not represent a true fair value for the securities. For those securities with a BACV significantly in excess of fair value, the analyst might consider verifying the NAIC designation assigned and determine whether it has recently been reviewed by the SVO, determine the current rating by a nationally recognized statistical rating organization, and evaluate whether there has been a permanent impairment in fair value. For bonds and sinking fund preferred stocks with permanent impairments, the analyst should also consider whether the investment should be written down to its fair value to properly reflect its investment. If the health entity has experienced negative cash flows or has other liquidity problems, the analyst should consider requesting information from the health entity regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

Procedure #6 assists the analyst in determining whether the fair value of common stock is significantly greater or less than the actual cost. The analyst should review Schedule D - Part 2 - Section 2 - Common Stocks Owned December 31 of Current Year, to determine what the aggregate fair value position is in relation to the aggregate actual cost of common stock. The analyst should also review individual stock issues to determine if the fair value is significantly above or below actual cost. If the fair value of a stock issue is significantly below cost (unrealized loss) the health entity may incur a loss upon disposition. However, since common stock is carried on the balance sheet at fair value, this unrealized loss is already reflected in statutory net worth and, therefore, there is no additional reduction in net worth at disposition. On the other hand, if the fair value of an individual stock is significantly greater than the actual cost (unrealized gain) the health entity may be reflecting an unrealized gain that might not be realized at disposition. However, the analyst should be careful about drawing conclusions from an unrealized gain. The implications of the gain may depend upon such things as how long the stock has been held or how the purchase price compares to the historical price range of the stock. A significant unrealized gain that has accumulated over a long holding period may simply represent the expected return on the stock, rather than indicating high volatility. In the contrary case, if a volatile stock was purchased at the beginning of its run-up in price, it might have accumulated a very significant unrealized gain, which could disappear.
later if the fair value decreases. However, if the same stock was purchased near its peak, there might have been little or no unrealized gain, but the stock would have been subject to the same loss in value. Therefore, whenever there are significant holdings of common stock, the analyst should conduct a more in-depth analysis.

Additional steps may be performed if there are concerns regarding the significance of any excess of cost over fair values of common stocks owned. The analyst should consider reviewing Schedule D - Part 2 - Section 2 - Common Stocks to determine which individual common stocks have a cost significantly in excess of fair value. The analyst should also determine whether the stock is listed on a national exchange and verify the price per stock and the total fair value listed in the statement. If the NAIC designation of the stock is “A” (unit price of the share of common stock is determined analytically by the SVO) determine when the price per share was last analyzed by the SVO. The analyst should also consider whether the common stock is permanently impaired by the market. The analyst should consider requesting the Audited Financial Statement and other documents necessary to support the value of the common stock. The analyst should also consider requesting information from the health entity regarding investment strategies and short-term cash flow needs.

Procedure #7 assists the analyst in determining whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year. The analyst can identify significant purchases or sales of securities by reviewing: 1) Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired During Current Year; 2) Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed of During Current Year; and 3) Schedule D - Part 5 - Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Current Year. If significant purchases or sales of securities occurred near the beginning and/or end of the year, the health entity might have “rented securities” or engaged in “window dressing” of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring the same or similar lower quality investments after year-end) in an attempt to avoid additional regulatory scrutiny which would have occurred with the health entity’s lower rated investment portfolio.

Additional steps may be performed if there are concerns regarding significant purchases or sales of securities near the beginning and/or end of the year. To determine the types of securities purchased and sold at or near the beginning and the end of the year, the vendors used for investment purchases and the purchasers of investments sold, the analyst should consider reviewing: 1) Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired During Current Year; 2) Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed Of During Current Year; and 3) Schedule D - Part 5 - Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed Of During Current Year. This information can then assist the analyst in determining whether the health entity might have engaged in “window dressing” of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end) in an attempt to avoid additional regulatory scrutiny, which would have occurred with the health entity's lower rated investment portfolio.

Procedure #8 assists the analyst in determining whether concerns exist due to the level of investment turnover. The analyst can identify significant turnover by reviewing: 1) Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed of During Current Year; and 2) Schedule D - Part 5 - Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Year. The turnover ratio represents the degree of trading activity in long-term bonds, preferred, and common stock investments that has occurred during the year. Investment turnover is an indication of whether a buy-and-hold or sell based on short-term fluctuation strategy is utilized. A high turnover of investments generally leads to greater transaction costs, operating expenses and the acceleration of realized capital.
gains. Sales result from securities reaching a price objective, anticipated changes in interest rates, and changes in creditworthiness of issuers or general financial or market developments.

Additional steps may be performed if there are concerns regarding investment turnover. To determine the types of securities purchased and sold, the analyst should consider reviewing: 1) Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired During Current Year; 2) Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed Of During Current Year; and 3) Schedule D - Part 5 - Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed Of During Current Year. This information can assist the analyst in determining the types of securities sold and acquired, as well as the length of time each security was held and the quality of the security. The analyst should also review realized capital gains from the sale of securities to determine any reliance on these gains. The analyst should also consider having a specialist review the health entity’s investment program.

Additionally, the analyst should also review the Statement of Actuarial Opinion (SOA) and memorandum to determine whether any concerns about investment turnover are noted.

Procedure #9 assists the analyst in determining whether concerns exist due to the level of investment in derivative instruments. A derivative instrument is a financial market instrument that has a price, performance, value or cash flow based primarily on the actual or expected price, performance, value, or cash flow of one or more underlying interests. Derivative instruments (which consist of options, caps, floors, collars, swaps, forwards and futures) are used by some health entities to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to its assets, liabilities or anticipated future cash flows. Health entities generally do not invest in derivative investments. If a health entity invests in derivative instruments, it is important for the analyst to understand the impact that these derivative instruments have on the investment portfolio of the health entity. If the health entity engages in derivative activity, the analyst should review information in Schedule DB columns for Description of Items Hedged or used for Income Generation, Types of Risk(s) to determine if the insurers detailed use of derivatives appears to be consistent with the overall strategy that the reporting entity has described elsewhere. Where the detail reported in Schedule DB differs from other information provided by the insurer, request further clarifying information from the report entity. The analyst should also review detail provided in Schedule DB columns for Hedge Effectiveness at Inception and at Year-End. Note anything unusual or any variances from the insurer’s current hedging program description. For health entities with significant investments in derivative instruments, this will probably require the analyst to obtain the assistance of an actuary.

Additional steps may be performed if there are concerns regarding the level of investment in derivative instruments. The analyst should consider obtaining a comprehensive description of the health entity’s hedge program in order to obtain an understanding of the health entity’s use of derivative instruments to hedge against the risk of a change in value, yield, price, cash flow or quantity or degree of exposure with respect to the health entity's assets, liabilities or expected cash flows. The hedge program could be evaluated to determine whether it appears to result in hedges that are appropriate for the health entity based on its assets, liabilities and cash flow risks and whether the health entity appears to be adhering to the hedge program. For significant derivative instruments that are open at year-end, the analyst should consider requesting and reviewing a description of the methodology used by the health entity to verify the continued effectiveness of the hedge provided, a description of the methodology to determine the fair value of the derivative instrument and a description of the determination of the derivative instrument's BACV to determine whether the requirements of the NAIC Accounting Practices and Procedures Manual have been met. The analyst might also consider having the health entity's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.
III. Analyst Reference Guide – D.1. Level 2 Investments (Health)

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for the investments section are designed to identify the following: 1) whether the health entity’s investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue, 2) whether the health entity has a significant portion of its assets invested, or has significantly increased its holdings since the prior year-end, in certain types of investments that tend to be riskier and/or less liquid than publicly traded bonds and stocks and cash and short-term investments; 3) whether the health entity has significantly increased its holdings since the prior year-end in certain types of derivatives that tend to be riskier and/or less liquid than publicly traded bonds and stocks and cash and short-term investments; 4) whether any of the health entity’s assets have been loaned or otherwise made available for use by another person during the quarter, and 5) whether the health entity has complied with the requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office, which requires all securities to be valued in accordance with standards promulgated by the Investment Analysis Office.

III. Annual Procedures – D.2. Level 2 Other Assets (Health)

1. Review Uncollected Premiums.
   a. Is the ratio of uncollected premiums and agent’s balances to capital and surplus greater than 20 percent?
   b. Have uncollected premiums and agent’s balances changed by greater than +/- 25 percent from the prior year?
   c. Is the ratio of uncollected premiums to net premium income greater than 5 percent?
   d. Does the amount due from any one group or subscriber equal or exceed 10 percent of the uncollected premiums?
   e. Does the health entity report any nonadmitted uncollected premiums?
   f. If the answer to 1.e. above is “yes,” do nonadmitted uncollected premiums exceed 10 percent of the balance of uncollected premiums?

   Additional procedures and prospective risk considerations if further concerns exist:
   g. Review Uncollected Premiums and perform the following:
      i. Contact the health entity and request adequate detail to allow for further analysis.
      ii. Obtain an explanation for the significant balance.
      iii. Request a listing of balances of subscribers, which individually account for 10 percent or more of the premiums uncollected and compare to a similar list from prior years.
      iv. Review amounts nonadmitted and compare to prior years.
      v. With respect to agents’ balances verify the creditworthiness of the agent.
      vi. Obtain and review the amounts of any uncollectable balances that have been written off in the current period. Compare the write-offs to those of the prior reporting period, if any.
      vii. Obtain and review the health entity’s written procedures for monitoring and collecting uncollected premiums, including amounts already written off.
      viii. Inquire whether the health entity has factored or sold its uncollected premium balances to a third party. Note whether the receivables were discounted in the transaction.

2. Review Health Care Receivables.
   a. Is the ratio of health care receivables to capital and surplus greater than 5 percent?
   b. Does the amount due from any one debtor equal or exceed 10 percent of gross health care receivables?
   c. Have health care receivables increased or decreased by greater than 20 percent from the prior year?
   d. Did the health entity report any nonadmitted health care receivable balances?
   e. If the answer to 2.d. above is “yes,” do nonadmitted health care receivables exceed 10 percent of admitted health care receivables?
Additional procedures and prospective risk considerations if further concerns exist:

f. Review Health Care Receivables and perform the following:
   i. Contact the health entity and request adequate detail to allow for further analysis.
   ii. Obtain an explanation for the significant balance.
   iii. Request a listing of balances of debtors which individually account for 10 percent or more of the balance of health care receivables and compare to a similar list from prior years.
   iv. Review amounts nonadmitted and compare to prior years.
   v. Obtain and review the amounts of any uncollectable balances that have been written off in the current period. Compare the write-offs to those of the prior reporting period, if any.
   vi. Obtain and review the health entity’s written procedures for monitoring and collecting uncollected premiums, including amounts already written off.
   vii. Inquire whether the health entity has factored or sold its health care receivables to a third party. Note whether the receivables were discounted in the transaction.

g. Review capitation and other agreements with providers and hospitals and the level of receivables from these parties.

3. Review Amounts Receivable Relating to Uninsured Accident and Health Plans.
   a. Is the asset for receivables relating to uninsured plans greater than 5 percent of capital and surplus?
   b. Review Notes to Financial Statements #18, Uninsured Plans. Do concerns exist regarding the profitability of uninsured accident and health plans and the uninsured portion of partially insured plans for which the health entity serves as an Administrative Services Only (ASO) or an Administrative Services Contract (ASC) plan administrator?

Additional procedures and prospective risk considerations if further concerns exist:

   c. Request a listing of plans administered by the health entity.
   d. Request an aging schedule of receivables related to uninsured plans.
   e. Evaluate the financial condition of the uninsured plans.
   f. Obtain and review the amounts of any uncollectable receivables under uninsured plans that have been written off in the current period. Compare the write-offs to those of the prior reporting period, if any.

4. Review Furniture, Equipment and Supplies.
   a. Is the ratio of admitted furniture, equipment and supplies greater than 5 percent of capital and surplus?
   b. Has the admitted balance of furniture, equipment and supplies changed by greater than +/-10 percent from the prior year?
III. Annual Procedures – D.2. Level 2 Other Assets (Health)

Additional procedures and prospective risk considerations if further concerns exist:

c. Review Exhibit 8 - Furniture, Equipment and Supplies Owned and review the reporting distribution of furniture, equipment and supplies.

d. Review disclosures made in the Notes to the Audited Financial Report regarding furniture and equipment and consider performing one or more of the following procedures:
   i. Contact the health entity or request access to its independent auditor for clarification of any unusual responses.
   ii. If the amount of admitted furniture and equipment is material, request information regarding depreciation and review for reasonableness. Determine if the depreciation period exceeds three years.

5. Review EDP Equipment.

   a. Is admitted EDP equipment and software greater than 3 percent of capital and surplus? (Refer to the Analysts Reference Guide.)

   b. Has the admitted balance of EDP equipment and software changed by greater than +/- 25 percent from the prior year?

Additional procedures and prospective risk considerations if further concerns exist:


d. Perform a review to determine whether the minimum capitalization amount, depreciable life and admissibility are in compliance with statutory limitations.

   e. Request a description of the methodology used to compute depreciation.
      i. Determine if the period of depreciation exceeds three years.
      ii. Determine if the health entity nonadmitted non-operating software.

   f. Review the management or service agreements, if any, which provide for EDP services and evaluate whether the charges appear reasonable for the services provided.

   g. If the health entity did not report an asset for EDP equipment and operating system software, does a management or service agreement exist that provides for electronic data processing services?

6. Are aggregate write-ins for other than invested assets greater than 10 percent of capital and surplus?

7. Has the health entity failed to comply with state-specific laws, regulations or guidelines for limitations related to other assets?

**Summary and Conclusion**

Develop and document an overall summary and conclusion regarding other assets. 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 health entity’s other assets under the specific circumstances involved.
III. Annual Procedures – D.2. Level 2 Other Assets (Health)

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

- Contact the health entity seeking explanations or additional information
- Obtain the health entity’s business plan
- Require additional interim reporting from the health entity
- Refer concerns to examination section for targeted examination
- 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 ________
III. Quarterly Procedures – D.2. Level 2 Other Assets (Health)

1. Review Uncollected Premiums.
   a. Is the ratio of uncollected premiums and agent’s balances to capital and surplus greater than 20 percent?
   b. Has the receivable for uncollected premiums and agent’s balances changed by greater than +/- 25 percent from the prior year-end?
   c. Has the level of non-admitted balances, if any, changed by greater than +/-25 percent from the prior year-end?

2. Review Health Care and Other Receivables.
   a. Is the ratio of health care and other receivables to capital and surplus greater than 5 percent?
   b. Have health care and other receivables changed by greater than +/- 20 percent since the prior year-end?
   c. Have non-admitted balances for health care and other receivables, if any, changed by greater than +/- 25 percent since the prior year-end?

3. Review the balance for amounts receivable relating to uninsured plans. Have receivables relating to uninsured plans changed by greater than +/- 10 percent since the prior year-end? If “yes,” indicate the amount.

4. Review Furniture and Equipment.
   a. Is the ratio of admitted furniture, equipment and supplies greater than 5 percent of capital and surplus?
   b. Has the admitted balance of furniture, equipment and supplies changed by greater than +/- 10 percent since the prior year-end?

5. Review EDP Equipment and Software.
   a. Is admitted EDP equipment and software greater than 3 percent of capital and surplus? (Refer to the Analyst Reference Guide).
   b. Has the admitted balance of EDP equipment and software changed by greater than +/- 25 percent since the prior year-end?

6. Are aggregate write-ins for other than invested assets greater than 10 percent of capital and surplus? If “yes,” document any concerns.

7. Has the health entity failed to comply with state-specific laws, regulations or guidelines for limitations related to Other Assets? If so, document any concerns.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding other assets. 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 health entity’s other assets under the specific circumstances involved.
III. Quarterly Procedures— D.2. Level 2 Other Assets (Health)

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

Health entities are authorized to report a number of assets in the Annual Financial Statement. According to SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4), an asset has the following three essential characteristics: (a) it embodies a probable future benefit that involves a capacity, singly or in combination with other assets, to contribute directly or indirectly to future net cash inflows, (b) a particular entity can obtain the benefit and control others’ access to it, and (c) the transaction or other event giving rise to the entity’s right to or control of the benefit has already occurred. Other than invested assets, some of the more significant items that meet the above definition are uncollected premiums and agent’s balances, health care receivables, health care delivery assets, amounts receivable relating to uninsured accident and health plans, electronic data processing equipment, and software. Each of the above types of other assets is individually unique and can carry its own risks. This can be particularly of concern for health entities, which may require a more liquid balance sheet than other types of insurers. The following discusses each of these other asset classes in greater detail including some of the unique circumstances and risks to the health entity.

1. Uncollected Premiums and Agent’s Balances

The asset for uncollected premiums includes amounts receivable on individual and group policies that have been billed, but have not yet been collected. Uncollected premium balances result from transactions conducted directly with the insured. For most health entities, the primary coverage written is comprehensive group business. While assessing a group’s credit risk, if permitted by law, is often an important part of the underwriting process, the credit risk on group business can actually be lower than the credit risk on individual business. This is because most comprehensive group business is written on a monthly installment basis billed and paid in advance of the effective date of the coverage. Said differently, the coverage period is usually one month and is usually due or paid before the coverage period begins. Because of this, a health entity’s credit risk is theoretically mitigated by its ability to stop coverage in a short period of time. However, from a practical standpoint, the health entity may desire to retain large or influential groups, either because of the prominence associated with writing to these groups or because the health entity may not want to be viewed as an inhibitor to health care services.

The sale of health insurance can differ significantly from the sale of other types of insurance. Although agents are used by health entities, they are generally not used as extensively as with property/casualty insurers or even life insurers. Agent’s balances are admitted to the extent that the assets conform to the requirements of SSAP No. 6 *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts due from Agents and Brokers* (SSAP No. 6), which also requires that premiums owed by agents should be reported net of commissions and are nonadmitted under a 90-day rule. Remaining amounts that are determined to be uncollectable must be written off. Generally, if a contract with an agent permits offsetting, amounts payable to an agent may be offset against a receivable from that agent. Agents’ balances carry credit risk and can have a material impact on the net income and capital and surplus of a health entity if the balances are significant. Significant or growing balances can also lead to liquidity problems if the health entity is unable to convert the receivables into cash to be used to pay claims.

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

The balance for uncollected premium may also result from amounts due from the Centers for Medicare and Medicaid Services or other government plans. Although coverage periods on this type of business are usually the same as comprehensive group business, the payment cycle can be much different due to the longer settlement periods experienced under government contracts. However, collectability of balances associated with government plans is usually not an issue. Because of this, the 90-day rule that is applied to other receivables is not applicable to receivables from these types of government plans.

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

Despite the efforts to mitigate the impact of uncollected premiums and agent’s balances, write-offs and nonadmitted unpaid premium assets can still have a material impact on the net income and capital and surplus of a health entity. These issues can lead to liquidity problems if the health entity is unable to convert the receivable into cash to be used to pay claims. The analyst should monitor the level of this asset as well as the change in the balance to help identify potential collection problems that can ultimately lead to significant decreases in capital and surplus. Since the asset includes agent’s balances as well as premiums, an analyst may refer to the Exhibit for Accident and Health Premiums Due and Unpaid to determine if the balance of the asset is primarily due to premiums or due to agent’s balances. See SSAP No. 6 for further discussion of uncollectable premiums and SSAP No. 54, Individual and Group Accident and Health Contracts (SSAP No. 54).

2. Health Care Receivables

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

According to SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), pharmaceutical rebates are arrangements between pharmaceutical companies and a health entity in which the health entity receives rebates based upon the drug utilization of its subscribers at participating pharmacies. Generally, this receivable can consist of amounts that have actually been billed but usually a significant portion of the receivable is based upon estimates of the health entity or a pharmacy benefits manager (PBM). Because the amounts can be material, SSAP No. 84 does allow these receivables to be admitted to the extent that they conform to certain requirements. Health entities are required to disclose certain information regarding the receivable in Annual Note to Financial Statements #27, Health Care Receivables. The analyst should use the information from the note, along with other knowledge of the health entity’s business, to assess whether the balance and the changes in the balance from period to period appear reasonable. See SSAP No. 84 for more specific information related to the determination of the admitted asset.

It should be noted that the disclosures to be included in Note #28 for pharmaceutical rebate receivables should include pharmaceutical rebates of insured and uninsured business. If there are rebates collected pursuant to these uninsured ASO/ASC arrangements, a liability for any payable must be established. Refer to Section VII. Guidance for Notes to Financial Statements, for guidance on reviewing Note #28.

Claim Overpayments

Due to the volume of transactions processed by health entities, the various coverage provided to different employer groups, and the use of deductibles, co-payments and coinsurance, it is not uncommon that claim overpayments may occur as a result of an error or miscalculation. Although the certainty of collection cannot always be estimated or determined, health entities are allowed to admit claim overpayments if certain requirements are met as set forth in SSAP No. 84. The most significant requirement is that the receivable must have been invoiced and specifically identifiable to a claim, and not just an estimate. Although claim overpayments are common, they are generally not material. To the extent they are material, the analyst should obtain a better understanding of how the receivable has become so significant and may consider the need to perform more specific procedures to address any collection issues. In addition, the analyst may consider the need to understand the processes and procedures the health entity is taking to minimize the balances.

Loans and Advances to Providers

A health entity may make loans or advances to hospitals or other providers. Unlike claim overpayments, these assets can be very material. Although SSAP No. 84 provides that these loans and advances can only be reported as admitted assets in certain circumstances, the analyst should obtain a clear understanding of these assets in order to effectively assess the overall financial condition of the health entity. Loans or advances to providers are generally made at the request of the provider to alleviate or prevent cash flow problems or in some cases, to serve as a semi-permanent component of the providers’ capital structure. In many cases, these loans or advances are actually paid monthly and are intended to cover one month of fee-for-service claims activity with the respective provider. For large hospitals with many sources of cash flow, these loans and advances can be offset with the reported and unreported claims liability and claims reserve. However, to be admitted assets under SSAP No. 84, loans to hospitals must be reconciled quarterly against actual claim utilization pursuant to contractual terms and is admitted up to the amount payable to the provider for reported claims. The quarterly reconciliation allows for more adequate run-out of claims but is required to avoid potentially material uncollectable balances. Clearly, the longer the balance builds without being reconciled, the greater potential for material adverse adjustment.

III. Analyst Reference Guide – D.2. Level 2 Other Assets (Health)

Loans or advances by a health entity to related parties must constitute arm’s-length transactions. Loans or advances made by a health entity to related parties (other than its parent or principal owner) that are economic transactions are admissible under SSAP No. 25. This includes financing arrangements with providers of health care services with whom the health entity periodically contracts. Again, the analyst should obtain as good of an understanding as possible of the health entity’s loans or advances to providers. This may include communication with the health entity or an examiner.

**Capitation Arrangement and Risk Sharing Receivables**

A health entity may also admit advances to providers under capitation arrangements under certain circumstances. Under SSAP No. 84, a capitation arrangement is defined as a compensation plan used in connection with some managed care contracts in which a physician or other medical provider is paid a flat amount, usually on a monthly basis, for each subscriber who has elected to use that physician or medical provider. To qualify as admitted assets under SSAP No. 84, among other things, the advances must be made under the terms of an approved provider services contract in anticipation of future services and must not exceed one month’s average capitation payments.

SSAP No. 84 defines risk-sharing agreements as contracts between health entities and providers with a risk-sharing element based upon utilization. The compensation payments for risk-sharing agreements are typically estimated monthly and settled annually. These agreements can result in receivables due from the providers if annual utilization is different than that used in estimating the monthly compensation. Consistent with pharmaceutical rebate receivables, although this asset is generally determined based upon estimates, it is allowed to be admitted to the extent it conforms to certain requirements of SSAP No. 84.

Despite these requirements, and the requirement that the collection of risk-sharing receivables be made quarterly, the analyst should closely monitor the balance of this asset. The analyst should use the information from Note #28, along with other knowledge of the health entity’s business, to assess whether the balance and the change in the balance from period to period appears reasonable. Refer to Other Provider Liabilities section for further discussion of risk-sharing arrangements and Guidance for Notes to Financial Statements section for guidance on reviewing Note #28.

**Government Insured Plan Receivables**

Government plan receivables may be included in either uncollected premiums or under health care receivables. The analyst should determine their state's method of accounting. However, in some cases, the receivables are not specifically for premiums but arise from coordination of benefits with the government contract (Medicaid carve-out). Amounts receivable under government insured plans that qualify as accident and health contracts in accordance with SSAP No. 50, *Classifications and Definitions of Insurance or Managed Care Contracts in Force*, are admitted assets. However, the collectability of these amounts must be periodically evaluated even though the 90-day past due rule does not apply. Any amounts deemed uncollectable must be written off and charged to income in the period the determination is made. See SSAP No. 84 for further discussion.

3. **Amounts Receivable Relating to Uninsured Accident and Health Plans**

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

Under uninsured plans, there is no underwriting risk to the health entity. The plan bears all of the utilization risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. Because of this, accounting for income and disbursements resulting from such uninsured plans, or the uninsured components of a combination plan should not be reported as insurance premiums and claims. As discussed in SSAP No. 47, amounts received on behalf of uninsured plans or the uninsured portion of partially insured plans are not reported as premium income. Administrative fees for servicing the uninsured plans are deducted from general expenses. Conversely, income relating to the insured portion of any plan is reported as premium income. It should be noted that plans that include a capitated payment method are automatically considered an insured plan.

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

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

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

### 4. Furniture and Equipment

Furniture and equipment includes not only administrative furniture and equipment but also health care delivery assets such as furniture, medical equipment and fixtures, pharmaceuticals and surgical supplies, and durable medical equipment.

SSAP No. 73, *Health Care Delivery Assets-Supplies, Pharmaceuticals and Surgical Supplies, Durable Medical Equipment, Furniture, Medical Equipment and Fixtures, and Leasehold Improvements in Health Care Facilities* (SSAP No. 73) describes health care delivery assets as those assets that are used in connection with the direct delivery of health care services in facilities owned or operated by the health entity. SSAP No. 73 further provides that these types of assets shall be
admitted provided they meet the definitions of health care delivery assets as set forth in the SSAP. As a result of this accounting guidance, it is possible that a health entity with these types of assets will have a much different mix of assets than other health entities that do not use these types of assets in its operations. It should be noted that the depreciation period for health care delivery assets is limited to three years, which varies from the depreciation period for similar assets that are nonadmitted.

Analysis of these assets should consist primarily of ongoing monitoring of the balances, the relative change, and the relationship of that change with what is expected based upon other trends/activity within the health entity.

5. **Electronic Data Processing Equipment and Software**

As discussed in SSAP No. 16R, *Electronic Data Processing Equipment and Software* (SSAP No. 16R) electronic data processing (EDP) equipment and operating system software are admitted assets to the extent they conform to the requirements of SSAP No. 4. The admitted asset is limited to three percent of capital and surplus; adjusted to exclude any EDP equipment and software, net deferred tax assets and net positive goodwill. However, SSAP No. 16R provides that non-operating system software is a nonadmitted asset. EDP equipment and software depreciated for a period not to exceed three years using methods detailed in SSAP No. 19, *Furniture, Fixtures and Equipment; Leasehold Improvements Paid by the Reporting Entity as Lessee; Depreciation of Property and Amortization of Leasehold Improvements* (SSAP No. 19).

EDP assets generally are subject to various state specific limitations, such as a minimum amount that can be capitalized as an asset, a maximum depreciable life, and/or limits that may be admitted as a percentage of total admitted assets or capital and surplus. These limitations are put in place to avoid undue concentrations of assets that have less marketability than other admitted assets and rapid technological obsolescence. Because of this, the amount reported by a health entity is generally limited to an amount that is not significantly material to the health entity’s financial position. It is also common to find that the health entity reports no EDP assets. In these cases, the health entity often relies upon a parent or an affiliated company to provide EDP services with a resultant charge back through a management or service agreement.

Analysis of EDP assets should consist primarily of ongoing monitoring of the balances, the relative change, and the relationship of that change with what is expected based upon other trends/activity within the health entity.

6. **Miscellaneous Assets**

Health entities may report miscellaneous assets not listed above. To qualify for admission, assets must comply with the provisions of SSAP No. 4 and any applicable state statutes. Examples may include amounts not received within 15 days of the end of the period that are due from brokers when a security has been sold, but the proceeds have not yet been received; the cash value of corporate owned life insurance (COLI), including amounts under split dollar plans; non-invested assets not included in other categories; intangible assets and goodwill where permitted; guaranty funds receivable or on deposit; deposits in suspended depositories; loans unsecured or secured by assets that do not qualify as investments; cash advances to or in the hands of officers or agents; travel advances; non-bankable checks; trade names and other intangible assets; automobiles, airplanes and other vehicles; and the company’s stock as collateral for a loan.
III. Analyst Reference Guide – D.2. Level 2 Other Assets (Health)

To the extent the health entity has reported material write-in assets, the nature of the write-ins should be carefully reviewed to determine if the health entity has properly accounted for and reported the item being reviewed. Because most of the items specifically identified in the AP&P Manual are included in the Annual Financial Statement Instructions, most admitted assets should be included in a specific line. Other items that are not specifically identified in the AP&P Manual should be nonadmitted, unless the health entity’s state of domicile has issued a permitted or prescribed accounting practice allowing the asset to be admitted.

Discussion of Level 2 Annual Procedures

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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board.

The procedures included in the Other Assets section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The purpose of this section is primarily to assist the analyst in identifying those entities with issues related to admissibility, collectability, valuation, or reporting. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Other Assets are intended to identify whether admissibility, collectability, valuation, and reporting issues associated with Other Assets would have a potential impact on the health entity’s solvency and if significant changes in Other Assets have occurred since the prior year Annual Financial Statement.
III. Annual Procedures – D.3. Level 2 Health Reserves and Liabilities (Health)

1. Determine whether an understatement of health reserves would be significant.
   a. Is the ratio of gross claims unpaid and gross aggregate health reserves to capital and surplus greater than 300 percent?
   b. Is the ratio of net claims unpaid and net aggregate health reserves to capital and surplus greater than 200 percent?
   c. Would a 10 percent understatement of net claims unpaid and aggregate claim reserves drop the health entity’s Risk-Based Capital ratio below 200 percent?

2. Determine whether health policies appear to have been adequately reserved.
   a. Review the results of the Actuarial Opinion Supplemental Procedures. Were any concerns noted regarding the valuation of the health entity’s total health reserves in accordance with minimum statutory valuation standards?
   b. Does any line of business report an underwriting loss?
   c. Compare the one-year reserve development to capital and surplus and review the Underwriting and Investment Exhibit Part 2B.
      i. Did the health entity report a reserve deficiency?
      ii. If “yes,” is the reserve deficiency greater than 5 percent of capital and surplus?
      iii. Review the Underwriting and Investment Exhibit Part 2C incurred claims development. Has there been an adverse trend or unusual fluctuation over the last five years?
      iv. Review the Underwriting and Investment Exhibit Part 2B – Analysis of Claims Unpaid and Part C Incurred Claims Development. Has the reserve been adequate to pay actual claims?
      v. Review the Underwriting and Investment Exhibit Part 2B - Analysis of Claims Unpaid - Prior Year – Net of Reinsurance. Has there been an increase or decrease in the claim reserve and claim liability as a percentage of incurred claims of more than +/-10 percentage points since prior year-end?
      vi. Provide an explanation for any adverse loss development results.
   d. Review the Notes, MD&A or other correspondence with the health entity. Has the health entity initiated any internal changes that may impact the reserve estimates?
   e. Has there been a significant point change in the loss ratio for any product line from the prior year (+/- 10 points)?
   f. Compare the direction of any changes in the loss ratio to the direction of changes in membership. Is there an indication that increased loss ratios may be resulting from falling membership?
   g. Has the annual per member per month medical claims expense increased since last year-end compared to similarly situated health entities?
   h. Compare the amount of claims in process of adjudication to the average incurred non-capitated claims per day. Is the number of days represented by the reserve greater than 30 days?
   i. Is the ratio of unpaid claims adjustment expenses to claims unpaid greater than 10 percent?
j. Is the ratio of unpaid claims adjustment expenses to incurred claims adjustment expenses greater than 20 percent?

Additional procedures and prospective risk considerations if further concerns exist:

  k. Determine which health lines of business are being written by the health entity.

  l. Review the health entity's most recent business plan to determine how it intends to reduce its risk exposure.

  m. Review the Underwriting and Investment Exhibit to determine which lines of business may have been under reserved at the prior year-end.

  n. Review the health entity’s health insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific features and benefits.

  o. Review the health entity’s risk-based capital filing to better understand the types of risk and risk management techniques being used, such as the types of managed care arrangements being used.

  p. Contact the policy forms section of the insurance department and inquire as to whether the health entity has filed any new and unusual health policy forms during the past year.

  q. Review the health entity’s description of the valuation standards used in calculating the additional contract reserves (which is required to be attached to and filed with the Annual Financial Statement) and consider whether the reserve bases, interest rates, and/or methods appear reasonable.

  r. Contact the qualified actuary who signed the health entity’s actuarial opinion to discuss the nature and scope of the health reserve valuation procedures performed.

  s. Request a copy of the qualified actuary’s actuarial memorandum and review the actuary’s comments regarding the analysis performed and conclusions reached regarding health reserves.

  t. Review the ratio of claims unpaid plus aggregate health reserve to incurred claims by line of business for past years to determine unusual fluctuations or trends between years.

  u. Compare the ratio of claims unpaid plus aggregate health reserve to incurred claims to similar companies in the industry to determine any significant deviations from the industry average.

  v. Obtain information from the health entity regarding health claims paid after year-end which were incurred prior to year-end, and test the reasonableness of the year-end claim liabilities established by the health entity.

Summary and Conclusion

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

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

- Contact the health entity seeking explanations or additional information
- Require additional interim reporting from the health entity
- Refer concerns to examination section for targeted examination
III. Annual Procedures – D.3. Level 2 Health Reserves and Liabilities (Health)

- Engage independent actuary to review health entity’s reserves and liabilities
- 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 ________
III. Quarterly Procedures – D.3. Level 2 Health Reserves and Liabilities (Health)

1. Determine whether an understatement of health reserves would be significant.
   a. Is the ratio of net claims unpaid and net aggregate health reserves to capital and surplus greater than 300 percent?
   b. Would the current estimate of the health entity’s claim unpaid and aggregate claim reserves drop the health entity’s prior year Risk-Based Capital ratio below 200 percent?

2. Determine whether health policies appear to have been adequately reserved.
   a. Have claims unpaid, the aggregate policy reserves, or aggregate claim reserves changed by greater than +/- 10 percent from the prior year-end?
   b. Review the Underwriting and Investment Exhibit Analysis of Claims Unpaid - Prior Year – Net of Reinsurance. Has there been an increase or decrease in the claim reserve and claim liability as a percent of incurred claims of greater than +/- 10 percent since prior year-end?
   c. Review, by line of business, the year-to-date member months for the current and prior year in Exhibit of Premiums, Enrollment, and Utilization. Have member months for any line of business changed by greater than +/-20 percent from the prior year, same period?
   d. Has there been a significant point change in the medical loss ratio for any product line from the same period in the prior year (+/- 10 points)?
   e. Compare the direction of any changes in loss ratio to the direction of changes in membership. Is there an indication that increased loss ratios may be resulting from falling membership? (See Quarterly Financial Profile).
   f. Has the annual per member per month hospital and medical claims expense increased since last year-end and/or since last quarter more than similarly situated health entities?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

   Analyst ________________  Date ________

Comments as a result of supervisory review.

   Reviewer ________________  Date ________
Overview

Health reserves are intended to 1) cover claims payments for claims that have been incurred prior to the valuation date and have not yet been paid or 2) to retain a portion of current revenues to cover future incurred claims that the company anticipates it will be obligated to pay. The NAIC Annual Financial Statement Instructions and the NAIC Accounting Practices and Procedures Manual (AP&P Manual) contain specific guidance for distinguishing between certain types of claim liabilities. Specifically, SSAP No. 54, Individual and Group Accident and Health Contracts (SSAP No. 54) and SSAP No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses (SSAP No. 55) differentiate between claims that have accrued costs (claim liabilities) and claims that may have been incurred but for which costs will be accrued in the future (claim reserves). For this handbook the term reserve will be used in its broader sense to include items denoted as reserves as well as other items called liabilities.

When there are reserves and liabilities for claim amounts to be paid in the future there will also be expenses associated with paying these claims. The liability for the administrative expense associated with paying these claims is entered in “Unpaid Claims Adjustment Expenses”.

The incurred date of a claim is the first date on which the company has an obligation to pay for a contracted benefit. The incurred date of a claim depends on the type of product and the contract language. Some examples of incurred date determination would include:

- Hospital claims are incurred on the date of admission.
- Some claims related to one diagnosis may be grouped together and are considered incurred on the first date of service.
- Maternity claims are incurred on the date of the first service related to the maternity.
- Other medical, dental and vision services are incurred on the date of service.
- Disability income claims are incurred on the date of disability.
- Long term care claims are incurred on the date of eligibility for benefits or date of first service, depending on the reserving method.
- Stop loss claims are incurred based on the contract specifications.

Other reserves are associated with provider contracts and experience rating contracts with employer groups. Provider contracts often result in funds being held for future payment based on claims experience for the members assigned to a provider group. Similarly some contracts with employer groups result in future premium due or premium refunds owed based on actual claims experience.

Health reserves and methods used for their estimation are discussed in detail in the NAIC Health Reserve Guidance Manual. The analyst should be familiar with the information addressed in that manual and should use it as a reference when looking for guidance about a particular item under review. Before contacting a company or a company’s actuary, the analyst should review the NAIC Health Reserves Guidance Manual to become more familiar with the terms and techniques for reserve estimation.

Due to the variety of types of health policies issued and the complexity of determining the aggregate reserves and liabilities for health policies, most health entities rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some health entities do not use actuaries to actually set the health reserves, health entities are required to annually obtain an opinion regarding the reasonableness of the established health reserves by a qualified actuary. Therefore, qualified
actuaries are involved in setting and/or reviewing the health reserve liabilities established for virtually all health entities.

There are eight categories of health reserves and liabilities:

1. Unearned premium reserves
2. Claim reserves
3. Reserves for future contingent benefits
4. Claims or claim adjustment expense liability
5. Contract reserves
6. Premium stabilization reserves
7. Provider liabilities
8. Premium deficiency reserves

1. **Unearned premium reserves**

   The unearned premium reserve is the amount of paid premium covering future periods. For example, an annual premium paid on January first is 75 percent unearned at the end of the first quarter. Health products often have monthly premiums that do not require unearned premium reserves if coverage is from the first of the month to the end of each month (typically the case for employer-based coverage).

   If a premium is paid before it is due it is considered an advanced premium. For example, if January’s monthly premium is paid on December 15 of the prior year it is advanced premium. Advanced premiums are entered in premiums received in advance on the Annual and Quarterly Financial Statements. See SSAP No. 54 for further guidance on this distinction.

2. **Claim reserves**

   Claim reserves are intended to cover claims that have been incurred, but have not been paid. They can be further divided into three categories based on where the claim is in the process of being reported, approved and paid. The allocation among these categories is usually based on past statistics and they are usually not estimated separately. In general, incurred claims are estimated using one of the techniques described in the NAIC Health Reserves Guidance Manual and paid claims are deducted from the incurred claims to get a claim reserve. Other methods may be used for non-medical lines of business.

   Claim reserves can fluctuate as a percentage of incurred claims. A possible reason for this fluctuation is a large increase or decrease in the health entity’s claims inventory. This often happens when a new claims system is installed. Other reasons for fluctuations in claims inventory can include a larger than normal turn over in claims processors, changes in the percentage of claims submitted electronically, changes in provider agreements such as moving to or from capitation arrangements, and adding large amounts of new business. One concern may be that a change in the ratio of claim reserve to incurred claims could indicate that reserves are being lowered to improve profits or raised to justify rate increases.
a. Claims reported and in process of adjudication:

Claims reported and in process of adjudication may be waiting for additional information or may be ready for payment. States have different laws and regulations concerning the maximum number of days between the time that a claim is received and paid or otherwise adjudicated. An average backlog can be very roughly estimated by comparing the Reported in Process of Adjustment in the Underwriting and Investment Exhibit Part 2A to the average daily-incurred claims amount (incurred claims divided by 365).

i. Due and unpaid claims:

These are claims that have been received, approved and adjudicated, but have not yet been paid. They generally represent a very small part of the claim reserve compared to the incurred-but-not-reported liability. Typically claims are considered paid when the check is issued.

ii. Claims in course of settlement:

These are claims that have been received by the company, but have not been paid. They are often claims that are waiting for some additional information before they can be adjudicated and approved for payment.

b. Incurred but not reported (IBNR) claims:

Although claim reserves are often called IBNR, technically the only part of the reserve that is IBNR is the part that represents claims that have NOT been reported to the company. This is almost always the largest part of the claim reserve.

Historically, physician claims take longer to be reported than hospital claims, but electronic filing of claim information is shortening the lag between the date of service and the date that a claim is submitted to the health entity.

The amount of claim reserve per member or per incurred claim dollar differs significantly between types of companies. If a company pays most of its claims on a capitated basis, its claim reserve will result only from services that are not covered by the capitation. Claims not covered by the capitation generally include claims for out-of-area emergencies and claims for referrals to non-capitated specialists. Also, because some companies pay a budgeted amount to the largest hospitals providing services to their insured’s with a periodic reconciliation for actual claims, there are additional reporting rules for these payments. SSAP No. 84, Certain Health Care Receivables and Receivables Under Government Insured Plans (SSAP No. 84), defines these payments as advances or loans to providers and distinguishes between advances to hospitals and advances to non-hospital providers. Regarding advances to hospitals, as long as a reconciliation is performed within the strict parameters set forth in SSAP No. 84, these advances are admitted assets up to the estimated amount of incurred claims still unpaid to the hospital (includes IBNR). For non-hospital providers, and when the advances to a hospital do not meet the specific reconciliation requirements of SSAP No. 84, the admitted asset is limited to the amount of claims due and unpaid or in course of settlement (does not include IBNR) to that particular provider. The claim reserve is not to be reduced in either situation. Accounting guidance found in SSAP No. 25, Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties (SSAP No. 25), should be followed for loans and advances to related party providers.
When companies contract with providers on a capitated basis, they may consider it appropriate to include an amount in the IBNR reserve for the contingency that the provider group becomes insolvent and is not able to perform under its contract. For example, if a capitation has been paid to a provider group for medical services and the provider group becomes insolvent and does not have the funds to pay member doctors, then the company may have to pay doctors directly for services rendered to members.

Claim reserves are estimated with some level of conservatism based on the health entity’s and the actuary’s determination of the amount of margin needed for potential adverse experience. Factors affecting the need for conservatism in reserve estimates include (1) statistical fluctuation in incurred claims, (2) data problems due to system changes or inadequate data reporting, (3) new or growing product lines and (4) changes in plan design or provider arrangements that may affect claims payment patterns. Conservatism can be achieved by using a tabular method based on a conservative table, by using conservative assumptions and/or by adding explicit margins to reserve estimates. The conservatism of past claim reserve estimates can be observed by comparing Claims Incurred in Prior Years with the Estimated Claim Reserve and Claim Liability December 31 of the Prior Year in the annual statement from the Underwriting and Investment Exhibit Part 2B.

c. Disabled life reserves:

Disabled life reserves are reserves for individuals who are currently eligible for claim payment on coverage such as disability income and long-term care. These claims will continue to be paid even if the contract ends until the individual is no longer eligible for claim payments due to an improvement in health status. More guidance can be found in SSAP No. 54 under claim reserves.

3. Reserves for future contingent benefits:

In some situations and for some types of products, benefits resulting from an incurred claim can extend beyond the valuation date and may extend even beyond the end of the contract period. For a hospitalization that extends past the end of the contract period, either the contract itself or state law may require payment of charges up to a specific time past the end of the contract period. Maternity claims may also result in a reserve for future contingent benefits, if the delivery is covered even if the contract is terminated. The federal Health Insurance Portability and Accountability Act (HIPAA) places restrictions on pre-existing condition exclusions resulting in new policies being responsible for continuing hospitalizations and maternity benefits, thus reducing the need for future contingent benefit reserves, but under state laws the prior carrier may still remain liable for the claim. A contingency benefit reserve may still be needed since there may be no replacement policy or the replacement policy may not cover all of the benefits of the old policy. Company experience and tabular methods are used to calculate these types of reserves.

Future benefits for disability income and long-term care claims are included in disabled life reserves rather than as reserves for future contingent benefits.

4. Claims or Loss Adjustment Expense Liability:

When incurred claims have not been paid as of the valuation date and a reserve is set up for their future payment, there will generally be an expense to process and pay the claims. This expense, although paid in the future, is associated with claims incurred prior to the valuation date. To achieve consistent financial reporting a liability is set up for the future claims payment expense.
Also, when provider contract provisions require a payment at the end of the contract period for financial and/or operational performance, there will be a cost of determining and paying the contingent payment. A liability should be included for the expense of processing the provider liability.

5. **Contract Reserves:**

Contract reserves are in addition to claim and premium reserves. A contract reserve is a reserve set up when a portion of the premium collected in the early years is meant to help pay for higher claim costs arising in later years. The reserve is calculated using actuarial assumptions and techniques, and in general, equates to the amount that the present value of future benefits exceeds the present value of a consistent portion of future premiums (the portion of the “gross premium” used for contract reserves is called the “net premium”).

Contract reserves are needed when premiums are collected in the early years of a policy and are intended to offset increasing claims in later years. This is usually seen when premiums are level over the life of a policy, but can occur when premiums are structured to increase, but still are not proportional to expected claims. Issue age rated policies often fall into this category where premiums can increase, but the ratio of expected claims to premiums are lower in early durations, by design, in order to avoid rate increases at later durations (or at least reduce their size).

The types of products that generally require contract reserves include (1) individual disability income (if premiums are not based on attained age), (2) long-term care, and (3) issue age rated medical policies (including those for specified diseases). Issue age rated medical policies are rare except for issue age Medicare Supplement and some issue age hospital indemnity policies. Many other types of health policies (accident coverage or AD&D coverage) may not need contract reserves because the likelihood of claims is the same for each age. Those contracts (most employer-based coverage) that are re-rated each year to cover the expected claims for the year do not need contract reserves.

Contract reserves may be needed for policies with multi-year rate guarantees. Many medical policies with multi-year rate guarantees have built in rate increases to cover anticipated increases in claims cost, but if premiums are level, contract reserves will be needed.

Appendix A-010, *Minimum Reserve Standards for Individual and Group Health Insurance Contracts*, (Appendix A-010) of the AP&P Manual prescribes the minimum standards used in determining the health policy reserves and specify some of the assumptions to use such as morbidity tables, maximum interest rate and valuation method. Health entities may establish health policy reserves that equal or exceed these minimum standards. The analyst should review that all changes to contract reserve assumptions for in force policies have been approved in accordance with State regulations.

6. **Premium stabilization reserves:**

These are reserves set aside to reduce the potential for large rate increases and smooth out the underwriting cycle. They are often associated with retrospectively rated contracts that require additional premium if claims are more than a specific percentage over expected or a premium refund if claims are less than a specific percentage of expected claims. The use of premium stabilization reserves due to retrospectively rated contracts is described in SSAP No. 66, *Retrospectively Rated Contracts* (SSAP No. 66).

There are other experience rating arrangements besides retrospectively rated contracts that build up premium stabilization reserves. These reserves are used in years of higher than expected claims cost.
and result in a smoothing effect on premiums since premiums will not have to be increased to compensate for one year of poor experience.

Most premium stabilization reserves are determined by contract, but a company may use a similar concept on a block of business. Care should be taken to insure that positive reserves from one contract are not used to offset material claims on other contracts that should be recognized. The reserve would be used to smooth out the need for large rate increases by building up a reserve in years when claims are less than expected and then drawing it down in years of larger than expected claims.

7. Provider liabilities:

There are many types of provider contracting arrangements in the marketplace today. Many of these arrangements base some portion of the amount paid to the provider on financial and/or operational goals that are measured periodically. Under these types of arrangements, payment for reaching goals is not dependent on any specific service, but rather is based on overall performance. As of the valuation date, a payment for performance under a provider contact may have been earned, but not paid. This payment must be set up as a liability to the company.

If a contract period has ended and there has not been a final settlement, any potential settlement with respect to provider liability should be included. If the valuation date occurs during a contract period, then an appropriate liability should be determined that represents the time period from the beginning of the contract period through the valuation date. When provider risks are minimized using stop-loss arrangements that take large claims out of the calculation, the effect of the stop-loss coverage should be estimated and included in the claim reserve calculation. In some situations, the provider contracts may allow for an additional provider payment to the company. These payments, which may be determined in a similar manner should be separated (not netted against the company’s liability) and may be admitted if recorded in accordance with SSAP 84.

Some conservatism for adverse fluctuations should be included when estimating provider liabilities. The level of conservatism depends on the variability of the liability, time period being estimated, and the quality of the data being used. Please note, conservatism that increases the claim reserve estimate and anticipates higher incurred claims can lower the estimate for provider payments under a risk-sharing contract. The health entity’s actuary should consider the total liability when doing his or her estimate.

For more information see the Risk-Transfer Other Than Reinsurance section.

8. Premium deficiency reserves:

When future premiums and current reserves are not sufficient to pay future claims and expenses, a premium deficiency reserve is required. HIPAA requires that all individual and small group medical products be issued on a basis that allows termination only of an entire line of business. These requirements may increase the number of instances where premium deficiency reserves will need to be reported for blocks of business. The analyst should be aware that some states have stricter termination rules than those imposed by HIPAA.

If contracts not protected by HIPAA or state termination restrictions are not profitable, they can be canceled. The contracts with many large groups allow them to be canceled. Also, certain lines of business can be canceled in total. In spite of contractual provisions, companies may decide not to cancel and therefore a deficiency reserve may be required. A company may not want to cancel a large
group or a line of business in a state either because of the effect on its reputation or because the membership represented gives it bargaining power with providers.

A reserve may even be required for an Administrative Service Only (ASO) or Administrative Services Contract (ASC) agreement if administrative fees are not sufficient to cover administrative expenses. An insufficient administrative fee may be acceptable to the health entity when the importance of writing a large group due to prestige or bargaining power is provided to the health entity. The analyst should refer to SSAP No. 5R, *Liabilities, Contingencies and Impairments of Assets* (SSAP No. 5R), for a discussion of the reporting of loss contingencies.

In instances where future premiums can be increased to cover projected claim levels for a block of business, these increases may cause better risks to drop coverage. This will result in even higher claims costs and potentially continuing deficient premiums. It is difficult to predict the effect of this type of selection, but the health entity’s actuary should attempt to include the effect of selection in his or her determination of the need for a deficiency reserve.

There is some state variation concerning limits on the assumptions that can be used in calculating premium deficiency reserves. Since these variations are not currently documented, the analyst should contact the department actuary for input on any guidance that has been given to health entities in the state.

Areas of confusion and inconsistency include:

- How to define a block of business for calculation of deficiency reserves
- The time period to use for calculation of deficiency reserves
- Assumptions to use concerning enrollment changes, premium increases, and marginal versus allocated expenses
- The level of claim reserves and claim reserve conservatism to be available at the end of the time period and thus included in the deficiency reserve

For a thorough discussion of deficiency reserves and an up-to-date position on issues surrounding deficiency reserves the analyst should refer to SSAP No. 54 and the *Health Reserves Guidance Manual*.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board.

The two procedures included in the Health Reserves and Liabilities section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The purpose of this section is primarily to assist the analyst in identifying those health entities that might have understated their health reserve liabilities. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.
Procedure #1 assists the analyst in determining whether an understatement of health reserves would be significant to the health entity. The ratios of gross and net health reserves to capital and surplus are leverage ratios that are calculated gross and net of reinsurance ceded. The net health reserves to capital and surplus ratio indicates the margin of error a health entity has in estimating its health reserves. For a health entity with a net health reserves to capital and surplus ratio of 300 percent, a 33 percent understatement of its health reserves would eliminate its entire surplus.

The effect of a reduction in capital and surplus of 10 percent of the net claim reserve on Risk-Based Capital (RBC) indicates if there would be a potential solvency problem if reserves were understated by 10 percent. A 200 percent RBC ratio is the Company Action Level of concern according to the NAIC Risk-Based Capital (RBC) for Health Organizations Model Act. A ratio below 200 percent indicates a health entity must file an RBC plan with the domiciliary state.

In evaluating these leverage ratios, the analyst should also consider the nature of the health entity’s business. For example, a health entity that has written primarily health business for many years and has proven that it can manage the business profitably is probably less risky as a health entity that has just begun writing health business, even if both entities have the same leverage ratio results.

Procedure #2 assists the analyst in determining whether health policies appear to have been adequately reserved. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary. Therefore, the analyst should review the results of the Actuarial Opinion General Checklist procedures to determine whether any concerns were noted regarding the valuation of the health entity’s health reserves. The valuation of these reserves should be in accordance with Appendix A-010 of the AP&P Manual.

A deficiency reserve is required when future premiums are not sufficient to pay future claims and expenses. If a line of business is showing an underwriting loss there may be a need for a deficiency reserve. It is possible that premium increases have been implemented to correct the deficiency, but the situation should be considered.

Part 2B of the Underwriting and Investment Exhibit provides information that allows the analyst to determine if the health entity has had adverse reserve development in the past year. Using this exhibit, a ratio of the paid claims plus reserves for prior periods to the reserves established in the prior year can be calculated. A positive result (ratio > 1) for this ratio represents additional or “adverse” development on the reserves originally established by the health entity (the estimated amount of the original reserves has proven to be understated based on subsequent activity). The amount of reserve deficiency is compared to the reserve to determine if the deficiency was > 10 percent.

Part 2C of the Underwriting and Investment Exhibit shows a history of reserve development. If the health entity’s ratio results consistently show additional development, this could be an indication that the health entity is understating its health reserves. The analyst should review this exhibit to determine if there have been any adverse trends or fluctuations and if reserves have been adequate to pay actual claims.

A significant decrease in health reserves to incurred claims may indicate that reserves have been weakened. Note, there are other possible explanations for this type of change such as a shift in provider contracting or product design, however the analyst should investigate if material changes occur.

The analyst should review the percentage of claims paid on a capitated basis. If this percentage is decreasing, indicating a shift from capitated to fee-for-service, there should be an increase in health reserves in proportion to incurred claims. A shift in the other directions should have the opposite effect.

The loss ratio for each product line should also be reviewed as a part of this procedure. Significant increases in this ratio might be indicative of additional health reserves being established due to prior understatements while significant decreases might be indicative of current health reserve understatements. The analyst should consider the effect of changes in membership on loss ratios. Conventional logic says that significant increases in membership will result in lower loss ratios since first year claims experience is typically lower in the first year. Dropping membership accompanied with increasing loss ratios may indicate that healthier individuals and groups are leaving. This is often the first sign of a potential adverse selection rate spiral where rates force healthier individuals to leave resulting in inadequate rates. Reviewing the per-member per-month medical expense in the prior year or quarter may be further indication of problems, especially if membership is dropping.

Other steps included in this procedure include the review of the Annual Financial Statement to determine whether there has been a change in the valuation basis of the health policies during the year, which resulted in a decrease in health reserves in an amount greater than 5 percent of capital and surplus.

The ratio of claims in process of adjudication to the average incurred non-capitated claims per day measures the average number of days of reported unpaid claims in inventory by reducing annual incurred claims to a daily average. An unusual result may indicate problems with claims administration or cash flow.

To determine the size of the backlog you must first determine the average daily-incurred claim expense less capitation. Once you have determined this amount, then determine the amount of claims in the process of adjudication, excluding capitation, divided by the average daily-incurred claim expense, to determine the average number of days of claims backlog.

Results for a recently licensed or rapidly growing health entity may have a high ratio because the growth of the numerator will be faster than the growth of the denominator. Reporting inventory valuation problems may also skew results for this ratio. Also, any IBNR changes will affect any results of this ratio.

Please note that a similar ratio might be calculated based on average daily paid claims instead of average daily incurred medical expense less capitation.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Health Reserves and Liabilities section are intended to identify if an understatement in reserves would have a potential impact on the health entity’s solvency and if significant changes in health reserves or health benefits have occurred since the prior year Annual Financial Statement.

Procedure #1 is similar to procedure #1 in the Level 2 Annual Procedures.

Procedure #2 assists the analyst in determining whether health policies appear to have been adequately reserved. A change in reserves of greater than 10 percent may indicate reserves should be looked at more closely. Actual claim payments and the current reserve for prior periods are reviewed in relationship to the prior year-end reserves to determine if the year-end reserve was adequate in light of subsequent experience.

Enrollment, premium, and utilization are reviewed to determine if there have been large changes in these key elements. Increasing utilization may lead to increasing loss ratios if premium were not increased adequately. Large increasing enrollment may require increasing reserves and large decreases in
enrollment may result in increasing loss ratios due to the loss of healthier individuals. This particularly happens when there are large rate increases and healthier individuals, families, and groups shop for better rates elsewhere. If healthier individuals are leaving, there may be a need for deficiency reserves on medical policies. Other types of coverage experience a release of contract reserves when enrollment drops resulting in increasing surplus.

Other items in procedure #2 are similar to the Level 2 Annual Procedures.

Additional steps may be performed if there are concerns regarding whether health policies have been adequately reserved. The analyst should consider reviewing the Underwriting and Investment Exhibit to determine which lines of business are being written by the health entity and which health lines of business may have been under reserved at the prior year-end. The analyst should also consider 1) reviewing the health entity’s health insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits, 2) reviewing the health entity’s RBC filing to better understand the types of managed care arrangements being used, and 3) contacting the policy forms section of the insurance department and inquiring as to whether the health entity has filed any new and unusual health policy forms during the past year. In addition, the analyst could review the health entity’s description of the valuation standards used in calculating the additional contract reserves and consider whether the reserve bases, interest rates, and methods used appear reasonable. (The health entity’s description of the valuation standards used is required to be attached to the filed Annual Financial Statement.) The analyst might want to contact the qualified actuary who signed the health entity’s actuarial opinion to discuss the nature and scope of the valuation procedures performed and/or request a copy of the qualified actuary’s actuarial memorandum to review for comments regarding the analysis of reserves performed and the conclusions reached.

Other steps for the analyst to consider include 1) reviewing the ratio of unpaid claims plus aggregate health reserves to incurred claims by line of business for past years for unusual fluctuations or trends between years and 2) if the ratio appears unusual, the analyst should consider comparing it to the average ratio of claim liability plus claim reserve to incurred claims or similar health entities in the industry to determine any significant deviations from the industry average. 3) If the adequacy of claim liabilities is a concern, the analyst might want to request information from the health entity regarding claims paid after year-end which were incurred prior to year-end in order to test the reasonableness of the year-end claim liabilities established by the health entity.
III. Annual Procedures – D.4. Level 2 Other Provider Liabilities (Health)

1. Determine whether the health entity’s liability for bonus and withhold arrangements are significant.
   a. Is the liability for accrued medical incentive pool and bonus payments greater than 5 percent of the total hospital and medical expense?
   b. Is the liability for amounts withheld from paid claims and capitations greater than 5 percent of the total hospital and medical expense?
   c. Is the ratio of incentive pool and withhold adjustment expense to total hospital and medical expense greater than 5 percent?
   d. Is the change in bonus/withhold accrual from prior year to current year greater than +/-25 percent?

Additional procedures and prospective risk considerations if further concerns exist:
   e. Requesting information concerning the specific contract provisions of the primary bonuses and withhold arrangements that the health entity is using.
   f. Requesting withheld and bonus liability amounts (included in “Accrued medical incentive pool and bonus payments” from Page 3, Column 3, Line 2) for the top five provider groups.
   g. Reviewing the actuarial opinion to determine if potential provider insolvencies were considered when determining the reserves and liabilities.
   h. Reviewing the actuarial opinion to determine if the provider’s financial strength was or was not reviewed or excluded by the opining actuary.
   i. Contacting the qualified actuary who signed the health entity’s actuarial opinion to discuss the nature and scope of the review of the provider contracts.

2. Verify that amounts reported for bonuses and withholds in the health entity’s Risk-Based Capital (RBC) filing are consistent with what is reported in the Annual Financial Statement filing.
   a. Is there an amount entered in accrued medical incentive pool and bonus Payments on Page 3, Column 3, Line 2, even though the RBC filing on worksheet XR016, Column 2, Lines 3 and 4, indicates that no business is subject to withholds or bonuses?
   b. Is there no amount entered in accrued medical incentive pool and bonus payments on Page 3, Column 3, Line 2, even though the RBC filing on worksheet XR016 Column 2, Lines 3 and 4, indicates that some business is subject to withholds or bonuses?
   c. Did the prior year withholds and bonuses paid differ by more than 40 percent from prior year withholds and bonuses available from RBC worksheet XR017 in the RBC filing? (XR017: ABS (Line 18 - Line 19) / (Line 18))

Additional procedures and prospective risk considerations if further concerns exist:
   d. If amounts reported for bonuses and withholds in the health entity’s RBC filing appear to be potentially inconsistent with what is reported in the annual statement filing, request that the health entity provide an explanation. If further analysis indicates that there is a disconnect between the two filings, request that the entity amend whichever filing is incorrect.
Summary and Conclusion

Develop and document an overall summary and conclusion regarding other provider liability. In developing a conclusion, consider the health entity’s use of these types of arrangements and the relative consistency of reporting between the Annual Financial Statement and RBC filing.

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

- Contact the health entity seeking explanations or additional contract information
- Require additional interim reporting from the health entity
- Speak to the opining actuary concerning any concerns he or she may have had
- Refer concerns to examination section for targeted examination
- Meet with the health entity’s management
- Obtain a corrective plan from the health entity
- Other (explain)

Analyst ________________ Date ________

Comment as a result of supervisory review.

Reviewer ________________ Date ________
III. Quarterly Procedures – D.4. Level 2 Other Provider Liabilities (Health)

1. Determine whether the health entity’s use of bonus and withhold arrangements are significant.
   a. Is the liability for accrued medical incentive pool and bonus payments greater than 5 percent of the annualized total hospital and medical expenses?
   b. Is the ratio of incentive pool and withhold adjustments to total hospital and medical expense greater than 5 percent?

Summary and Conclusion

Develop and document overall summary and conclusion regarding the provider liability. In developing a conclusion, consider the health entity’s use of these types of arrangements.

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comment as a result of supervisory review.

Reviewer ________________ Date ________
Overview

Health entities can use many types of risk-sharing arrangements with a provider that transfers part of the financial risk to the provider. Although the type and form of these arrangements may differ, all will ultimately result in the settlement of the risk transfer arrangement. The most frequent arrangements are capitation arrangements where the provider is paid a per-member-per-month amount for providing specified medical services to the members that are enrolled with the provider. Other types of contracting arrangements may contain provisions for bonuses or withholds dependent on the provider meeting specific financial, utilization, and/or quality goals. Financial goals under these types of arrangements may include targets for loss ratios, total claims per-member-per-month, or average prescription drug costs per-member-per-month. Utilization or operational goals may include target hospital inpatient days per 1,000 members or goals for provision of a target number of preventative services per 1,000 members covered. Bonus payments and withhold payments are both dependent on performance over a period of time and are not based on any particular provider service.

Under bonus arrangements, bonuses are paid based on criteria defined in the provider contract. Under withhold arrangements, part of each payment, either fee-for-service or capitation, is retained until a specified point in time when a contractual formula determines the amount of the withholding that is to be paid to the provider. Bonus and withhold arrangements can be very complicated with separate pools being established for specific types of medical costs. For example, a pool can be established for prescription drug costs, another for inpatient days, and another for specialist referrals. Separate pools can be established for hospital services and for physician services.

If provider contract liabilities are percentage withholds from provider payments, they are included in Page 3 Line 1, claims unpaid, otherwise they are included in Page 3 Line 2, accrued medical incentive pool and bonus payments. The amounts included in Page 3 Line 1 are detailed in the Underwriting and Investment Exhibit – Part 2A Line 3, amounts withheld from paid claims and capitations. The current year’s accrued medical incentive pool and bonus payments is also entered in the Underwriting and Investment Exhibit – Part 2 on Line 5, while last year’s accrued medical incentive pool and bonus payments is entered on Line 10 of that exhibit. The liability is determined according to a formula contained in the provider contract describing the amount to be paid based on specific performance. For further information, see the health reserve and liabilities section and for further accounting guidance, see SSAP No. 55, Unpaid Claims, Losses, and Loss Adjustment Expenses (SSAP No. 55).

A provider contract liability should be established for all contracts that have outstanding amounts due. This includes estimated liabilities prior to the contract settlement date, as well as finalized liabilities that have not been paid as of the valuation date. For contracts prior to the settlement date, the actuary should have estimated the amount accrued based on the contract provisions and performance from the beginning of the contract period to the valuation date.

Methods used to estimate provider liabilities are discussed in detail in the NAIC Health Reserve Guidance Manual. The health entity can estimate the liability by reviewing each provider contract separately or by estimating groups of like contracts together. Historical information may be used as a basis for estimating the provider liability using ratios of the provider liability to incurred claims or of the provider liability to member months. Because provider liabilities are based on claims experience, the lower the PMPM claims experience, the higher the provider liability will be. Consequently, in order to ensure that the estimated provider liability is appropriately conservative, the estimate of the unpaid claim liability used by the actuary in calculating the provider liability may contain fewer margins for adverse deviation than the estimate of the unpaid claim liability used in the financial statement. In any case, the
actuary should have ensured that the unpaid claim liability and the provider liabilities, in total, make allowance for adverse circumstances.

Receivables from provider contracts are subject to the analysis and reporting requirements of SSAP No. 84, Certain Health Care Receivables and Receivables Under Government Insured Plans. In the situation where the provider contract requires payments from, as well as, to the provider, the health entity should separate ultimate results into the liability entry and the receivable entry (see Other Assets section of this Handbook for further discussion).

These amounts do not include the company’s liability if a contracting provider becomes insolvent. Provision for the effect of provider insolvencies should be included in the claim liability and/or premium deficiency reserve as appropriate. For further information, see the health reserve and liabilities section of this reference guide.

If the contract period has not ended as of the valuation date or if the settlement has not been paid, there will be expenses associated with the determination and payment of the settlement of the risk-sharing arrangement. A prorated share of this expense should be included on Page 3 Line 3, unpaid claims adjustment expenses.

When withholds and bonuses are paid they are included in Underwriting and Investment Exhibit – Part 2 Line 2, paid medical incentive pools and bonuses, and are split between claims incurred during the year and claims incurred in prior years in Underwriting and Investment Exhibit – Part 2B Line 12, medical incentive pools, accruals and disbursements.

Withhold and bonus information is also included in the Risk-Based Capital (RBC) filing and is used in the determination of the managed care credit in the RBC calculation. Worksheets XR015 and XR016 contain claim payments subject to withholds, withholds and bonuses available, and withholds and bonuses paid. Some of the information used in the RBC filing corresponds to Exhibit 7 – Part 1, while other information is from company records. Since bonuses and withholds paid in conjunction with capitation arrangements are not itemized in Exhibit 7 or in the RBC filing, they do not provide a total breakout of bonuses and withholds paid.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board.

There are very few tests that can be made to verify that provider liabilities are appropriate. Provider contracts are changing dramatically from year to year, making comparisons meaningless. These liabilities build up over the contract period and then are paid, decreasing the liability to zero. Contract periods for different providers may cover different periods so that wide fluctuations can be seen from period to period. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.
Procedure #1 assists the analyst in determining if the health entity’s use of bonus and withhold arrangements are significant. Since health entities use these arrangements to different degrees, it is important to determine the significance of their use by the health entity under review. This procedure determines if the amount of bonus and withhold liabilities and expenses compared to the total hospital and medical expense is significant.

Procedure #2a and 2b assists the analyst in verifying that information that is reported in the financial statement for the health entity is consistent with what is reported in the health entity’s RBC filing. Since withholds and bonuses are reported both in the Annual Financial Statement and in the RBC filing, they should not appear in one and not the other.

Procedure #2c assists the analyst in determining if a significant amount of the prior year’s withholds and bonuses available were not paid during that reporting year. Withholds and Bonuses Available represent the total amount that could have been paid in withholds and bonuses. (This information is provided in the RBC filing page XR016). The amount paid compared to the amount available provides the analyst with a rough indication of how well provider groups were able to meet their contract goals. Further analysis may be necessary in order to determine whether the provider group is able to meet its financial or operational goals in its contracts with the health entity, currently and going forward. Provider groups not being able to meet their financial and operational goals and thus not earning all of their withholds in one year can result in higher claims costs than anticipated and/or less favorable contracts in the next contracting cycle.

Additional procedures may be performed if there are concerns regarding the amount of prior year withholds and bonuses available not paid were significant. If the level of these arrangements is significant it is important to determine if any actual risk is being transferred. Potentially, these arrangements could be used to create the appearance of capitated risk transfer when in fact the bonus and withholds result in no actual risk transfer. Since these arrangements reduce RBC, capital requirements could be understated. Some health entities have many types of contracts with providers, but it is possible to request that a health entity provide the primary contracts with its largest contracting providers.

It is also important to determine if these arrangements are concentrated within a few providers. If there is a concentration, any financial weakness of the providers could result in them not being able to fulfill their part of the risk transfer contract. Standards published by the Actuarial Standards Board of the American Academy of Actuaries (Actuarial Standard of Practice 16) requires that the actuarial opinion disclose the actuary’s knowledge of the health entity’s capitated risk contracts indicating if the actuary evaluated the financial position of the contracting providers. The actuarial opinion should be reviewed to determine if the capitated risk contracts, as well as the financial strength of the contracting providers were or were not reviewed by the opining actuary. It may be necessary to contact the qualified actuary to discuss his or her review and potential concerns.

It is possible that the contracting provider is actually an affiliate of the health entity. This can be the case where hospitals own HMOs who then contract back to the parent hospital. These arrangements should be understood for potential impact of the financial weakness of any of the participants.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Other Provider Liabilities are designed to identify significant use of these types of arrangements. Arrangements such as these are subject to significant estimate and if liabilities for these arrangements are materially misstated, it can result in material misstatement of the financial statements taken as a whole.
1. Determine whether concerns exist based on the primary operating ratios.
   a. Is the profit margin ratio less than 0 percent or greater than 10 percent?
   b. Is the combined ratio greater than 100 percent? Display the combined ratio for each of the past five years.
   c. Is the medical loss ratio greater than 85 percent?
   d. Is the administrative expense ratio greater than 15 percent?
   e. Based upon the health entity’s primary lines of business, do the combined, medical loss, and administrative expense ratios appear reasonable?
   f. Review Note 18 regarding ASO/ASC plans. Were any losses incurred from these plans?

2. Determine whether concerns exist based on the change in primary operating ratios when compared to the prior year.
   a. Has the profit margin ratio (see Procedure 1a above) increased more than 5 points or decreased more than 10 points?
   b. Has the combined ratio (see Procedure 1b above) increased more than 5 points or decreased more than 10 points?
   c. Has the medical loss ratio (see Procedure 1c above) increased more than 5 points or decreased more than 10 points?
   d. Has the administrative expense ratio (see Procedure 1d above) increased more than 3 points or decreased more than 5 points?

Additional procedures and prospective risk considerations if further concerns exist:
   e. Review the Analysis of Operations by Line of Business to determine which lines of business were profitable for the health entity and which lines of business generated a loss.
   f. Compare the combined ratios on each of the lines of business with approximate industry averages by line of business. Determine which lines of business the health entity is most successful in, and which lines of business the health entity could improve upon the most to become more profitable.
   g. Compare each of the primary operating ratios for the current period with the prior periods to determine any unusual fluctuations or trends between years.
   h. Compare all of the income and expense items from the revenues and expenses section of the Company Profile Reports to determine any unusual fluctuations or trends between years.
   i. Compare the current year combined ratios on each line of business with the prior year combined ratios by line of business to determine where the health entity experienced the most significant changes.
   j. Describe any known trends that have had or that the health entity reasonably expects will have a material impact on net revenues or net income, or a material impact on the relationship between benefits, losses and expenses.
   k. Compare the health entity’s actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
III. Annual Procedures – D.5. Level 2 Income Statement and Surplus (Health)

3. Determine whether concerns exist based on other profitability indicators.
   a. Is the investment yield less than 2 percent or greater than 6 percent? (See Financial Profile Report.)
   b. Is the ratio of return on capital & surplus less than 3 percent or greater than 50 percent?
   c. Are net realized capital gains or losses more than (i) +/- 3 percent of capital & surplus or (ii) +/- 25 percent of net income?

Additional procedures and prospective risk considerations if further concerns exist:
   d. Review the health entity’s investment yield ratio for unusual fluctuations and trends between years.
   e. Compare the investment yield ratio to the industry average investment yield to determine any significant deviation from the industry average.
   f. Review the detail of investment income in the Exhibit of Investment Income and the detail of realized gains or (losses) in the Exhibit of Realized Gains (Losses) for reasonableness.
   g. Compare the ratio of return on capital and surplus to the industry average return on capital and surplus to determine any significant deviation from industry average.
   h. Review the components of the Statement of Revenues and Expenses line item aggregate write-ins for other health care related revenues for reasonableness.
   i. Review the components of the Statement of Revenues and Expenses line item aggregate write-ins for other income or expenses for reasonableness.

4. Determine whether concerns exist regarding changes in the volume of premium, enrollment levels or changes in the health entity’s mix of business (lines of business written and/or geographic location of premiums written).
   a. Has there been a significant change ( +/- 10 percent) in net premium income from the prior year? Display the percent change and the net premium income for each of the past five years.
   b. Has there been a significant change ( +/- 10 percent) in enrollment from the prior year-end? Display the percent change and the enrollment for each of the past five years.
   c. Review the Annual Financial Profile Report. Has there been a shift in the mix of premium income?
   d. Have direct premiums written for any line of business changed by greater than +/-33 percent?
   e. If premiums are being written in any new lines, do they account for more than 10 percent of the total net premium income?
   f. Review Schedule T, and determine if any direct business is being written in a state in which there were no prior writings.

Additional procedures and prospective risk considerations if further concerns exist:
   g. Determine whether any lines of business have experienced a significant increase or decrease in premium writings.
i. Determine if the changes are consistent with the health entity’s most recent projections and business plan. Request additional information for variances not discussed in the most recent plan.

ii. For an overall increase in premium, obtain specific information on when additional funds are expected to be deposited into the health entity to support the growth.

iii. For an overall decrease, determine the health entity’s plans for addressing its expense structure under its new premium base.

h. In new or increasing lines of business, determine whether the health entity has the expertise (systems, underwriting, claims and reserving) needed. (Consider reviewing the health entity’s Management’s Discussion and Analysis and or seeking additional information from the health entity to determine the health entity’s expertise in the lines of business written.)

i. If the health entity has entered a new region or has significantly increased the business written in an existing region, request information on how the health entity establishes product prices in those regions, the provider contracts used by the health entity in that region and a discussion of the health entity’s future expected changes in the region. Compare this information with information available from the health entity’s competitors.

5. Determine whether the health entity is excessively leveraged due to the volume of premiums written.

a. Are premiums and risk revenue to capital and surplus greater than:

   i. 10 to 1 for HMOs?

   or

   ii. 8 to 1 for non-HMOs?

b. Has the ratio of premiums and risk revenue (see Procedure 5a) to capital and surplus increased more than 1.5 points or decreased more than 2 points? Display the point change in the ratio of premiums and risk revenue to capital and surplus and the ratio for each of the past five years.

c. Does the health entity write long-term care and disability income (long-tailed lines) premium? If “yes,” list the percentage of total direct premium.

Additional procedures and prospective risk considerations if further concerns exist:

d. Request information from the health entity on how it shares risk with other entities in order to minimize the overall underwriting risk to the health entity.

e. If long-tail business is being written by the health entity, consider the impact that a reserve shortfall could have on the health entity’s overall leverage risk.

f. Consider requesting information from the health entity on how it intends to address its operating leverage issue.
III. Annual Procedures – D.5. Level 2 Income Statement and Surplus (Health)

6. Determine whether concerns exist regarding the pricing of the health entity’s products.
   a. Is current year premium per member per month less than 105 percent of prior year’s premium per member per month?
   b. Is the change in claims per member per month less the change in premium and risk revenue per member per month greater than zero? (See Financial Profile Report.) Display the change in premium per member per month, the change in claims per member per month and the variance between the two.
   c. Review Health General Interrogatories – Part 2, #9.1 and #9.2. Does the health entity have a significant amount of multi-year contracts with premium rate guarantees?

Additional procedures and prospective risk considerations if further concerns exist:
   d. Determine if there any lines of business with a combined ratio greater than 105 percent.
   e. Consider if the health entity is dependent upon investment income.
   f. Determine whether a premium deficiency reserve has been established by the health entity on any products in question.
   g. For lines of business for which a premium deficiency reserve has been established, request information monthly from the health entity that details estimates of how actual claims compare with expected claims, and details the estimated impact on the reserve established.

   a. Did the health entity report an underwriting loss of either group or individual coverage?
   b. Did the health entity report a medical loss ratio greater than 85 percent on either group or individual coverage?
   c. Did the health entity report an expense loss ratio greater than 15 percent on either group or individual coverage?
   d. Did the health entity report a combined ratio greater than 100 percent on either group or individual coverage?

Additional procedures and prospective risk considerations if further concerns exist:
   e. Obtain and review information regarding the contracted benefits, premium and cost sharing with the U.S. Centers for Medicare & Medicaid Services.
   f. Review the types of products being written, including any enhanced benefit products.
   g. Request information on and review the assumptions for reserves, utilization and benefit costs projected in the development of the contract.

8. Determine whether concerns exist regarding the amount of the health entity’s capital and surplus.
   a. Has capital and surplus decreased more than 10 percent or increased more than 40 percent from the prior year-end?
   b. Review the five-year historical data in the Annual Financial Statement. Has the health entity’s capital and surplus decreased by more than 10 percent from the ending balance for any of the prior four years?
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c. Did the health entity declare dividends to stockholders during the year?
   i. If the answer to 8.c. above is “yes,” was the amount of the stockholder dividend at a level that required prior regulatory approval or notification?
   ii. If the answer to 8.c.i. above is “yes,” did the health entity fail to obtain proper prior regulatory approvals?

d. Provide details of any financial guaranty, of any form, in place between the company and any member within its holding company system.

e. Review surplus notes. Is the ratio of surplus notes to capital and surplus greater than 10 percent?

f. Are write-ins for other than surplus funds greater than 10 percent of capital & surplus?

g. Does the absolute value of the current year change exceed 3 percent of current year capital and surplus for any of the following items: 1) reserve valuation basis, 2) net unrealized capital gains/losses, 3) foreign exchange capital gains/losses, 4) net deferred income tax, 5) nonadmitted assets, 6) the liability for unauthorized reinsurance, 7) surplus notes, 8) change in accounting principles?

h. Did the health entity report interest expense on capital or surplus notes during the year?
   i. Are unassigned funds negative?

Additional procedures and prospective risk considerations if further concerns exist:

j. Review the procedures in the Risk-Based Capital Level 2 Annual Procedure.

k. If the health entity has outstanding surplus notes issued, review Note to Financial Statements #13 - Capital and Surplus, Shareholders Dividend Restrictions and Quasi-Reorganizations and consider the following:
   i. Date issued
   ii. Interest rate
   iii. Amount of note and current value
   iv. Interest paid-current year and in total
   v. Accrued interest
   vi. Date of maturity
   vii. Name of holder (and indication of whether holder is an affiliated entity)
   viii. Description of assets received
   ix. Repayment conditions or restrictions

l. If the health entity has outstanding debt issued, review Note to Financial Statements #11 - Debt and consider the following:
   i. Date issued
   ii. Interest rate
   iii. Amount of note and current value
   iv. Interest paid-current year and in total
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v. Accrued interest 
vi. Date of maturity 

vii. Name of holder (and indication of whether holder is an affiliated entity) 

viii. Description of assets received 
ix. Repayment conditions or restrictions 

m. If capital or surplus notes were issued during the year, determine whether they were approved by the domiciliary state insurance department. 

n. If principal was repaid and/or interest was paid on surplus notes during the year, determine whether the principal repayments and/or the interest payments were approved by the domiciliary state insurance department. 

o. If surplus notes represent a significant portion of capital and surplus, recalculate important ratios excluding the amount of surplus notes to determine the effect of surplus notes on the ratio results. 

p. Review the write-ins for special surplus funds and for other than special surplus funds for reasonableness. 

q. Review the Capital and Surplus Analysis (roll forward) in the Financial Profile Reports for unusual fluctuations or trends in the changes in the individual components of capital and surplus between years. 

r. Review the detail of unrealized gains or (losses) in Exhibit of Capital Gains (Losses) for reasonableness. 

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the health entity’s income statement and capital and surplus. 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 health entity’s income statement and capital and surplus under the specific circumstances involved. 

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

- Contact the health entity seeking explanations or additional information 
- Obtain the health entity’s business plan 
- Require additional interim reporting from the health entity 
- Refer concerns to examination section for targeted examination 
- 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 ________
III. Quarterly Procedures – D.5. Level 2 Income Statement and Surplus (Health)

1. Determine whether concerns exist based on the primary operating ratios.
   a. Is the profit margin ratio less than 0 percent or greater than 10 percent?
   b. Is the combined ratio greater than 100 percent?
   c. Is the medical loss ratio greater than 85 percent?
   d. Is the administrative expense ratio greater than 15 percent?
   e. Based upon the health entity’s primary lines of business, do the combined, medical loss, and administrative expense ratios appear reasonable?

2. Determine whether concerns exist based on the change in primary operating ratios when compared to the prior year-end.
   a. Has the profit margin ratio (See procedure 1a above) increased more than 5 points or decreased more than 10 points?
   b. Has the combined ratio (See procedure 1b above) increased more than 5 points or decreased more than 10 points?
   c. Has the medical loss ratio (See procedure 1c above) increased more than 5 points or decreased more than 10 points?
   d. Has the administrative expense ratio (See procedure 1d above) increased more than 3 points or decreased more than 5 points?

3. Determine whether concerns exist based on the change in primary operating ratios when compared to the prior year quarter.
   a. Has the profit margin ratio (See procedure 1a above) increased more than 5 points or decreased more than 10 points?
   b. Has the combined ratio (See procedure 1b above) increased more than 5 points or decreased more than 10 points?
   c. Has the medical loss ratio (See procedure 1c above) increased more than 5 points or decreased more than 10 points?
   d. Has the administrative expense ratio (See procedure 1d above) increased more than 3 points or decreased more than 5 points?

4. Determine whether concerns exist based on other profitability indicators.
   a. Is the investment yield less than 2 percent or greater than 6 percent? (See the Quarterly Financial Profile Report.)
   b. Is the ratio of return on capital & surplus less than 5 percent or greater than 20 percent?
   c. Are net realized capital gains or losses more than (i) +/-3 percent of prior year capital & surplus or (ii) +/- 25 percent of year-to-date net income?

5. Determine whether concerns exist regarding changes in the volume of premium, enrollment levels or changes in the health entity’s mix of business (lines of business written and/or geographic location of premiums written).
   a. Has there been a significant change (+/- 10 percent) in net premium income from the prior year-to-date?
b. Has there been a significant change (+/- 10 percent) in enrollment from the prior year-end?

c. Have direct premiums written for any line of business changed by greater than +/-33 percent?

d. If premiums are being written in any new lines, do they account for more than 5 percent of the total earned premiums?

e. Review Schedule T, and determine if any direct business is being written in a state in which there were no prior writings.

6. Determine whether the health entity is excessively leveraged due to the volume of premiums written.

a. Are premiums and risk revenue to capital and surplus greater than:

   i. 10 to 1 for HMOs?

   or

   ii. 8 to 1 for non-HMOs?

b. Has the ratio of premiums and risk revenue (see procedure 6a) to capital and surplus increased more than 1.5 points or decreased more than 2 points?

7. Determine whether concerns exist regarding the pricing of the health entity’s products.

a. Has premium per member per month increased by less than 10 percent from the prior year-end?

b. Is the change in claims per member per month less the change in premium and risk revenue per member per month greater than zero from the prior year-end?

8. Determine whether concerns exist regarding the amount of the health entity’s capital and surplus.

a. Has capital and surplus decreased more than 10 percent or increased more than 40 percent from the prior year-end?

b. Did the health entity declare dividends to stockholders during the quarter?

   i. If the answer to 8.b. above is “yes,” was the amount of the stockholder dividend at a level that required prior regulatory approval or notification?

   ii. If the answer to 8.b.i. above is “yes,” did the health entity fail to obtain proper prior regulatory approvals?

c. Review surplus notes. Is the ratio of surplus notes to capital and surplus greater than 10 percent?

d. Are write-ins for other than surplus funds greater than 10 percent of capital & surplus?
III. Quarterly Procedures – D.5. Level 2 Income Statement and Surplus (Health)

9. If there are concerns (e.g. changes in: surplus, writings, reserves, investments) about the current level of RBC, has the analyst considered completing and/or requesting an interim RBC projection?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the health entity’s income statement and capital and surplus. 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 health entity’s income statement and capital and surplus under the specific circumstances involved.

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

Statutory accounting principles emphasize the balance sheet because statutory accounting is primarily directed toward the determination of a health entity’s financial condition on a specific date. However, the income statement is also important and should be reviewed as an integral part of the financial analysis process. Ultimately, most problems encountered in maintaining adequate levels of capital and surplus within a health entity are first revealed in the income statement. Income statement analysis primarily focuses on the operating performance of a health entity. One of the most common measures of a health entity’s overall profitability and operating performance is its profit margin. This ratio considers the four principal factors which affect the health entity’s net gain or loss: 1) morbidity (claims) experience, 2) expense and commission structure, 3) investment income, and 4) realized capital gains or losses. The return on capital and surplus, which considers net income as a percentage of capital and surplus, is another important measure of overall operating performance.

Measures such as profit margin and return on capital and surplus are very general measures of a health entity’s profitability. Although these ratios generally do not allow an analyst to determine the primary source of profits or losses, they provide an overall measure of profitability that the health entity’s ultimate parent is likely to monitor in evaluating the performance of its strategic business units. Measures such as the combined ratio, the medical loss ratio and administrative expense ratio provide the analyst with more specific measures of the health entity’s source of profits or losses and are an important part of the Level 2 Annual Procedures for this section. The health entity’s management as well as external analysts generally use these more precise ratios. However, even these ratios are somewhat limited in their ability to target the sources of a health entity’s profitability. There may be different loss or risk characteristics by product type, or even by region within the same product. Ratios will not reveal those issues.

Health insurance is provided to consumers through various means and products. Some products provide very specific coverage (e.g., medical only, dental, vision and stop loss) while others provide much broader coverage (e.g., comprehensive, federal employees health benefit plan, Medicare and Medicaid). As previously mentioned, each of these products contains different loss and risk characteristics. Different mixes of these products can significantly impact the profitability of a health entity.

Prior to completing the Level 2 Annual Procedures for income statement and surplus, the analyst should consider the results of the initial review performed in the Level 1 Analysis, including the review of the health entity’s Annual Financial Statement, the Annual Scoring Results, and the Annual Financial Profile. In reviewing these items, the analyst should determine the overall risk associated with the health entity’s operating statement. This would include noting the primary lines of business written by the health entity and the general operating results of the health entity. If based on this initial review, the analyst determines that a more thorough analysis of the operations is necessary; the Level 2 Annual Procedures would be completed.

In completing and reviewing the Level 2 Annual Procedures, the analyst should keep in mind the information obtained regarding the health entity's lines of business. This is critical in evaluating the health entity's operating ratios from the Level 2 Annual Procedures. The operating ratios that may be impacted the most by the lines of business include the medical loss ratio, the administrative expense ratio and even the investment yields. These ratios can be significantly different if the health entity writes long-tailed business such as disability or long-term care. This is because the suggested Annual Financial Statement thresholds of 85 percent, 15 percent, and between 2 percent and 6 percent, respectively, are based upon health entities that write only "comprehensive health products." As discussed in the Health Insurance Industry section of this Handbook, medical loss ratios on long-term care insurance are generally much lower than the 85 percent threshold used in the Level 2 Annual Procedures. Meanwhile, the

administrative expense ratio and the investment yield usually tend to be much higher for a health entity that writes this line of business compared to one that just writes "comprehensive health." Different distortions will occur if the health entity writes small amounts of specific disease plans, student accident, etc. However, a health entity typically writes primarily "comprehensive health products." Therefore, the percentage of revenue that represents other health business will be small, but the effect on the ratios may be significant.

Fluctuations in operating ratios are also important indicators of potential financial problems and concerns. For example, even if the health entity’s medical loss ratio was considered good, an increase may indicate a loss of control in the health entity’s underwriting or pricing standards. An increase in the administrative expense ratio may indicate escalating costs or an expense structure that no longer supports the health entity’s premium volume.

Fluctuations in premium or enrollment may also indicate a reason for concern. Uncontrolled, excessive growth has been found to be one of the major causes of insolvency. If the growth is not accompanied by additional surplus, the capital and surplus may not be able to support the additional exposure. Growth is often times driven by a health entity’s desire for greater market share. Many times, the health entity is able to gain that market share by lowering its prices or setting prices below the rest of the market. This desire for greater market share can lead to considerable underpricing. This underpricing can increase the amount of risk to the health entity for every dollar of premium written. Additionally, in many cases, the health entity may establish reserves as a percentage of premiums when it enters a new market, which can lead to additional risk. Therefore, if the product is underpriced, it's possible the reserves may be understated. As a result, growth by a health entity is often associated with underpricing and under reserving, which is a risky combination. In effect, the company may need to establish a greater reserve when unsure about its pricing.

In addition, growth can make administering the operations difficult and can create claims inventory backlogs. A change in premium might also reflect a health entity’s entrance into new lines of business or sales regions. This could result in financial problems if the health entity does not have expertise in these new lines of business or regions. This is particularly true in the health insurance market where margins are traditionally very thin and critical mass is necessary in establishing new provider contracts. Finally, significant increases in premiums might also be an indication that the health entity is attempting to increase cash inflow in order to cover current benefit payments, particularly if the health entity is writing more longer tail insurance (e.g., long-term care).

In cases where premium or enrollment has not significantly changed, the analyst should still assess the level of business written by the health entity by comparing premium and risk revenue to capital and surplus. This comparison should include premium and risk revenue recorded by the health entity in its income statement since both sources of revenue represent exposure to the health entity. This type of comparison is generally considered a measure of a health entity’s operating leverage and is important in determining the potential losses to the health entity. The higher the writings ratio, the more likely the health entity will record a material loss when morbidity spikes. For example, if a health entity is writing at a 5 to 1 ratio, and reports a combined ratio of 105 percent (assuming no investment income and no federal income taxes) the health entity would report a 25 percent decrease in capital and surplus based upon the net loss alone. Therefore, for every $5 in writings at a loss of 5 percent, surplus would be impacted 5 times greater and incur a 25 percent loss. If a health entity is writing at a 10 to 1 ratio, and reports a combined ratio of 105 percent (assuming no investment income and no federal income taxes) the health entity would report a 50 percent decrease in capital and surplus. Therefore, for every $10 in writings at a loss of 5 percent, surplus would be impacted 10 times greater and incur a 50 percent loss.
In assessing financial condition, considerable emphasis is placed on the adequacy of a health entity’s capital and surplus (See section III.B.6. for a detailed discussion of Risk-Based Capital (RBC)). Capital and surplus provides protection (or “cushion”) for policyholders against adverse underwriting results, inadequate reserve levels and fluctuations in the value of assets. In addition, capital and surplus provides underwriting capacity and allows a health entity to expand its business. The RBC formula is designed to calculate a minimum threshold measure of capital and surplus adequacy based on each health entity’s unique mix of asset risk, insurance risk, and business risk. Refer to the RBC section of the Handbook for discussion on RBC.

The components of capital and surplus can include common capital stock, preferred capital stock, gross paid-in and contributed surplus, surplus notes, unassigned funds (or retained earnings), and special surplus funds (usually established through an appropriation of unassigned funds). Each state has, by statute, established a minimum required amount of capital and surplus for health entities. In some states, these minimum amounts are based on the lines of business written while, in other states, the minimum amounts are based on the type of health entity. In addition, the RBC requirements must also be met in states that have implemented health RBC.

Health entities may issue capital or surplus notes as a source of financing growth opportunities or to support current operations. Surplus notes (sometimes referred to as “surplus debentures,” “contribution certificates,” or subordinated debt) have the characteristics of both debt and equity. Surplus notes resemble debt in that they are repayable with interest and sometimes (depending upon the requirements of the domiciliary state insurance department) include maturity dates and/or repayment schedules. However, key provisions of the surplus notes make them tantamount to equity. These provisions include approval requirements as to form and content and the requirement that interest may be paid and principal may be repaid only with the prior approval of the domiciliary state insurance department. SSAP No. 41, Surplus Notes, requires that interest on surplus notes is to be reported as an expense and a liability only after payment has been approved. Accrued interest that has not been approved for payment should be reflected in the Annual Financial Statement Notes to Financial Statements. Surplus notes are considered subordinate to all other liabilities of the health entity.

Provided that the domiciliary state insurance department has approved the form and content of the surplus notes and has approval authority over the payment of interest and repayment of principal, surplus notes are considered to be surplus and not debt. The proceeds from the issuance of surplus notes must be in the form of cash, cash equivalents or other assets having a readily determinable value satisfactory to the domiciliary state insurance department. Information regarding surplus notes must be reported in the Annual Financial Statement Notes to Financial Statements.

Health entities may also issue capital notes, which are reported as a liability by the health entity and are therefore treated as debt instruments. In liquidation, they rank with surplus notes and are subordinate to the claims of policyholders, claimants and general creditors. Capital notes are included in the health entity’s total adjusted capital for RBC calculations.

Capital notes are repayable with interest and include maturity dates and/or repayment schedules. However, payments of interest and repayment of principal generally do not require regulatory approval. When total adjusted capital falls below certain levels or if other adverse conditions exist, capital note payments may be required to be deferred. While deferred, any interest on the capital note should not be reported as an expense or the accrual as a liability, but instead should be reflected in the Annual Financial Statement Notes to Financial Statements, similar to surplus note interest payments that have not been approved.
Capital and surplus notes may have the effect of enhancing surplus or providing needed funds. The holder of the capital or surplus note may expect repayment on a scheduled basis and may exert pressure on the health entity to generate cash in order to be able to make the payments. As a result, the analyst should be aware when reviewing health entities that rely heavily on these notes. Capital and surplus notes are not inherently bad. They may provide a source of capital to health entities whose surplus levels are deemed inadequate to support current operations and that do not have access to traditional equity markets.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board.

The procedures included in the Income Statement and Surplus section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The purpose of this section is primarily to assist the analyst in reviewing and analyzing the health entity’s operating performance, with emphasis on basic operating ratios and the change in those ratios, and the level and change in the health entity’s premiums. In addition, separate focus is given to the change to and quality of a health entity’s capital and surplus. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.

*Procedure #1* assists the analyst in determining whether concerns exist regarding the health entity’s income statement or operating performance. Each of these ratios is designed to provide the analyst with an overall assessment of the health entity’s profitability. The profit margins in the health insurance industry have traditionally been fairly low. As a result, the threshold for this ratio is established at less than 0 percent or greater than 10 percent. A profit margin ratio less than 0 percent indicates the health entity has experienced a net loss and operating problems may exist. With continued losses, the health entity’s capital cushion to support the business is likely to be diminished. Conversely, a profit margin greater than 10 percent is unusual in the health insurance industry and should be investigated.

Another ratio that provides an assessment of a health entity’s profitability is the combined ratio. The threshold for the combined ratio is set at greater than 100 percent. A health entity with a combined ratio of 100 percent should have investment income for profit. The combined ratio consists of the medical loss and the administrative expense ratios. The administrative expense ratio includes administrative expenses as well as claims adjustment expenses. Claims adjustment expenses are the costs incurred relating to reported and unreported claims and are considered to be administrative in nature. The threshold for the medical loss ratio is set at greater than 85 percent and the administrative expense ratio is set at greater than 15 percent. These thresholds are based upon a typical relationship between the combined, medical loss, and administrative expense ratios. Some health entities may have a higher medical loss ratio but a lower administrative expense ratio. Some view this relationship as positive because more benefits are provided to the consumer. Other health entities may have a lower medical loss ratio and a higher administrative expense ratio. In some cases, this relationship may be positive because sometimes this is indicative of a health entity with lower operating leverage. Also, the medical loss ratio measures the direct cost of business as related to premiums earned and should have a consistent trend, while the administrative expense ratio which measures indirect expenses as related to premiums earned should decrease as the company becomes more efficient over a period of time. Typically, premium increases are
driven by claim cost trends that exceed general inflation, which drives administrative costs. On the other hand, in situations where general inflation is less than medical cost trends, administrative cost ratios may actually increase since administrative trends will be higher than premium trends. As previously mentioned, the analyst should also be familiar with the health entity’s primary lines of business in order to evaluate their operating performance. This includes lines with business risk (ASO/ASC) but no underwriting risk, which report fees as a reduction of expenses, instead of as premium.

Additional steps the analyst may perform if there are concerns regarding the health entity’s primary operating ratios include obtaining a greater understanding of where the losses have occurred by reviewing the Analysis of Operations by Line of Business page. The analyst should also consider the need to compare the line of business gains and losses with industry averages. A comparison to industry average combined ratios can assist in this matter. However, the analyst should consider not only those problematic lines of business, but also those in which the health entity has been successful. These procedures will assist the analyst in assessing the current operating performance of the health entity. The analyst should also assess the health entity’s current performance against prior periods to determine where fluctuations or trends have occurred. The analyst should consider comparing the primary operating ratios with prior periods to assist in this matter. The analyst should also make the same type of comparison with specific lines on the profile report. This process may help pinpoint specific problems that are not obvious from reviewing the period-to-period ratios. A further analysis of the lines of business information may be helpful and the analyst should consider comparing the current year combined ratios by line of business with the prior year combined ratios by line of business to assist in this analysis. The analyst should also consider comparing the health entity’s actual experience with its projections.

Procedure #2 assists the analyst in determining whether concerns exist regarding changes in the health entity’s operations. As previously mentioned, an increase in a health entity’s medical loss ratio may indicate a loss of control in the health entity’s underwriting or pricing processes. An increase in the administrative expense ratio may indicate escalating costs or an expense structure that no longer supports the health entity’s premium volume. Changes may also be the result of a change in the health entity’s business mix. As previously mentioned, a health entity’s entrance into new lines of business or sales regions might result in financial problems if the health entity does not have expertise in these new lines of business or regions. All of these items should be further investigated to further assess the risk to the health entity.

Procedure #3 assists the analyst in identifying other potential areas of concern. The items contained in this procedure are generally not primary operating indicators for most health entities. However, they do impact the overall financial position of the health entity and in some cases may materially impact some health entities. Specifically, the investment yield is an indicator of the profitability of the health entity’s invested assets. Generally, this indicator is not heavily weighted because most health entities are concerned with maintaining high liquidity and low risk within their asset portfolio. In other words, a health entity, which generally writes short-tailed business, will invest in short term investment assets (which need to be highly liquid to satisfy short term obligations). However, if a health entity writes a considerable amount of long-tailed business, which usually does not require short-term obligations, the health entity will invest in long-term investment assets. This method of investing is known as the “matching principle.” As a result, in comparison to a life insurer and even a property/casualty insurer, most health entities have a much shorter average maturity on their bonds and hold much more in cash and short-term investments. Typically, short-term investments usually offer lower interest rates, lower investment yields and, if any, lower capital gains and losses. However, some health entities take a more aggressive investment approach and do have a fair amount of asset risk. The analyst should review the health entity’s investment yield and its investment gains and losses to better assess the extent to which the
entity relies upon their investment returns. Refer to the Investments section of the Handbook for discussion on investments.

Additional steps may be performed to assess the impact that other items can have on the health entity’s overall operating income. Consideration should also be given to the size and type of health entity. Although the profit margin ratio generally considers the impact of all income and expense items, a review of investment income and capital gains and losses may not typically be considered part of the primary operating figures within a health entity. As discussed above, the investment results of a health entity are typically secondary to its underwriting results and most health entities maintain a fairly conservative asset base to increase their liquidity. However, the analyst should consider the need to review the investment yield over a period of time for unusual fluctuations as well as against the industry average. This review and other items may indicate a need to perform a detailed review of the source of the income and the source of any investment gains or losses to determine if there are any particular assets that are not providing an adequate return. Similarly, the analyst may need to perform a more detailed review of write-in lines, which impact the profit margin, but not the other primary operating ratios of a health entity.

Generally, most write-in lines are not material to the health entity, but in cases where they are, they should be reviewed for their reasonableness.

**Procedure #4** assists the analyst in determining the business stability. As previously discussed, a significant increase in premiums and enrollment may indicate rapid growth, which can present many different types of problems to a health entity or can also be an indication of the health entity’s entrance into new lines of business or sales regions. Significant increases in premiums might also be an indication that the health entity is attempting to increase cash inflow to cover current benefit payments, particularly if the health entity primarily writes longer tail insurance.

Additional steps may be performed if there are concerns regarding the financial impact that changes in the volume of premiums or changes in the health entity’s mix of business (lines of business written and/or geographic location of the premiums written) could have on its financial position. The analyst should consider comparing any significant changes in premiums to the health entity’s most recent projections and business plan. Variances could suggest that consumers have responded to the health entity differently than anticipated. As previously discussed, growth can have a material impact on the operations of a health entity, and the analyst should gain more information from the health entity when this has occurred, including how current and future growth is expected to be supported. However, decreases in premium can also place some pressure on the health entity through forced expense reductions. The analyst should attempt to understand how decreases in premiums are expected to impact this issue. If new lines of business are being written or if premiums are being written in new regions, the analyst should review the health entity’s Management’s Discussion and Analysis (MD&A) for related information. Otherwise, information may be requested from the health entity showing operating results vs. projections for the new lines of business or territories, and describing any changes in implementation strategy or revisions in financial projections for future periods. The analyst should also consider determining if, as a result of increases in sales regions, how the health entity prices its products, the contracts used with providers and any future expected changes in the health entity’s business. The business of health insurance is very localized and the health entity must have a reasonable understanding of that market to be successful.

**Procedure #5** assists the analyst in determining whether the health entity is excessively leveraged due to its volume of business. Capital and surplus can be considered as underwriting capacity. The ratios of net premiums and risk revenue to capital and surplus measures the extent to which that capacity is being utilized and the adequacy of the health entity’s capital and surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A net premium and risk revenue to capital and surplus ratio greater than 10 to 1 (8 to 1 for non-HMOs) may indicate that the health entity is excessively leveraged.
Special attention should be given to the type of coverage provided and the extent to which the health entity is able to transfer some of the risk from the business to another entity. Two health entities both with a 10 to 1 ratio may have different leverage depending on the type of coverage that they write. For example, to the extent the health entity has written primarily comprehensive business for many years in the same region, and is able to capitate some of its business, it may not be as risky as a health entity which has just begun writing Medicare business in a new region and is unable to transfer any of its risk. Even if both of these health entities have the same leverage ratio results, the one starting Medicare Risk coverage will have a riskier financial position. The analyst should also specifically consider if a significant portion of the premium is written on longer tail lines. On these lines, the ultimate experience may not be known for some time, thereby increasing the risk of reserve understatemant. The analyst should also determine whether there has been an increase in the writings ratio or an increase in the amount of long-tail business that is being written, to assist in identifying future trends.

Additional steps may be performed if there are concerns regarding whether the health entity may be excessively leveraged due to its volume of business. Generally, the threshold for health business on leverage ratios is set at a much higher level than for property/casualty business. This is because property/casualty business tends to carry more catastrophic risk (risk of large loss) than health business, due in part to the long-tailed nature of property/casualty major lines of business. The threshold for HMOs tends to be set at a higher level than other health entities. This is because some extent, HMOs are able to transfer some of their risk to other entities, thereby reducing their overall risk in comparison to their premium volume. Because of the above, a 10 to 1 threshold is generally used for HMOs (8 to 1 for most other health entities). However, the analyst should consider the type of business written by the health entity and the health entity’s use of risk transfer in considering the extent to which a health entity may be leveraged. These procedures assist the analyst by directing the analyst to consider how these items may impact the health entity’s overall leverage. Once an analyst has a better understanding of these issues for a health entity, the analyst may want to consider requesting additional information from the health entity on how it intends to address this issue.

Procedure #6 assists the analyst in determining whether concerns exist regarding the pricing of the health entity’s products. To the extent the health entity’s premium per member per month (PMPM) has not increased by an amount that approximates the expected increase in health care costs PMPM, this may be an indication that the health entity’s premium rates may not be able to keep pace with the health entity’s medical inflation. Although this ratio is a measure of what has occurred since the prior year, it can be used as a gauge in evaluating whether a health entity may be exposed. The ratio is also limited since it can’t be applied at the product level using Annual Financial Statement information. However, the purpose of the ratio is to provide the analyst some sense of how the entity’s premium rate changes compare with medical inflation in general. The analyst should also use the ratio of change in claims PMPM to change in premium PMPM. A result greater than zero indicates that claims increased from the prior year at a faster rate than premiums have increased from the prior year. A result less than zero would indicate that premiums have increased from the prior year at a faster rate than claims have increased from the prior year. The use of PMPM allows the ratio to be broken down to a more meaningful comparison. One other item that the analyst should consider is the health entity’s use of multiple year provider contracts. Multiple year provider contracts allow a health entity and a provider to lock in agreed upon rates for an extended period of time. Although not necessarily an indication of underpricing, clearly it is much more difficult to predict the cost of health care three years out than it is one year out. As a result, multiple year contracts by their nature lend themselves to greater pricing risk. The analyst should be aware of the use of these contracts and the extent to which they are used.

Additional steps may be performed if there are concerns that one or more of the health entity’s products may be underpriced. Although it may be difficult to determine if any specific products are underpriced,
one procedure the analyst may want to consider is the level of losses on the individual statutory lines of business. To the extent the health entity had a combined ratio of greater than 105 percent on any line of business, it may be an indication that the product is underpriced. To the extent a health entity has underpriced a product, the financial impact could be significant depending upon the health entity’s leverage and the type of product. The analyst should also consider the need to determine if the health entity has established a premium deficiency reserve on a line of business. As discussed in the Health Reserves and Liabilities section, this reserve is established when future premiums and current reserves are not sufficient to pay future claims and expenses. This type of reserve is established because it meets the definition of a loss contingency and should therefore be considered in evaluating the current financial position of the health entity. The analyst should use the information, along with any information from the health entity, to better assess the current financial position of the health entity. Other information could include a monthly assessment from the health entity on the adequacy of the current deficiency reserve based upon updated information. Since the reserve is essentially an estimate of the expected losses from one or more contracts, updated information can assist in ensuring that the reserve continues to be adequate and that the health entity’s financial position has not materially deteriorated.

Procedure #7 assists the analyst in evaluating the underwriting performance of the Medicare Part D Prescription Drug coverage. The procedures utilize data in the Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, the analyst should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated in the contract. If the insurer is reporting unusual results, the analyst should consider if any delays in payments from the U.S. Centers for Medicare & Medicaid Services (CMS) are impacting results.

Additional steps may be performed if there are concerns regarding the Medicare Part D business. Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for a period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If the policyholder’s utilize more benefits than were projected in the contract, the insurer may experience losses since the income from CMS is set for a full year. The analyst should consider obtaining and reviewing information on the contracted benefits, premium and cost sharing with CMS. The analyst should also evaluate a comparison of premiums, reserves, expected utilization and benefit costs to actual experience on each plan.

Procedure #8 assists the analyst in evaluating a health entity’s capital and surplus. The RBC formula is designed to calculate a minimum threshold of capital and surplus based on each health entities’ unique mix of asset risk, insurance risk and business risk. The level of, and changes in, premiums (see procedure 3 above) and reserves must be considered in evaluating the amount of a health entity’s capital and surplus. The net change in capital and surplus measures the improvement or deterioration in the health entity’s overall financial condition from the prior year. Even increases in the change in capital and surplus ratio, when significant, may indicate instability or mask financial problems attributable to fundamental changes in the health entity. Another step is designed to assist the analyst in identifying dividend payments or declarations, to determine if any necessary approvals were obtained.

Other steps in procedure #8 are designed to assist the analyst in identifying significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds, which don’t carry the same level of quality as unassigned surplus. Also, significant changes in capital and surplus due to changes in 1) reserve valuation basis, 2) net unrealized capital gains/losses, 3) foreign exchange capital gain/loss, 4) net deferred taxes, 5) nonadmitted assets, 6) the liability for unauthorized reinsurance, 7)
surplus notes, or 8) change in accounting principle are reviewed. This step is designed to assist the analyst in identifying other activity during the year related to the health entity’s overall capital and surplus.

Additional steps may be performed if there are concerns regarding the amount of the health entity’s capital and surplus. If there are concerns regarding the adequacy of the health entity’s capital and surplus, the analyst should consider reviewing the procedures in the RBC Level 2 Procedures. If the health entity has issued surplus notes, which are significant, the analyst should consider reviewing the information regarding the surplus notes in Note to Financial Statements #13. If surplus notes were either issued or repaid or if interest was paid during the year, the analyst should determine if the domiciliary state insurance department approved these transactions. In addition, if surplus notes represent a significant portion of capital and surplus, the analyst should consider recalculating important ratios excluding the surplus notes to determine their affect on the ratio results. If the health entity has issued capital notes which are significant, the analyst should consider reviewing the information in Note to Financial Statements #11 for pertinent information such as repayment, redemption price or interest features. Other steps to consider in procedure #7 include the review of the detail of unrealized gains or losses and the review of other components of capital and surplus for reasonableness.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Income Statement and Surplus are designed to identify the following: 1) operating problems based upon primary operating ratios, 2) significant changes in the primary operating ratios from the prior year, 3) significant changes in the primary operating ratios from the prior year quarter, 4) operating problems based upon other financial indicators, 5) significant changes in the volume of premiums or the health entity’s mix of business (lines of business written and/or geographic location of premiums written), 6) signs of excessive leverage, 7) signs of potential underpricing, or 8) any changes in capital or surplus notes that have occurred or dividends paid to stockholders since the prior year Annual Financial Statement or prior Quarterly Financial Statement.
III. Annual Procedures – D.6. Level 2 Health Care Pursuant to Public Health Service Act (Health)

NOTE: As the U.S. Department of Health and Human Services (HHS) continues to provide further direction on issues related to the implementation of federal Patient Protection and Affordable Care Act (PPACA), certain procedures and/or guidance in this chapter may be subject to change.

The intent of this chapter is to provide instruction and guidance to analysts regarding the new Supplemental Health Care Exhibit (SHCE). This Exhibit was developed in order to provide a mechanism to ensure that states have the ability to understand and review the elements that make up the numerator and denominator of the medical loss ratio (MLR) that will be calculated pursuant to federal law. THIS EXHIBIT DOES NOT PERMIT A CALCULATION OF THE FINAL MLR FOR REBATE PURPOSES.

The following procedures are intended to supplement other Level 2 Procedures in the Handbook and established analytical procedures of the insurance department.

1. Were the Supplemental Health Care Exhibit (SHCE) and the Supplemental Health Care Exhibit’s Expense Allocation Report filed in accordance with the Annual Statement Instructions?

2. Determine whether there are concerns regarding the components of the health entity’s Preliminary Medical Loss Ratio (MLR). Review the SHCE, identify the components of the Preliminary MLR calculation and consider the following:
   a. Is the Preliminary MLR (either the national Preliminary MLR or the state level MLR) less than 80 percent for individuals or small group employers, or less than 85 percent for large group employers, (or the thresholds applicable under state law)? (See Reference Guide Discussion of Procedures for #2 for guidance on an aggregate vs. by state review of Preliminary MLR.)
   b. Review the trend in the Preliminary MLR (either the national Preliminary MLR or the state level MLR). Did the Preliminary MLR increase or decrease by more than 5 percentage points from the prior year? (See Reference Guide Discussion of Procedures #2 for guidance on an aggregate vs. by state review of Preliminary MLR).
   c. In the analyst’s review of the components of the Preliminary MLR, review and assess any material differences between the unadjusted and adjusted amounts for premium and claims.
      • Health Premium Earned (Line 1.1) compared to Adjusted Premium Earned (Line 1.8)
      • Incurred Claims excluding prescription drugs (Line 2.1) compared to Total IncurredClaims (Line 5.0)
   d. Review the Financial Profile Report’s PMPM data and explain any amounts that appear unusual.
   e. Did the analyst note any components that appear unusual, or that increased or decreased materially from the prior year that would indicate further review is warranted?
   f. Review the SHCE Part 3 and the Expense Allocation Report including the expense allocation methodology to determine whether quality improvement (QI) expenses are appropriate and properly accounted for.

Document any unusual items or areas of concern.
III. Annual Procedures – D.6. Level 2 Health Care Pursuant to Public Health Service Act (Health)

3. Determine whether there are concerns regarding the impact by line of business to the health entity’s overall operating results and financial solvency.
   a. Is the Preliminary MLR (either the national Preliminary MLR or the state level MLR) greater than 90 percent for individuals or small group employers, or greater than 95 percent for large group employers? If “yes,” assess the financial solvency of the plan and the impact of the plan on the overall financial solvency of the health entity.
   b. Compare the results of your analysis of the Preliminary MLR to your analysis of the existing medical loss ratio calculations (refer to Financial Profile Report or Handbook chapter III.D.5. Income Statement and Surplus) and assess the impact to the overall solvency of the health entity.
   c. Analyze the underwriting gain/ (loss) result by line of business. Did any line of business on the SHCE report an underwriting loss?
      i. If “yes,” determine the reasons for the loss.
      ii. Assess the impact of each line of business to the overall operating results of the health entity.

Document any unusual items or areas of concern.

4. Review the liability for rebate as reported in the Notes to the Financials as well as reported on the NAIC Supplemental Health Care Exhibit – Part 1 and in the final rebate reporting to HHS (when available).
   a. If the amount reported is material (e.g. greater than 5 percent of capital and surplus) determine whether there are concerns regarding the health entity’s liability for rebates.
   b. Compare the MLR components as provided in the SHCE and the HHS Medical Loss Ratio Reporting Form. Were any material differences identified? If so, consider requesting an explanation of the differences from the health entity.

5. Determine whether there are concerns regarding recent rate filing requests.
   a. Contact internal state insurance department staff responsible for the rate review and request information on any recent rate reviews. Were any concerns noted by the rate review staff? (e.g., were rate adjustment requests disapproved or modified) If “yes,” explain.
   b. Review the trend in rate filing requests. Are there any concerns with the frequency or amount of the requests? If “yes,” explain.
   c. Review the Financial Profile Report’s PMPM premium data and compare it to rate increases. Explain any results that appear unusual.

6. During the review of the health care business pursuant to the Public Health Service Act and all applicable filings, did the analyst note any unusual items or areas of concern, not previously noted above, that indicate further review is warranted? If “yes,” explain.

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Summary and Conclusion

Develop and document an overall summary and conclusion regarding health care business pursuant to the Public Health Service Act. 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 health entity under the specific circumstances involved.

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

- Contact the health entity seeking explanations or additional information
- Obtain the health entity’s business plan
- Require additional interim reporting from the health entity
- Refer concerns to examination section for targeted examination
- 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 ________
III. Quarterly Procedures – D.6. Level 2 Health Care Pursuant to Affordable Care Act (Health)

1. Determine whether the health entity wrote accident and health insurance premium which is subject to the federal Affordable Care Act (ACA) risk-sharing provision and if the amount of premium written exceeded projections as well as ascertain whether the health entity’s level of capital can support the impact of underestimation of the qualified premium.

2. Review underwriting results, including the medical loss and administrative expense ratios to determine whether the insurer may be experiencing difficulties in covering claims and administrative expenses at current premium levels.

3. Determine whether the health entity has limited access to capital or has low liquidity levels.

4. Review the health entity’s current RBC to identify if it is at a deteriorating level due to ACA risk-sharing provisions or as a result of the ACA fee assessment payable.

5. Analyst review of reinsurance and risk-adjustment accruals to identify health entities that:
   a. Might not be adequately accruing liabilities for premium adjustments payable and for risk adjustment user fees payable.
   b. Might be overestimating premium and adjustments receivables.
   c. Might have liquidity issues because payments will be delayed until final determination can be made.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding health care business pursuant to the ACA. 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 health entity under the specific circumstances involved.

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
NOTE: As the U.S. Department of Health and Human Services (HHS) continues to provide further direction on issues related to the implementation of federal Patient Protection and Affordable Care Act (PPACA), certain procedures and/or guidance in this chapter may be subject to change.

The intent of this chapter is to provide instruction and guidance to analysts regarding the new Supplemental Health Care Exhibit (SHCE). This Exhibit was developed in order to provide a mechanism to ensure that states have the ability to understand and review the elements that make up the numerator and denominator of the medical loss ratio (MLR) that will be calculated pursuant to federal law. THIS EXHIBIT DOES NOT PERMIT A CALCULATION OF THE FINAL MLR FOR REBATE PURPOSES.

Overview

The federal Patient Protection and Affordable Care Act (Pub. L. 111–148) (PPACA) was enacted on March 23, 2010 and the federal Health Care and Education Reconciliation Act (Pub. L. 111–152) was enacted March 30, 2010. The two statutes collectively are referred to as the federal Affordable Care Act (ACA). The ACA reorganizes, amends, and adds to the provisions of Part A of title XXVII of the federal Public Health Service Act (PHSA) relating to group health plans and health insurance issuers in the group and individual markets.

On May 19, 2011, the U.S. Department of Health and Human Services (HHS), working in partnership with States, issued a final regulation to implement consumer protection regarding rate increase disclosure and review from the ACA.

On Oct. 21, 2010, the NAIC adopted uniform definitions and standard methodologies for medical loss ratios (MLRs) as required in section 2718 of the PHSA as added by the PPACA. The definitions and standards are contained in the NAIC model regulation, The Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2012 and 2013 (Per Section 2718 (b) of the Public Health Service Act), (Model #190). The NAIC transmitted this model, which contains its recommendations regarding the uniform definitions and standard methodologies to HHS on Oct. 27, 2010. On Dec. 1, 2010, HHS published its Interim Final Rule (IFR) which adopted many – but not all – of the NAIC recommendations. (See, 45 CFR 158, at 75 Fed Reg 74863, Dec. 1, 2010). The IFR to date has not been finalized.

The PHSA, Model #190 and the Annual Statement Instructions contain definitions for individual, small group and large group health plans. These three sets of definitions are not necessarily the same, and state law may also differ. In all cases, state law will control. For the purposes of financial analysis of the supplemental health care exhibit (SHCE), analysts should refer either to the Annual Statement Instructions (in the absence of a state law definition) or to state law for a definition of individual, small group and large group health plans. Per the Annual Statement Instructions:

- Individual comprehensive health coverage plans include health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes group conversion policies.

- Small group employer comprehensive health coverage plans include all policies issued to Small Group Employers. Small group health plan means a health plan offered in the small group market as such term is defined in the state law, consistent with the group’s state of situs reporting.
Large group employer comprehensive health coverage includes all policies issued to Large Group Employer (including Federal Employees Health Benefit Program and similar insured State and local fully insured programs, and TRICARE plans)

**Mini-Med and Expatriate Plans**

The Federal Interim Final Regulation defines mini-med and expatriate policies as follows:

Mini-med plans: “For the 2011 MLR reporting year, an issuer with policies that have a total annual limit of $250,000 or less must report the experience from such policies separately from other policies.”

Expatriate plans: “For the 2011 MLR reporting year, an issuer with group policies that provide coverage for employees working outside their country of citizenship, employees working outside their country of citizenship and outside their employer’s country of domicile, and citizens working in their home country, must aggregate the experience from these policies but report the experience from such policies separately from other policies.”

**Annual Statement Reporting**

As stated in the Annual Statement Instructions, the purpose of the SHCE is to assist state and federal regulators in identifying and defining elements that make up the MLR as described in Section 2718(b) of the PHSA and for purposes of submitting a report to the HHS Secretary required by Section 2718(a) of the PHSA. The SHCE is also intended to track and compare financial results of healthcare business as reported in the annual financial statements. Thus, the numbers included in this supplemental health care exhibit are not the exact numbers that will be utilized for rebate purposes due to possible revisions for claim reserve run-off subsequent to year end, statistical credibility concerns and other defined adjustments (Note: regulators will continue to consider the need for a reconciliation from the data in this supplemental exhibit to the data used for rebate purposes).

Comprehensive health care business as defined in the PHSA is written primarily by health entities, life and accident and health insurers, and to a lesser extent, property and casualty insurers and fraternal societies. The SHCE is filed by insurers on April 1st. The analyst should refer to the Annual Statement Instructions for specific guidance on reporting requirements.

MLR rebates required by the PHSA and various state laws should follow the guidance in Statement of Statutory Accounting Principles SSAP No. 66 – Retrospectively Rate Contracts. Beginning in 2011, MLR rebate disclosures are included as an inset to various liability lines of the annual statement and the Notes to the Financial Statement, Note #24 – Retrospectively Rated Contracts and Contracts Subject to Redetermination, disclosures include paid and incurred MLR rebates.

**State Insurance Department Analyst’s Roles and Considerations**

State’s responsibility regarding Analysis of Supplemental Health Care Exhibit Filings, Medical Loss Ratios, Rebates, and Other Confidential Filings

A state’s primary responsibility for analysis of the SHCE, MLRs, rebates and other filings generally focuses on financial solvency assessment; however as part of this overall assessment other responsibilities

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1 Federal Interim Final Regulation 45 CFR 158-120(d)(3)
2 Federal Interim Final Regulation 45 CFR 158.120(d)(4)
for analysts and benefits resulting from analysis performed may exist. For example, in some states
analysts may also be responsible for rate review.

Analysis of SHCE, MLR, rebates and other filings includes, but is not limited to:

- Analysis of the SHCE filings and other related filings should assess completeness and accuracy of
  the filings. (In some states, this may be performed by financial examiners.)
- Analysis should assess the financial solvency of the plan.
- Analysis should assess the impact of MLR requirements on the overall solvency of the health
  entity, including assessing if any solvency issues are the results of MLR requirements.
- Analysis may assess quality improvement expenses and/or trends for reasonableness.
- Analysis results may assist in facilitating the communication with staff responsible for rate
  review and market conduct, and assist in the analysis of rate filings.
- Analysis provides ongoing assessment of risks that should be communicated to the financial
  examiner.
- Analysis should assist in the subsequent review of the final MLR reporting.
- Analysis results may assist in facilitating communication with and reporting to HHS.

Special Considerations Based on the Type of Business Written

Health coverage will be issued on a guaranteed basis beginning Jan. 1, 2014. Many state high-risk pools
will be eliminated or significantly modified because of the ACA. People who were previously uninsurable
will be able to obtain coverage under the new law. ACA makes provisions to reduce the impact of the
 guaranteed issue requirement by:

- Requiring states to provide for reinsurance on high cost services for at least three years;
- Providing for risk-sharing between the health entity and the federal government through risk
  corridors similar to those used in the Medicare Part D program. The corridors will also be in place
  for three years.
- An ongoing risk adjustment mechanism to limit the risk of companies with a higher risk
  population.

The reinsurance and risk corridor allow health entities time to adjust their pricing strategy for changes in
the market as a result of ACA.

The small group line of business will have the risk adjustment mechanism noted above. There are no
such provisions for large group business because this line of business is typically experience-rated.

For group coverage written across multiple states, the allocation of premiums and claims should be based
on the situs of the contract, namely the jurisdiction in which the contract is issued or delivered as stated in
the contract. In the case of an employer with employees in more than one state, the experience of the
employer would be aggregated in the state where the contract was issued.

Where a group health plan involves health insurance coverage obtained from two affiliated issuers, one
providing in-network coverage only and the second providing out-of-network coverage only, solely for
the purpose of providing a group health plan that offers both in-network and out-of-network benefits,
experience may be treated as if it were all related to the contract provided by the in-network issuer.
However, if the issuer chooses this method of aggregation, it must apply it for a minimum of three MLR
reporting years.
Analysts should consider the allocations of premiums and claims between jurisdictions for reasonableness.

**Communication with Financial Examiners on Examiners’ Review of the Accuracy of Reporting**

Based on the results of the financial analysis, the analyst should communicate any areas of concern regarding the accuracy of reporting to the financial examiners. Analysts should also evaluate whether any issues were discovered by the financial examination staff with respect to the accuracy of the information reported on the exhibit or issues regarding a health entity’s allocation methodology. Such findings may affect the company’s rebate calculation. Analysts should determine the financial impact of the examination findings to factor into their analysis. (Refer also to the *Financial Condition Examiners Handbook*).

**Communication with Market Analysis Staff on Outstanding Issues Regarding Rate Review**

The ACA requires states to review unreasonable premium rate increases. The HHS will perform the review if a state lacks the authority to perform rate reviews. The ability of a health entity to raise rates may be hindered by the review process. Analysts in organizations that house the rate review function in a department separate from the analysis function should consult with the rate review staff as often as necessary to stay on top of any issues uncovered during the review of rates.

The results of the financial analysis process and the analyst’s concerns should be considered in the rate review process. The analysts should provide those responsible for the rate review a snapshot of the Company’s overall financial condition including, but not necessarily limited to, the following:

- Analysis of current year capital and surplus requirements; stability over the past three years; and percentage increase/decrease of capital and surplus between current and prior periods with a brief discussion of reasons for changes.
- Whether there have been capital infusions – changes in paid-in and contributed surplus.
- Whether there have been dividends paid to stockholders.
- Discussion about surplus notes, if applicable.
- Historical run out of the unpaid claim reserves. Does the company have a history of reserve deficiencies or redundancies?
- Risk-based capital (RBC).
- Minimum capital requirements and the company’s position in regard to the minimum to determine if the company is holding excess surplus.

**Discussion of Level 2 Annual Procedures**

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary (IPS) 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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors (board) and the effectiveness of management, including the code of conduct established by the board.

The procedures included in this section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The analyst may choose to perform these procedures in conjunction with other Level 2 Procedures, as applicable (e.g. III.D.5 Income Statement and Surplus).

Additional procedures, including prospective risk, are also available if the level of concern warrants further review as determined by the analyst.

Procedure #1 asks the analyst to determine if the SHCE and the Supplemental Health Care Exhibit’s Expense Allocation Report have been filed in accordance with the Annual Financial Statement Instructions. Refer to the Annual Financial Statement Instructions for details on reporting requirements for health entities in run-off or that only have assumed and no direct business, health entities meeting the Aggregate 2% Rule, and health entities that have no business that would be reported in the columns for Comprehensive Health Care, Mini-Med Plans and Expatriate Plans.

If the health entity’s SHCE was reviewed or is under review by examination staff, the analyst should contact the examiner-in-charge (EIC) to inquire about any material examination findings.

Procedure #2 assists the analyst in a review of the components of the Preliminary MLR.

The ACA requires health entities to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the MLR. The ACA requires health entities to spend at least 80% of premium for individual and small group policies or 85 percent of premium for large group policies on medical care, with review provisions imposing tighter limits on health insurance rate increases. When reviewing the results of the preliminary MLR, by state, by line of business, the analyst should be aware that individual states can and may require a higher MLR pursuant to state law. If the health entity fails to meet these standards, the health entity will be required to provide a rebate to policyholders starting in 2012 on premium earned in 2011. The purpose of the SHCE is to assist state and federal regulators in identifying and defining elements that make up the MLR as described in Section 2718(b) of the PHSA and for purposes of submitting a report to the HHS Secretary required by Section 2718(a) of the PHSA. During the review of the Preliminary MLR, the analyst should also consider how the individual state’s Preliminary MLR compares to the grand total. (Refer to the Financial Profile Report)

For some procedures, particularly in procedure #2 and procedure #3, it may be more useful to use the Preliminary MLR that is calculated by totaling the data from all SCHEs submitted by a company to the states where it has business. This national Preliminary MLR will reduce the impact of potential issues with statistical credibility of claims experience and allocation of various expenses over states and lines of business.

For lines of business in a given state with exposures of less than 1000 life-years looking at a 5-year trend is of very limited usefulness since in such cases, claims experience is not considered credible and is subject to greater variability. More than 1000 life years, the experience is considered credible, but still subject to large variations until exposures are well above 1000 life years.

The MLR will not be calculated in the traditional sense where medical expenses are simply divided by premiums. Premiums are adjusted for certain taxes and expenses. The numerator in the calculation will include health improvement expenses and fraud in addition to medical expenses.

The MLR calculated on the SHCE is a preliminary calculation and will not be used in determining rebates. Health entities will report information concerning rebate calculations directly to the HHS. The numbers that will be utilized for rebate purposes include revisions for claim reserve run-off subsequent to year end, statistical credibility concerns and other defined adjustments.


The state’s responsibility regarding the analysis of the SHCE relates to the financial solvency of the plan. The SHCE gives regulators pertinent information by state and by line of business in more detail than was available previously. A significant amount of detail is provided on health improvement and administrative expenses by line of business. The SHCE also includes an allocation report to assess the reasonableness of a company’s allocations by line of business and across expense categories. Detailed information on the nature of quality improvement expenses is provided for analyst consideration.

The analyst should review completeness or consistency validation exceptions on I-SITE that may indicate if the SHCE has not been prepared and submitted for each jurisdiction in which the company has written direct comprehensive major medical business in accordance with the Annual Statement Instructions.

The aggregation of data reported on the SHCE is by state, by market (individual, small group, large group) and by licensed entity. In other words, each health insurance issuer needs to meet the minimum loss ratio targets in each state, and market.

The NAIC I-SITE Financial Profile Report for the SHCE should be reviewed and significant fluctuations investigated. For example, how does the percentage change from the prior year in incurred claims (Line 2.1) compare to total incurred claims (line 5.0)?

The focal point for the financial analysis for all lines of business and line items should be on a per member per month (PMPM) basis. It may be difficult to identify where significant changes are occurring when analysis is not brought down to a PMPM level. For example, the percentage change in premiums, claims incurred or expenses may be significant. However membership levels may have also increased such that on a PMPM basis the change is not as significant. Similarly, if membership levels are dropping analysis on a PMPM basis may reveal significant increases in these items.

In addition, the analyst should ensure that the Supplemental filing was made providing a description of the methods utilized to allocate “Improving Healthcare Quality Expenses” to each state and to each line and column on the SHCE Part 3. When reviewing this Supplemental filing the analyst should consider whether the detailed descriptions of the Quality Improvement expenses were included and whether such descriptions conform to the definitions provided in the Annual Statement Instructions.

Procedure #2a. The national Preliminary MLR for a health entity is only one component that may be considered in the analysis of company solvency. Note, however that the Preliminary MLR is preliminary data and is not used for the final rebate calculation. Analyses of Preliminary MLRs for each state a company writes business in is potentially useful in assessing a company’s compliance and accuracy in computing Preliminary MLRs and ACA rebates. In a given state, if a line of business (individual, small group or large group) has less than 1000 life years of exposure, then the experience is not deemed credible and no rebate is calculated. In such cases, it is likely not useful to review Preliminary MLRs.

Procedures #2 and 3. Note that the preliminary MLR included in this supplemental health care exhibit (for any given state) is not the MLR that is used in calculating the Federal mandated rebates.

The MLR used in the rebate calculation (i.e. the ACA MLR) will differ for two reasons. First the ACA MLR will reflect the development of claims and claims reserves between Dec. 31 of the Statement Year and Mar. 31 of the following year. The second and far more important reason is that the ACA MLR includes a credibility adjustment that is based on the number of covered lives and certain benefit provisions of the coverages provided. The adjustment takes the form of an addition of percentage points to the calculated MLR. The ACA MLR is then used to determine if a rebate is due and to calculate the amount of the rebate. If the ACA MLR is greater than the relevant MLR standard no rebate is due. If the
ACA MLR is less than the relevant MLR standard the rebate is calculated by multiplying the difference between the ACA MLR and the standard MLR by earned premium. Except for very large blocks of business (75,000 lives or more), the ACA MLR will always be larger than the Preliminary MLR. Conversely, for very small blocks of business (under 1000 lives) the ACA MLR is not calculated since no rebate is due.

Despite the differences, the validity and reasonableness of the ACA MLR calculation, and therefore of the rebate calculation can be assessed using the data from the SHCE. The following elements from the SHCE and the rebate calculation can be used for such an assessment.

For the following items there should be little or no difference between the amounts in the SHCE and the rebate calculation.

- Earned premium.
- Federal and state taxes and licensing or regulatory fees.
- Expenses to improve health care quality.

For other items there are expected to be differences between the SHCE and the rebate calculation due to the difference in the time of reporting between the two.

- Paid claims, unpaid claim reserve, and incurred claims.
- Experience rating refunds and reserves for experience rating refunds.
- Change in contract reserves.
- Incurred medical pool incentives and bonuses.
- Net healthcare receivables.

For the Contingent Benefit Reserve, the expected relationship between the SHCE and the rebate calculation is unknown as yet.

Procedure #3 assists the analyst in reviewing the underwriting gain or loss by line of business and assessing the impact of each line to the health entity’s total operating results and financial solvency.

Procedure #4 assists the analyst in a review of the health entity’s rebate liability. (Also refer to the guidance above).

The analyst may consider performing a comparison of the components of the MLR as reported in the SHCE and the HHS Medical Loss Ratio Reporting Form to identify any material differences in line items. If, in the analyst’s judgment, any material differences require explanation, consider requesting such explanation from the health entity.

The MLR rebates are mandated by the PHSA to be returned to the policyholders if the ratio of medical losses and various other items paid to the ratio premiums paid (with various adjustments) is below specified thresholds (80 percent for individuals or small group employers or greater than 85 percent for large group employers, or a threshold established in state law).

As stated above, the analysts should be aware that the preliminary MLR is not the MLR to be used for federal rebate calculations and payment purposes. For example, for federal rebate purposes issuers that have blocks of business less than a given size can make a credibility adjustment to their MLR on the federal MLR reporting form. A credibility adjustment refers to the adjustment to account for random

statistical fluctuations in claims experience for smaller plans. Blocks of business with less than 1,000 life years are considered non-credible and will not be required to pay rebates in most cases. Blocks of business with greater than 1,000 but less than 75,000 life years may add a credibility adjustment to the calculated MLR. Blocks of business with greater than 75,000 life years are considered fully credible and cannot use a credibility adjustment. (Refer to the Federal Interim Final Rule 45 CFR 158.230, 158:231 and 158:232 for specific details of the credibility adjustment calculation.)

Procedure #5 assists the analyst in identifying any risks or concerns with recent rate reviews. As stated above, the rate review process may be performed by HHS or by the state department of insurance (DOI), depending on the states’ authority. The analyst should review any recent rate reviews performed (or if a different department, communicate with the rate review staff) and assess if any concerns exist. An analyst should also consider how the increase in the PMPM premiums compares with approved rate increases. Consider that there may have been different rate increases for different plans. Also consider the overall increase in premium PMPM for reasonableness compared to the approved rate increase.

In 2010, the NAIC adopted a form used to meet the requirements of Section 2794 of the PPACA that specifies health entities must provide justifications for any rate filing request that meets an "unreasonable" threshold. The form is not an endorsement of any definition of “unreasonable” that HHS may develop. The form does not apply to large group business.

The analyst should have a general understanding of the states’ rate regulation laws and practices. Currently, states have a number of ways to regulate rates. In the individual market, the majority of states rely on actuarially justified ratings, while some states rely on community ratings, adjusted community ratings and rating bands. In the small group market, rating bands are more prevalent, while a small number of states utilize community ratings and adjusted community ratings. Rating bands limit the variation in premiums attributable to health status and other characteristics. Community ratings prohibit the use of any case characteristics besides geography to vary premium. Adjusted community ratings prohibit the use of health status or claims experience in setting premiums. Actuarial justification requires the health entity to demonstrate a correlation between the case characteristics and the increased medical claims costs. The NAIC has adopted safe harbors for case characteristics commonly used for setting premiums without providing justification. For further guidance refer to the applicable state law or regulation.

Discussion of Level 2 Quarterly Procedures

Due to uncertainties created by the ACA, state insurance departments may perform Level 2 quarterly reviews in 2015 for all health entities. Insurance regulators should take special measures to identify carriers that have deteriorating solvency strength due to misestimating the market. The 2014 risks are likely to be as much or more liquidity risks as they are solvency risk.

The ACA imposes 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 Jan. 1, 2014. A health entity’s portion of the assessment is paid no later than Sept. 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. As such, 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.

A description of each of the programs is as follows:

**Risk Adjustment Program**

The risk adjustment program is a permanent risk-spreading program and is effective beginning in the 2014 benefit year. All risk adjustment covered plans are required to participate in the risk adjustment program. This includes all health plans in the individual or small group markets both on and off the exchange that are compliant with the ACA market reforms. Grandfathered plans and non-compliant plans that have been granted extensions are not subject to risk adjustment. Additionally, there is a carve-out for student plans.

The purpose of the risk adjustment program is to transfer funds from lower risk plans to higher risk plans within the same market in the same state in order to adjust premiums for adverse selection among carriers caused by membership shifts due to guarantee issue and community rating mandates.

States may set up their own risk-adjustment programs, or they may permit HHS to develop and manage this program in the state. HHS will determine a user fee. In states operating their own risk-adjustment program, the state will determine the fee.

**Program payments** – Each state shall assess health plan issuers if the actuarial risk score of all of their enrollees in a state is lower than the average risk score of all enrollees in full-insured plans in that state. Payments will be made to health plan issuers whose enrollees have an actuarial risk score that is greater than the average actuarial risk scores in that state.

**Program contributions** – An issuer that offers risk adjustment covered plans and that has a net balance of risk adjustment charges payable will be notified and payment to the state or HHS on behalf of the state will be required by June 30 of the calendar year following the benefit year. Payments will be computed based on the health insurer’s risk score versus the overall market risk score after applying adjustments. The reinsurance program is not considered in the computation.

**Program administration** – HHS intends to collect a user fee to support the administration of HHS-operated risk adjustment. This fee would apply to issuers of risk adjustment covered plans in states in which HHS is operating the risk adjustment program. HHS projects that the per capita risk adjustment user fee 2014 will approximate $1 per enrollee per year. HHS will invoice risk adjustment program charges and payments. The same terms will apply for the user fee.

**Timing of payments** – All payments made to issuers must be completely funded through the charges assessed to other issuers within the same market in the same state to ensure proper balancing between
payments and charges. Consequently, charges will be invoiced prior to processing issuer payments. Once all applicable charges are received by HHS or the state, funds will be redistributed to the higher risk plans. Each issuer will be notified of risk adjustment payments owed to, or charges owed by, the issuer by June 30 of the year following the benefit year to align the payments and charges processing. Charges owned by an issuer to HHS or the state must be remitted within 30 days of notification of the risk adjustment payments. Once all applicable charges are received by HHS or the state, funds will be redistributed to the higher risks.

The ACA risk-adjustment mechanism has several elements that may lead to increased uncertainty in an issuer’s reported financial statements, particularly with respect to 2014 financial reporting. These include the following:

- **Uncertainty as to the issuer’s risk score.** With the risk-adjustment mechanism being based on concurrent analysis, as of year-end, the issuer does not possess all of the data that ultimately will be relevant to calculating its own risk score.

- **Uncertainty as to other issuers’ risk score.** This is perhaps the largest uncertainty. Even if an issuer had perfect knowledge of its own aggregate risk score for a particular risk-adjustment cell, the ultimate payment it makes or receives for that cell is dependent not on its absolute aggregate risk score, but on the relative relationship between its aggregate risk score and those of all issuers participating in that risk-adjustment cell.

This uncertainty will be greater in 2014 than in subsequent periods because after 2014, carriers will have an understanding of what the aggregate risk score is for each risk-adjustment cell based on the prior year’s reported data.

- **Uncertainty as to member exposure.** There has always been some uncertainty as year-end around the issuer’s membership, due to premium grace period provisions that customers may exercise after year-end that keeps their coverage in force. However, the ACA could increase the uncertainty around estimating the issuer’s member exposure, since it requires that issuers extend the grace period from 30 days to 90 days for any member receiving a premium subsidy via the exchanges.

- **Granularity of the calculation.** The commercial risk-adjustment mechanism, as contrasted with the existing Medicare Advantage risk-adjustment mechanism, is not a single national calculation but rather a series of separate calculations for each risk-adjustment cell. Even an issuer operating in only one state likely will have no more than three risk-adjustment cells to evaluate, namely individual catastrophic, other individual, and small group.

- **Implications of data review.** Although the data supporting the risk scores is maintained by each issuer, the regulations call for a data validation review that could lead to payment adjustments. The current regulations are proposing that no payment adjustments be made in 2014 or 2015.

Regulations specify no interaction between the risk-adjustment mechanism and the reinsurance mechanism. The risk-adjustment mechanism will be settled prior to the risk corridors and the calculation of any minimum loss ratio liability. These other programs will not contribute to the uncertainty related to the risk-adjustment program.
Reinsurance Program

Transitional reinsurance is effective for plan years 2014 through 2016 as a temporary transitional reinsurance program.

Starting in 2014, issuers offering products in the individual market can no longer deny coverage based on pre-existing conditions. As a result, in 2014, the individual risk pool is expected to include a greater proportion of people with chronic conditions, resulting in increased incidence of large claims. The transitional reinsurance mechanism is designed to protect issuers in the individual market from this expected increase in large claims. The reinsurance protection is funded by assessments from the commercial health insurance market and from sponsors of self-funded health benefit plans.

All issuers of major medical commercial products and third-party administrators (TPAs) on behalf of uninsured group health plans are required to contribute funding at the national contribution rate to HHS. States establishing reinsurance programs may collect additional funding. Non-grandfathered individual plans are eligible to receive benefit program distributions via an excess-of-loss reinsurance system. Grandfathered plans are ineligible. All group plans are required to contribute funding, but they are not eligible to receive reinsurance program distributions.

This transitional reinsurance program provides funding to issuers in the individual market that incur high claims costs for enrollees. The program requires assessments from all issuers and TPAs on behalf of group health plans based on a per member annual fee established by HHS. The reinsurance assessment will fund reinsurance program distributions plus disbursements to the U.S. Department of the Treasury, in addition to covering administrative expenses of the program.

Program Contributions – The national contribution rate for all issuers and TPAs was established by HHS and is designed to collect more than $12.0 billion in 2014 to cover the required $10 billion in reinsurance payments, the $2.0 billion contribution to the U.S. Treasury, and additional amounts to cover the administrative costs of the federal and applicable reinsurance entities. States electing to operate their own reinsurance program have the option to increase the contribution rate to provide additional funding for reinsurance payments or to fund the administrative expenses of the applicable reinsurance entity. Contributions for the reinsurance program must fund reinsurance payments of $10.0 billion in 2014, $6.0 billion in 2015 and $4.0 billion in 2016, plus disbursements to the U.S. Treasury of $2.0 billion, $2.0 billion and $1.0 billion, respectively in those years, in addition to covering administrative expenses of the applicable reinsurance entity or HHS.

Program Payments – Reinsurance payments will be processed either by the applicable reinsurance entity or by HHS and will be made to issuers of non-grandfathered individual market plans for high claim costs of enrollees. Payments from the applicable reinsurance entity to insurers providing individual coverage will be calculated as a coinsurance rate multiplied by the eligible claims submitted for an individual enrollee’s covered benefits between an attachment point and the reinsurance cap for each benefit year. The coinsurance rate, attachment point and reinsurance cap are initially determined by HHS, but they may be modified by the state, if the state chooses to establish its own reinsurance program.

Program Administration – Each state is eligible to establish a reinsurance program, regardless of whether the state establishes a Marketplace Exchange. If a state establishes a reinsurance program, the state must enter into a contract with an applicable reinsurance entity or entities or establish a reinsurance entity to carry out the program. If a state does not elect to establish its own reinsurance program, HHS will administer the reinsurance program on behalf of that state. HHS has established that the administrative
portion of 2014 will be $0.11 per-member per-year, resulting in $20.3 million of administrative expense funding.

**Timing of Contributions/Payments** – Contributions to fund the program are made on an annual basis beginning Dec. 15, 2014. An insurer may submit claims for reimbursement when an enrollee of the reinsurance-eligible plans has met the applicable criteria as determined by either the state or HHS. Claims may be submitted through Apr. 30 of the year following the benefit year. HHS will distribute reinsurance payments among issuers nationally based on submitted claims. Issuers will be notified of pending reinsurance payment amounts by June 30 following the benefit year. If the requests for payments exceed actual contribution amounts, HHS will reduce reinsurers’ payments on a pro rata basis. In 2014, if the request for payments is less than actual contributions, reinsurance parameters would be adjusted to achieve full payout without a carryforward.

There are a number of aspects of the reinsurance program that can increase uncertainty and/or impair comparability in the 2014 financial statements for an issuer. These include the following:

- **Accrual for reinsurance on unpaid claims.** With respect to excess-of-loss reinsurance, many issuers historically have accrued for reinsurance receivables on specifically identified claims only. However, the magnitude of the expected ACA reinsurance benefit in relationship to premium will motivate issuers to consider estimating the potential reinsurance recovery on unpaid claims for which no specific information is available.

- **Magnitude of the reinsurance recovery accrual.** Since the regulations do not require interim settlements, an issuer will be recording an accrual at Dec. 31 for the full year’s reinsurance recovery.

- **Potential valuation allowance on reinsurance recoverable.** Since reinsurance benefits are limited to available funds in the reinsurance pool, there is potential for reinsurance benefits to be reduced due to availability of funds.

- **Potential for denied reinsurance claims.** The review process for reinsurance claims may lead to some denial of filed claims. Since this review process will not occur until after the year-end financial statements are filed, the issuer either will have to estimate a probability of claim denial or accept the possibility that future income could be affected adversely by any claim denial. Since there is no prior history for the ACA-specific reinsurance program, any estimates of the probability of a claim denial likely will vary significantly by issuers. Some issuers may conclude that they are unable to make such an estimate.

**Risk Corridors Program**

This program is effective for benefit years beginning in 2014 through 2016. The risk corridors program applies to qualified health plans (QHPs) in the individual and small group markets whether sold on or outside of an exchange.

The purpose of the risk corridors program is to provide limitations on issuer losses and gains for QHPs through additional protection against initial pricing risk. The risk corridors program creates a mechanism for sharing risk for allowable costs between the federal government and QHP issuers. The ACA establishes the risk corridors program as a federal program; consequently, HHS will operate the risk corridors program under federal rules without state variations. The risk corridors program is intended to protect against inaccurate rate setting in the early years of the exchanges by limiting the extent of issuer losses and gains. Although the ACA implies a level of governmental responsibility to fund the program,
current rules and statements from HHS indicate that the program will be budget-neutral, and HHS has further indicated that program rules will be changed as needed and program distributions delayed until the subsequent year in order to achieve budget neutrality. However, HHS has indicated it will make risk corridor payments regardless of budget neutrality, subject to sufficiency of funds appropriated.

The risk-corridor program was designed to provide some aggregate protection against variability for issuers in the individual and small-group markets during the period 2014 through 2016. In many cases, the risk corridor will lessen much of the potential volatility and uncertainty in ultimate earnings that may be driven by the other two premium stabilization programs.

The risk-corridor calculation is to be performed after considering any amounts transferred to or from the issuer as a result of the risk-adjustment or reinsurance programs. Although the risk-corridor mechanism provides protection against extreme bounds of experience, there is a substantial corridor in which all variance in experience directly affects the financial return to the insurer. In estimating the risk-corridor receivable or liability, it will be important that the insurer fully consider the expected impact of the risk-adjustment and reinsurance mechanism.

The final risk corridors settlement calculation will be communicated by HHS after the end of the benefit year and after premium and loss adjustments related to the reinsurance and risk adjustment programs have been determined.

Due to the uncertain future of health insurer solvency, it is recommended to consider the following procedures in reviewing insurers who write health insurance as they pertain to the ACA. The procedures are more in line with Level 2 procedures as they are presented in the Handbook as opposed to Level 1.

Procedure #1 recommends the analyst 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. This procedure also recommends 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 and assess Note 22 – Events Subsequent of the Notes to Financial Statement, Type II – Nonrecognized Subsequent Events, item C. Premium Written subject to ACA 9010 assessment. An insurer’s annual ACA fee is allocated to individual health insurers based on the ratio of the amount of the entity’s net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A fluctuation in premium would generally be an indication of a reason for concern.

In an instance of excessive growth not accompanied by additional surplus, the capital and surplus may not be able to support the additional exposure. Additionally, the health insurer may adjust reserves as a percentage of premiums, which can lead to additional risk.

In cases where the premium has significantly changed, the analyst should assess the level of business written by the health insurer by comparing premium and risk revenue to capital and surplus. This comparison should include premium and risk revenue recorded by the health insurer in its income statement since both sources of revenue represent exposure to the health insurer. This type of comparison is generally considered a measure of a health insurer’s operating leverage and is important in determining the potential losses to the health insurer. The higher the writings ratio, the more likely the health insurer will record a material loss when morbidity spikes.
Determine whether the health insurer is excessively leveraged due to the volume of premium written. The ratios of net premiums and risk revenue to capital and surplus measures the extent to which that capacity is being utilized and the adequacy of the health entity’s capital and surplus cushion to absorb losses due to pricing errors, adverse underwriting results and underestimating market conditions.

In assessing financial condition, considerable emphasis is placed on the adequacy of a health insurer’s capital and surplus. Capital and surplus provides protection for policyholders against adverse underwriting results, inadequate reserve levels and fluctuations in the value of assets. In addition, capital and surplus provides underwriting capacity and allows a health insurer to expand its business.

Procedure #2 assists the analyst to determine whether there are concerns regarding the insurer’s overall operating results and financial solvency. This procedure recommends the analyst review underwriting experience including the MLR and administrative expense ratios to identify those health entities that are experiencing difficulties in covering claims and administrative expenses based on current premium levels.

When premiums are not sufficient to cover all claims and administrative expenses, the health insurer 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.

With the uncertainty of the ACA health plan, premiums are more likely to be inadequate in situations where claims are difficult to predict.

The analyst should review Note 24 – Retrospectively Rated Contracts & Contracts Subject to Redetermination item D. disclosures of the amounts for MLR rebates required pursuant to the PHSA for the current reporting period year-to-date and prior reporting year including incurred rebates, amounts paid and unpaid liabilities.

A health entity’s administrative expense ratio is a moderate indicator of financial problems for most health entities. It is an indicator of how much of a health entity’s premium is expended on general expenses, and how efficient the health entity is in its operations. It also measures the cost of acquiring and maintaining business for a health entity.

High acquisition and administrative expenses in relation to premiums can indicate current or future profitability concerns. The administrative expense ratio not only includes administrative expenses but also claims adjustment expenses. Claims adjustment expenses are the costs incurred relating to reported and unreported claims and are considered to be administrative in nature.

Procedure #3 assists the analyst in determining whether a health entity has limited access to capital or has low liquidity levels. The analyst should address the parent or holding company’s ability to provide capital to the health insurer as needed.

This procedure also assists the analyst in determining a health insurer’s ability to meet its current obligations with its current cash and invested assets. A significant increase in the liabilities to liquid assets ratio could indicate the health insurer’s growing inability to satisfy its financial obligations without having to sell long-term investments.

On a quarterly basis, the analyst should review cash flow and liquidity ratios:

1. Are the liquid assets and receivables to current liabilities ratio less than 200 percent?
2. Is the ratio of working capital to total assets less than 30 percent?

3. Are affiliated investments and receivables greater than 20 percent of capital and surplus?

*Procedure #4* recommends reviewing quarterly estimates of health RBC based on quarterly financial information to identify deteriorating RBC levels.

The RBC formula is designed to calculate a minimum threshold measure of capital and surplus adequacy based on each health entity’s unique mix of asset risk, insurance risk, and business risk.

Since it is retrospective, the current annual RBC formula will not identify any negative result of these risks until the end of 2014. As such, the solvency of a company could be negatively affected by mispricing due to these factors.

*Procedure #4* directs the analyst to identify a health entity that may have deteriorating solvency strength due to misestimating the current year market. The procedure recommends that the analyst perform an RBC quarterly estimation based on underwriting and business risk. Underwriting risk represents the risk associated with unexpected fluctuation of incurred claims while business risk includes the risk associated with excessive growth levels of the health entity’s premiums. The analyst should use the Quarterly RBC Estimation tool within I-SITE. This procedure assists the analyst in determining whether the overall amount of total adjusted capital and surplus is adequate to support growth.

For the annual reporting period ending Dec. 31, 2013 and thereafter, an insurer subject to the ACA assessment will provide a disclosure in Note 22 – Subsequent Events of Notes to Financial of the annual financial statement of the assessment payable in the upcoming year and an estimate of its financial impact, including the impact on its RBC position as if it had occurred on the balance sheet date. Additionally, for annual reporting periods ending on or after Dec. 31, 2014, the disclosure has been expanded to include information on the amounts reflected in special surplus in the data year.

The disclosure provides information regarding the nature of the assessment estimated amount of the assessment payable for the upcoming year (current 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 based on net assessable premium.

The disclosure also provides the Total Adjusted Capital (TAC) and Authorized Control Level (ACL) before and after adjustment to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The disclosure also provides a statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

Additionally, on an annual basis, schedule XR012-A of the Health RBC blank has been added to the Underwriting Risk section for informational purposes only for 2014 reporting for health entities. This page will break out premiums, claims and the loss ratio by individual, small group and large group.

The purpose of this page is to break out premiums, claims and the loss ratio on a more granular level to allow regulators to analyze the impact of the ACA on an insurer. By breaking out the premiums, claims and loss ratio into individual, small group and large group, regulators will be able to better identify if the insurer has had a change in their writings through the individual or group markets and also analyze a company’s risk pool by the claims reported. This information provides regulators with the data needed to analyze and identify if separate risk charges should apply to individual, small group and large group plans in the future. This data will again only be for informational purposes at this time for 2014 reporting.
It should be noted that if the insurer is unable to complete the schedule, an explanation should be provided in the footnote as to why the health entity is unable to provide this additional information.

_Procedure #5_ recommends the analyst review Note 24 - Retrospectively Rated Contracts & Contracts Subject to Redetermination Item E. disclosures to assess the impact of the Risk Sharing Provisions of the Affordable Care Act on admitted assets, liabilities and revenue for the current year.
III. Annual Procedures – D.7. Level 2 Risk-Based Capital (Health)

1. Determine whether concerns exist regarding the health entity’s Risk-Based Capital (RBC) position.
   a. Review the Annual Financial Statement, Five-Year Historical Data Schedule, RBC Analysis and/or the RBC filing, and consider the following:
      i. Is the ratio of Total Adjusted Capital divided by Authorized Control (RBC Ratio) less than or equal to 250 percent?
      ii. If the current RBC ratio is less than or equal to 300 percent, has there been a significant change of +/-30 points in the RBC Ratio from the prior year?
      iii. Has the RBC Ratio declined each of the past two years? If “yes,” show the percentage point decline over the two years and the current year’s RBC Ratio.
      iv. Has the Total Adjusted Capital declined by 15 percent or greater from the prior year?
      v. Has the Authorized Control Level increased by 15 percent or greater from the prior year? If “yes,” review the five RBC risk factors for material changes from the prior year and document the leading underlying causes for the changes.

2. Did the health entity fail the RBC Trend Test? If yes, discuss the plans to address the RBC Trend Test failure.

3. If the health entity has triggered an action level RBC event and if authorized by statute:
   a. Obtain and review a copy of the health entity’s RBC Plan.
   b. Monitor the health entity’s RBC plan and overall progress in implementing plan initiatives and improving the RBC level.

Summary and Conclusion

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

Recommendations for further action, if any, based on the overall conclusion above:
- Contact the health entity seeking explanations or additional information
- Obtain the health entity’s business plan
- Require additional interim reporting from the health entity
- Refer concerns to examination section for targeted examination
- 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 ________

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Overview

Beginning with the 1998 Annual Financial Statement, health entities became subject to a new Annual Financial Statement requirement that they calculate and report an estimated level of capital needed for financial stability, depending upon the health entity’s risk profile, known as Risk Based Capital (RBC). The RBC ratio is defined as the ratio of Total Adjusted Capital divided by Authorized Control Level Risk-Based Capital. States that enact the Risk-Based Capital (RBC) for Health Organizations Model Act (#315) are required to take regulatory action when this ratio falls below specified levels. Historically, minimal capital requirements were imposed on health entities by various state laws. Those minimums frequently were arbitrary, generally low, varied widely from state to state, and generally did not consider the risk profile of the health entity. The RBC Model Act supplements the system of absolute minimums and considers the risk profile of each individual health entity.

The RBC formula and Model Act #315 were the result of several years of work by the American Academy of Actuaries, insurance regulators, and representatives of Health Maintenance Organizations (HMO) and other health entities. The formula is detailed and lengthy, but in concept is simple. There are five major categories of risk requirements: 1) asset risk-affiliates, 2) asset risk-other, 3) underwriting risk, 4) credit risk, and 5) business risk. A health entity’s RBC requirement is calculated by applying risk factors to various asset, premium, claims, and expense items, where the factor is higher for those items with greater underlying risk and lower for those items with lower underlying risk. Total RBC is then calculated using a “covariance” formula, which adjusts the total based on the fact that these risks are generally statistically independent of each other. If the RBC is distributed among the five categories rather than concentrated in one or two, then the total RBC is significantly less than the sum of the RBC calculated for each of the categories.

Historically, underwriting risk constitutes the largest portion of the aggregate RBC. One of the primary determinants of the underwriting risk is the managed care discount factor, which is based upon the type of managed care arrangements the health entity uses. The health entity’s asset size is also a major factor that impacts the RBC calculation. Although most HMOs do not carry significant asset risk, as the asset size becomes larger, the risks tend to increase. Generally, this has impacted Hospital, Medical, and Dental Service or Indemnity Corporations (HMDI) and larger HMOs the most.

The information in this overview should provide a sense of typical levels of RBC and the RBC ratio. Some entities are not typical, in which case this information will give a sense of how these entities differ from more typical entities.

Each risk category is summarized below.

1. **Asset Risk-Affiliates (H0)**

   This is the risk of default for certain affiliated investments. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the subsidiary’s statutory surplus, multiplied in either case by the percentage of the subsidiary owned by the health entity. There are 10 categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items are included in this risk component and include non-controlled assets, guarantees for affiliates, and contingent liabilities. Refer to the Affiliated Transactions section of the Handbook for more discussion on transactions with affiliates.
Generally HMOs have a low affiliated asset risk of less than 5 percent of the total RBC (before covariance); however, more complex health organizations, such as HMDIs, will carry higher affiliated asset risk between 14 percent and 20 percent of RBC (before covariance).

2. Asset Risk-Other (H1)

Asset risk attempts to measure the risk that a health entity’s assets will default or will decline in fair value. Each category of assets is assigned a factor that increases with the perceived riskiness of the asset. For example, high quality bond investments are assigned a low factor and non-investment grade bonds are assigned a high factor. Similar factors are assigned to other asset categories. An asset concentration factor adds RBC for holdings of a single issuer that represent a substantial proportion of the health entity’s assets. Refer to Analyst Reference Guide—Investments for more discussion on concentration of investments.

The Other Asset Risk component of RBC is usually low for HMOs, between 5 percent and 10 percent (before covariance), while HMDIs are generally higher, between 20 percent and 24 percent (before covariance). The difference between HMOs and HMDIs is reflected primarily in unaffiliated common stock with less than 2 percent for HMOs and up to 10 percent for many HMDIs. Fixed income and property & equipment can account for up to 4 percent of RBC for both HMOs and HMDIs.

3. Underwriting Risk (H2)

Underwriting risk represents the risk associated with the unexpected fluctuation of incurred claims, typically resulting from variations in such factors as mortality, morbidity, and persistency. The risk factors are applied to the previous year’s incurred claims or earned premiums for different categories of health insurance.

The factors are smaller for large volumes of business, because less fluctuation is expected than for small volumes. Similarly, the factors are reduced by a credit for managed care arrangements, which generally reduce the fluctuation of incurred claims relative to fee-for-service arrangements. Note: The factors are larger for coverage that can fluctuate more in claim experience, such as Comprehensive Medical, which can have individual claims of $1 million or more, compared to the smaller factors for less volatile coverage, such as Dental.

The underwriting risk calculation does not directly reflect the risk of under-pricing or other poor management decisions by the health entity, although these risks were implicitly reflected in the studies of needed capital on which the formula is based, to the extent they existed in the general population of health entities.

A minimum RBC requirement is applied for each category for small companies, equal to the dollar amount of two unusually large claims, which are assumed to be no less than $750,000 each. For companies that have purchased stop-loss reinsurance and are liable for less than $750,000 per claim, the minimum requirement is reduced to reflect their lower liability.

Refer to the Income Statement and Surplus and Health Reserves and Liabilities sections for more discussion.

As previously mentioned, net underwriting risk accounts for the largest percentage of RBC for both organization types. HMOs typically have a higher percentage of RBC in net underwriting risk, between 70 percent and 75 percent (before covariance), while HMDI’s have less net underwriting
risk, but still have between 45 percent and 55 percent of RBC (before covariance) in net underwriting risk.

4. **Credit Risk (H3)**

Health credit risk is the risk that health benefits (or other receivables) that are due from health care providers or other creditors will become an obligation of the health entity as a result of a default by the providers or other creditors. Refer to the Other Assets, TPAs, IPAs and MGAs, and Reinsurance sections for more discussion.

Health organizations typically have low credit risk, less than 7 percent of RBC (before covariance) for HMOs and less than 4 percent of RBC (before covariance) for HMDIs. The higher credit risk on HMOs tends to be driven by the risk with intermediaries.

5. **Business Risk (H4)**

Business risk includes the risk of loss on the health entity’s non-insurance business such as Administrative Services Only (ASO) agreements, and the risk associated with growth in the RBC that exceeds growth levels of the health entity’s premiums. Refer to the Risk Transfer Other Than Reinsurance section for further discussion of non-insurance business.

The business risk component of RBC is generally low for health organizations, between 7 percent and 13 percent (before covariance). HMOs typically have 7 percent or less in administrative expenses base and 5 percent or less in excessive growth risk. HMDI’s business risk is distributed somewhat differently, with 4 percent or less in administrative expenses base and 6 percent or less in non-underwritten and limited risk business.

The covariance formula is applied to the RBC results for the individual risk categories. Total Adjusted Capital is divided by Authorized Control Level Risk-Based Capital to arrive at the RBC ratio. The Model Act #315 then defines several action levels of RBC depending on the level of the ratio. The description of each level includes a brief summary of what happens if a health entity’s RBC ratio is below that level. For example, one of the levels is called the “company action level,” because a health entity must take action if its RBC ratio falls below that level. The various levels are related to one another by fixed percentages. The levels, which are the ratio of Total Adjusted Capital to Authorized Control Level Risk-Based Capital, are as follows:

- $\geq 300\%$  No Action Level
- $> 200\%$ to $< 300\%$  Trend Test Level
- $\geq 150\%$ to $< 200\%$  Company Action Level
- $> 100\%$ to $< 150\%$  Regulatory Action Level
- $\geq 70\%$ to $< 100\%$  Authorized Control Level
- $< 70\%$  Mandatory Control Level

Every health entity that does business in a state that has adopted the Model Act #315, regardless of the level in which it falls, is required to file an RBC report. For states that have adopted this Act, the Regulatory Action Level is also triggered when the health entity fails to file an RBC report by March 1st, unless the health entity has provided an explanation for such failure, which is satisfactory to the commissioner and has cured the failure within 10 days after March 1st. The report shows the calculation of the Total Adjusted Capital and the calculation of the RBC levels. A health entity that falls within or
below the trend test level and has a combined ratio greater than 105 percent may trigger an action level. A health entity whose Total Adjusted Capital is greater than or equal to 200 percent of the Authorized Control Level Risk-Based Capital is in the No Action Level. Other than filing the RBC report, no further action is required by the health entity.

A health entity whose Total Adjusted Capital is greater than or equal to 150 percent but less than 200 percent of the Authorized Control Level Risk-Based Capital is in the Company Action Level. That health entity must file an RBC plan with the domiciliary state. The plan must include proposals for corrective steps by the health entity. The Model Act provides that the plan is confidential. A health entity whose Total Adjusted Capital is greater than or equal to 100 percent but less than 150 percent of the Authorized Control Level Risk-Based Capital is in the Regulatory Action Level. The required actions by the insurance commissioner are to perform whatever examination of the health entity is deemed necessary and issue an order specifying the corrective steps to be taken by the health entity. A health entity whose Total Adjusted Capital is greater than or equal to 70 percent but less than 100 percent of the Authorized Control Level Risk-Based Capital is in the Authorized Control Level. The commissioner may seize the health entity if that step is deemed “to be in the best interests of the policyholders and creditors of the health entity and of the public.” A health entity whose Total Adjusted Capital is below 70 percent of the Authorized Control Level Risk-Based Capital is in the Mandatory Control Level. The commissioner must seize the health entity; however, that step may be forgone if there is “a reasonable expectation” that the circumstances causing the health entity to be in that level will be eliminated within 90 days.

Although most health entities fall into the “no action level,” the analyst should not assume that health entities that fall into this level are in strong financial condition. Health entities may be in weak condition but have not triggered one of the regulatory action levels. The RBC calculation utilizes risk components that have been established to focus on the areas of the health entity’s business that pose the highest risk to the health entity. These components and the risk factors used in the calculation of risk charges have been pre-established over time and are generally based on industry experience, statistical models or other data. While the impact of each risk component applies to all health entities using the formula, some health entities’ risk levels may differ from the industry. When reviewing the RBC report, the analyst should consider those areas where the health entity’s risk factors could be greater than the industry’s. The analyst should also consider items that could impact the health entity’s future capital and surplus levels when reviewing the RBC report. This type of review will allow the analyst to identify potential issues surrounding the health entity’s capital adequacy based upon factors not reflected in the calculation.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the health entity’s corporate governance, which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.

The procedures included in the Risk-Based Capital section of the Level 2 Annual Procedures are designed to identify potential areas of concern regarding RBC.
Procedure #1 assists the analyst in identifying whether the current RBC Ratio is near Company Action Level. Some examples that may cause the RBC Ratio to fall into an RBC Action Level include, but are not limited to, increased writings, heightened investment risk, catastrophic loss events, or an unexpected surplus decline. The procedure also identifies insurers with an RBC Ratio below 300 percent that have recorded significant increases or decreases from the prior year. Additionally, the procedure identifies insurers that have recorded RBC Ratio declines over two successive years. The procedure also identifies significant changes in the RBC Ratio components compared to the prior year. The analyst should document the leading underlying causes for the changes in the authorized control level and total adjusted capital.

Procedure #2 determines for the analyst whether the health entity failed the RBC Trend Test. A health entity that falls below an RBC Ratio of 300% (the Trend Test level) and has a combined ratio greater than 105 percent may trigger an action level.

Procedure #3a directs the analyst to obtain and review a copy of the health entity’s RBC plan. If applicable in your state, the analyst may participate in the review and approval process of the RBC plan. The RBC plan is a comprehensive financial plan which is described in the Model Act, and:

1) Identifies the conditions in the health entity that contribute to the Company Action Level event.
2) Contains proposals of corrective actions that the health entity intends to take and that would be expected to result in the elimination of the Company Action Level event.
3) Provides projections of the health entity’s financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component.
4) Identifies the key assumptions impacting the health entity’s projections and the sensitivity of the projections to the assumptions.
5) Identifies the quality of, and problems associated with, the health entity’s business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

The analyst reviewing the plan should take the following steps:
1) Verify the accuracy of all historical information provided.
2) Review the plan’s assumptions for reasonableness.
3) Estimate the impact of the proposed corrective actions on financial results and review the projected experience in the plan for reasonableness.
4) Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results.
5) Identify any internal or external problems not considered in the plan that may impact future financial results. Examples of such problems include the following: the existence of competitors to limit future sales levels, recent state legislation restricting the company’s product designs, or the loss of key marketing personnel.
6) If necessary, request a corrected plan addressing any issues identified in the analyst’s review.
Procedure #3b directs the analyst to monitor, on a periodic basis, the health entity’s progress in achieving the initiatives included in the RBC plan and the impact of those initiatives on the total adjusted capital and the risk factors in the authorized control level RBC. The goal of any RBC plan is the improvement of the underlying causes that led to an RBC Action Level, and an improvement in a subsequent RBC Ratio that will remove the health entity from Action Level status.
D.8. Level 2 Cash Flow and Liquidity (Health)

1. Determine whether concerns exist regarding the health entity’s overall level of liquidity.
   a. Is the ratio of total liabilities to liquid assets greater than 100 percent?
   b. Review changes in the total liabilities to liquid assets ratio in past years for unusual fluctuations or negative trends between years.
   c. Is the change in liquid assets greater than 75 percent or less than -15 percent?
   d. Is the liquid assets and receivables to current liabilities ratio (excluding non-investment grade bonds) less than 200 percent?
   e. Review changes in the liquid assets and receivables to current liabilities ratio in past years for unusual fluctuations or negative trends between years.
   f. Are affiliated investments and receivables greater than 20 percent of capital and surplus?
   g. Is the average number of days of unpaid claims greater than 30 days?
   h. Review changes in the average number of days of unpaid claims in past years for unusual fluctuations or negative trends between years.

Additional procedures and prospective risk considerations if further concerns exist:
   i. Describe any material commitments for capital expenditures as of the end of the reporting period indicating the purpose, source of funds, changes in equity and debt, and any off-balance sheet financing arrangements.
   j. Compare the health entity’s liability to liquid assets ratio or liquid assets and receivables to current liabilities ratio with industry and peer group averages in order to identify significant deviations.

2. Determine whether concerns exist regarding the health entity’s cash flow. Review Cash Flow.
   a. Is net cash from operations negative? If “yes”:
      i. Calculate the ratio of net cash from operations to capital and surplus.
      ii. Calculate the ratio of net cash from operations to premiums collected net of reinsurance.
      iii. Was the prior year net cash from operations negative?
   b. Review the trend in cash flow in past years for unusual fluctuations or negative trends between years.
   c. Is other cash provided greater than 10 percent of capital and surplus?
   d. Is other cash provided greater than 20 percent of net cash from operations?
   e. Review the trend in other cash provided in past years for unusual fluctuations such as significant reliance on other cash provided.
   f. Is the ratio of benefits and loss related payments to premiums collected net of reinsurance greater than 85 percent?

Additional procedures and prospective risk considerations if further concerns exist:
   g. Compare liability to liquid assets ratio or liquid assets & receivables to current liabilities ratio and cash flow from operations with industry and peer group averages in order to identify significant deviations.
III. Annual Procedures – D.8. Level 2 Cash Flow and Liquidity (Health)

3. Review the Z-Score Analysis included in the Financial Profile Report.
   a. Is the total Z-Score less than 2.6?
   b. If the total Z-Score is 6.0 or less in the current year, has the Z-Score decreased 1.5 or more points from the prior year?
   c. Review the trend of the Z-Score. If the Z-Score is 6.0 or less in the current year, has the Z-Score decreased 2.0 or more points over the past three years?
   d. Is the ratio of working capital to total assets less than 30 percent?
   e. Review the working capital to total assets ratio for past years and review any unusual fluctuations or negative trends between years.

4. Review other sources, including the Management’s Discussion and Analysis (MD&A) and the Asset Adequacy Analysis from the Statement of Actuarial Opinion (if required). Do concerns exist relating to cash flow and liquidity or asset adequacy?

5. Review Schedule E Part 3 and determine whether concerns exist regarding the health entity’s special deposits.
   a. Is the book adjusted carrying value of all other special deposits, (not for the benefit of all policyholders), greater than 50 percent of total special deposits?
   b. Is the difference between the book adjusted carrying value of total special deposits to the fair value of total deposits greater than 5 percent?

Additional procedures and prospective risk considerations if further concerns exist:
   c. Review the listing of special deposits held by the health entity not for the benefit of all policyholders and consider:
      i. The number of states in which the health entity has these types of deposits. The greater the number, the more difficult it may be for the domiciliary state to call on these deposits in rehabilitation.
      ii. The amount of concentration in any one particular state.
   d. Contact the domiciliary state or perform research to determine if any of the states have restrictions on the ability of those deposits to be called by the domiciliary state during rehabilitation.

Summary and Conclusion

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

Recommendations for further action, if any, based on the overall conclusion above:
- Contact the health entity seeking explanations or additional information
- Obtain the health entity’s business plan
- Require additional interim reporting from the health entity
- Refer concerns to examination section for targeted examination
III. Annual Procedures – D.8. Level 2 Cash Flow and Liquidity (Health)

- 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 ________
III. Quarterly Procedures – D.8. Level 2 Cash Flow and Liquidity (Health)

1. Determine whether concerns exist regarding the health entity’s overall level of liquidity.
   a. Is the change in liquid assets greater than 75 percent or less than -15 percent from the prior year-end?
   b. Are the liquid assets and receivables to current liabilities ratio less than 200 percent?
   c. Is the ratio of working capital to total assets less than 30 percent?
   d. Are affiliated investments and receivables greater than 20 percent of capital and surplus?

2. Determine whether concerns exist regarding the health entity’s cash flow. Review the Cash Flow page for the current quarter and prior year quarter.
   a. Is net cash from operations negative?
   b. Does the decline in net cash from operations from the prior year to date exceed 5 percent of capital and surplus?
   c. Is the ratio of benefits and loss related to payments to premiums collected net of reinsurance greater than 85 percent?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

Cash Flow is one of several core financial statements presented in the Annual Financial Statement of every health entity. It provides information about the primary sources of cash (inflow) and applications of cash (outflow). Cash Flow is organized to readily identify the net cash flow from operations separately from the net cash flow from investments and financing. Sources and applications of cash within financing are shown, such as dividends to stockholders and borrowed money received. The net change in cash and short-term investments as reflected on the Statement of Cash Flow reconciles to the change in the balance sheet accounts of cash and short-term investments for the year.

While Cash Flow provides information about historical sources and applications of cash, the analyst should analyze the liquidity of the balance sheet in order to evaluate the health entity’s ability to fund policyholder benefits and other demands for cash in the future. There are several procedures that an analyst can perform to measure a health entity’s liquidity. One of the most common ways of accomplishing this is to compare the total liabilities of the health entity to its total liquid assets available to fund those liabilities. Variations of this comparison focus on which assets are available to fund the liabilities.

There are a number of situations that can elevate the risk of a negative impact on a health entity’s cash flow and liquidity including the credit risk of receivables, the level of borrowed money and other liabilities, and dividends to shareholders. For example, if a health entity relies heavily on risk transfer arrangements with provider groups and the parties involved in the arrangements are unable to meet their obligations, the collectability of those obligations could negatively impact the liquidity of the health entity. Credit risk is a concern for other receivables as well, including amounts due from affiliates and reinsurance receivables. An analyst should be aware of the domiciliary state’s requirements for downstream risks such as provider groups and reinsurance. Other situations involve significant increases in liabilities such as unpaid claim reserves or borrowed money, which can increase the health entity’s short-term cash requirements. Additional cash would also be needed in order for the health entity to pay dividends to a parent company or other shareholder.

Health entities have a shorter benefit payout period than other insurers, and consequently understanding the need for liquidity is an important issue for management. Because a health entity writes short-tail business, it will generally have a shorter average maturity on its bonds and hold more cash and short-term investments than other insurers. The key liquidity risks to a health entity include substantial decline in enrollment and also include underpricing and spikes in claims. If this were to occur, the entity’s cash outflows for claims payments would exceed its inflows from newly received premiums. However, a health entity with a relatively stable enrollment and claims experience within expectations may feel it can safely accept some durational mismatch between its assets and liabilities, and may invest in more long-term invested assets in order to increase its investment yield. Those health entities writing long-tailed business may also own long-term invested assets to support those lines’ liabilities.

Discussion of Level 2 Annual Procedures

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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board.
The procedures included in the cash flow and liquidity section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. One concern relates to the liquidity of the health entity’s balance sheet in terms of its ability to fund future liabilities. Other concerns relate to situations where negative cash flows from operations are being generated or where cash outflows from certain types of non-operating activities are significant. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.

Procedure #1 assists the analyst in evaluating the health entity’s overall balance sheet liquidity. The primary method of accomplishing this is to compare the health entity’s liabilities with its liquid assets available to fund such liabilities in the future. However, as previously mentioned, various other comparisons can be used to help assess liquidity or potential liquidity concerns. Liquid assets in this calculation include all bonds but exclude affiliated investments.

Procedures #1a and 1b assist the analyst in determining a health entity’s ability to pay maturing obligations with cash and invested assets. A significant increase in the liabilities to liquid assets ratio could indicate the health entity’s growing inability to satisfy its financial obligations without having to sell long-term investments. Liquid assets in this calculation include all bonds but exclude affiliated investments.

Procedure #1c alerts the analyst to fluctuations in total liquid assets. A significant increase in total liquid assets could indicate that the health entity has been unable to collect on receivables. If the change is significant, an analyst may consider a more detailed review of the change in the asset mix from the prior period to determine the cause of the fluctuation.

Procedures #1d and 1e measures the health entity’s ability to pay current obligations with current assets including marketable securities. Results of less than 200 percent may not pose a serious threat to the health entity if it has access to other assets that can be liquidated. This ratio excludes non-investment grade bonds and affiliated investments but includes certain receivables not included in the two procedures above.

Procedure #1f measures the extent to which capital and surplus relies on assets that are due from affiliated entities. Affiliated investments are often illiquid. Excessive affiliated investments and receivables may indicate the health entity has invested heavily in affiliated stock and bonds instead of cash or short-term investments and may also indicate an affiliate’s inability to pay current amounts due. The analyst may consider reviewing and understanding the financial statement of the affiliate. Refer to the Affiliated Transactions section for more guidance on affiliated transactions.

Procedures #1g and 1h measures a health entity’s average number of days of unpaid claims. When the time it takes to pay claims lengthens, the liability for unpaid claims generally increases. An analyst should consider also reviewing the health entity’s liability for unpaid claims balances, since an understatement of these liabilities could overstate the results of procedures 1a, 1c and 1d. An increase in current liabilities increases the health entity’s current cash requirements. A longer claims payment period could indicate the health entity is holding cash for other purposes.

Procedures #2a and 2b assists the analyst in identifying situations where the health entity’s operations are generating negative cash flow, or the potential for future negative cash flows. Cash outflows from operations can result in decreases in the overall liquidity of the health entity. If a health entity already maintains low liquidity, cash outflows from operations can have significant implications. It is important for the analyst to focus on specific components of the health entity’s operations to determine what is causing the cash outflows.
Procedures #2c, 2d and 2e compare the relationship of other cash provided from financing to capital and surplus and cash from operations. Since other cash provided (applied) contains miscellaneous changes in assets and liabilities, it may be difficult for an analyst to determine the true source of this cash flow item.

Procedure #2f assists the analyst in determining the impact of benefit payments on cash flow. Changes in liabilities for unpaid claims reserves are included in the medical loss ratio however, by calculating the benefits to premiums ratio from the cash flow statement, the analyst may be able to determine if the loss ratio matches the health entity’s benefit payment ratios. The analyst should be aware however that variations in this ratio can occur due to the changes in the health entity’s volume of business resulting from the lag between claim incurral and claim payment. For example, if the volume of business is declining, this ratio will typically be higher than the medical loss ratio. If the volume of business is increasing, this ratio will typically be lower than the medical loss ratio.

Procedure #2g offers the analyst an additional procedure to assess how the health entity’s liquidity results compare to industry averages (some ratios included in the Financial Profile) and peer companies that have similar business mix and asset composition.

Procedure #3 requires the analyst to review the Z-Score analysis included in the Annual Financial Profile. The Z-Score is a way to measure and monitor financial performance by analyzing specific ratios over a period of time. If a result of less than 2.6 occurs, the analyst should consider reviewing the individual ratios within the Z-Score. An unstable trend of the Z-Score or a low Z-Score may indicate increased risk to the solvency of the health entity and the analyst should take a closer look at each of the ratio results in the Financial Profile. There are four ratios in the Z-Score; however, the Z-Score places the most emphasis on working capital and earnings. The following briefly explains each ratio within the Z-Score, although more detail is available in the link to the Z-Score Document on I-SITE.

- Working Capital to Total Assets measures the ability of a health entity to manage working capital, which is fundamental for all business. While a health entity may have sufficient surplus, they may have insufficient working capital to pay claims due to related party transactions and other non-liquid long-term investments. Analysts should also consider that while working capital may be above the threshold, it may still not provide a sufficient cushion for significant unexpected losses. Refer to the discussion of procedure #1d above.

- Retained Equity to Total Assets reflects the age of the business and the philosophy of management. This assumes that a more mature business would normally have more capital and surplus. Companies that have been in business fewer years and have insufficient management experience tend to have higher failure rates.

- Earnings Before Interest & Taxes (EBIT) to Total Assets measures a health entity’s earnings performance. This ratio is weighted the highest for several reasons including the following: 1) significant shifts in earnings may indicate a highly risky industry with unstable cash flows, 2) health entities must balance consumer demands with cost management, and 3) Medicare & Medicaid programs and other outside factors can have a significant impact on the health entity’s financial condition.

- Capital and Surplus to Total Liabilities is the leverage measure within the Z-Score and is the inverse of the traditional debt to equity ratio.

Procedure #4 requires the analyst to review cash flow and liquidity information, which may be found in sources available to the analyst, such as the Management Discussion & Analysis and the asset adequacy analysis in the Statement of Actuarial Opinion. The analyst should determine if any information disclosed

in these filings cause concern regarding cash flow and liquidity. An asset adequacy analysis is generally not required for a health entity; however, for companies filing the health blank that also write life business, this may be required. Refer to the Actuarial Opinion section, for more discussion on asset adequacy analysis.

Procedure #5 assists the analyst in determining if the health entity is exposed to greater than normal liquidity risk with respect to special deposits. Special deposits are segregated into two sections, “for the benefit of all policyholders” and “not for the benefit of all policyholders.” Deposits for the benefit of all policyholders are deposits held by individual states but are aggregated on one summary line. Deposits not held for the benefit of all policyholders must be itemized by security. The assets comprising these deposits are held on the various investment schedules in the financial statement. However, the assets are not held in custody of the health entity and restrictions are placed on their disposal. In a situation of a rehabilitating or troubled health entity, these restrictions on assets may cause concerns, particularly those not held for the benefit of all policyholders.

Additional steps the analyst may perform are intended to assist the analyst in determining if the domiciliary state may have difficulty in calling deposits which are deemed “not for the benefit of all policyholders.” These procedures specifically apply when the level of deposits not for the benefit of all policyholders as a percentage of total assets is high or in cases when the health entity has been determined to be troubled. The analyst may consider this assessment necessary in either of those cases because once the health entity is moved into rehabilitation, the cash flow position of the health entity may deteriorate rapidly.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Cash Flow and Liquidity are intended to identify significant changes in cash flow and liquidity that have occurred since the prior year Annual Financial Statement, or the prior Quarterly Financial Statement.
III. Annual Procedures – D.9. Level 2 Risk Transfer Other Than Reinsurance (Health)

1. Determine if uninsured volume or receivables is material.
   a. Review Note #18 Parts A and Part B and compare the ratio of ASO/ASC claim payments to total hospital and medical expenses plus ASO/ASC claim payments. Is the ratio greater than 10 percent?
   b. Review Underwriting and Investment Exhibit Part 3 and compare the ratio of reimbursements from uninsured plans to total expenses plus reimbursements from uninsured plans. Is the ratio greater than 25 percent?
   c. Are uninsured receivables relating to uninsured accident and health plans greater than 5 percent of capital and surplus?
   d. Has the uninsured receivable relating to uninsured accident and health plans increased or decreased by greater than 20 percent since last year-end?
   e. Does the health entity report any non-admitted uninsured receivables relating to uninsured accident and health plans?

Additional procedures and prospective risk considerations if further concerns exist:
   f. Request a listing of plans administered by the health entity.
   g. Request an aging schedule of receivables related to uninsured plans.
   h. Evaluate the adequacy of funds held for the plans’ claims and expenses.
   i. Evaluate the financial condition of the uninsured plans.
   j. Request a copy of the I.D. card used by members covered under ASO and ASC arrangements to determine potential exposure to financial risk and compliance penalties.
   k. Has the health entity reported ASO and/or ASC amounts in its Risk–Based Capital (RBC) filing (worksheet XR018) and not reported receivables or assets related to uninsured accident and health plans on its Annual Financial Statement?
   l. Has the health entity reported receivables or assets related to uninsured accident and health plans on its Annual Financial Statement and not reported ASO and/or ASC amounts in its RBC filing?
   m. Does the analyst believe that the asset receivables relating to uninsured accident and health plans on page 2 of the Annual or Quarterly Financial Statement have been netted against the liability on page 3 for amounts held under uninsured accident and health plans? One indication that these amounts have been netted would be if there was an uninsured receivable relating to uninsured accident and health plans (Page 2, Column 3, Line 15) without a Liability for amounts held under uninsured accident and health plans (Page 3, Column 3, Line 20) or vice versa.
   n. If ASO and/or ASC contracts are indicated, have the Notes to Financial Statements failed to be completed with regard to the profitability to the health entity of uninsured accident and health plans and the uninsured portion of partially insured plans for which the health entity serves as an Administrative Services Only (ASO) or an Administrative Services Contract (ASC) plan administrator?
   o. Have disclosures been made in the Notes to Financial Statements regarding the possible uncollectability of amounts receivable under uninsured plans?
III. Annual Procedures – D.9. Level 2 Risk Transfer Other Than Reinsurance (Health)

2. Determine if experience rating arrangements are significant.
   a. Compare reserve for rate credits or experience rating refunds in Underwriting and Investment Exhibit Part 2D, Line 4 to total hospital and medical expenses. Does the health entity report reserve for rate credits or experience rating refunds?
   b. Compare amounts due from experience rating arrangements from the write-in for other than invested assets to total hospital and medical expenses. Does the health entity report amounts due from experience rating arrangements?

Additional procedures and prospective risk considerations if further concerns exist:
   c. Determine whether the health entity has reported appropriate reserves. Has a premium stabilization reserve been included in the reserve for rate credits or experience rating refunds on Part 2D of the Underwriting and Investment Exhibit line 4 in the Annual Financial Statement?

3. Determine if capitation payments are material or their distribution is a problem.
   a. Compare total capitation payments to intermediaries from Exhibit 7, Part 1 to total hospital and medical expenses. Is the ratio greater than 10 percent?
   b. Is the ratio of net health care receivables to capital and surplus greater than 8 percent?
   c. Based on capitation payments to total payments, is the percentage of members covered by capitated arrangements greater than 50 percent?

Additional procedures and prospective risk considerations if further concerns exist:
   d. Has the health entity failed to complete Exhibit 7, Part 1 – Summary of Transactions with Providers?
   e. Does the health entity have capitation arrangements with providers?
      i. Has the health entity failed to file copies of provider agreements, if required, with the domiciliary commissioner?
      ii. If the health entity has capitation arrangements with providers did it fail to enter the appropriate information in the RBC filing (worksheet XR015)?
   f. Determine if capitation to groups or intermediaries reported in Exhibit 7 is actually disbursed or withheld by the health entity for future payment of claims as they are submitted.
   g. Determine if the health entity pays or processes claims for the participating providers of a capitated intermediary.
   h. Request the most recent independent audited report of the intermediary (TPA or IPA). If not available, request the most recent annual report.
   i. Obtain the opinion of an actuary attesting to the adequacy of claim reserves and claim adjustment expenses established for claims incurred and outstanding on business produced by the intermediaries, if available.
   j. Review analyst notes or exam reports for the other companies using the same intermediaries if there is reason to believe problems exist with those entities.
III. Annual Procedures – D.9. Level 2 Risk Transfer Other Than Reinsurance (Health)

k. Did the health entity fail to complete General Interrogatory Part 2 – Health Interrogatories in the Annual Financial Statement?
   i. Does the health entity have bonus/withhold arrangements with providers?
   ii. If the health entity has bonus/withhold arrangements with providers did it fail to enter the appropriate information in the RBC filing?

4. Determine if special payment arrangements with providers are material.
   a. Compare total bonus/withhold arrangement payments to total hospital and medical benefits. Is the ratio greater than 20 percent?
   b. Compare pool/withhold arrangement payments to total bonus/withhold accrual. Is the ratio greater than 100 percent?
   c. Did the health entity report bonus/withhold payments and prior year underwriting losses?

Additional procedures and prospective risk considerations if further concerns exist:

d. Determine if risk transfer arrangements with providers have had a negative impact on utilization. Review the Exhibit of Premiums, Enrollment, and Utilization in the Annual Financial Statement and compare to prior years. Has utilization compared to membership increased?

e. Has the health entity failed to comply with state-specific laws, regulations, or guidelines regarding arrangements for risk transfer other than reinsurance?

f. Request a listing of provider groups contracting with the health entity.

g. Review the Statement of Actuarial Opinion to determine if capitation arrangements were reviewed.

h. Review the Statement of Actuarial Opinion to determine if the financial strength of contracting provider groups was reviewed.

i. Evaluate the financial condition of the largest contracting provider groups.

j. Review bonus/withhold provisions of the provider contracts.

k. Obtain detailed calculation of direct bonus and withhold payments, and accruals and those covering capitated arrangements.

l. Evaluate the appropriateness of withhold distributions or bonus payments made to providers relative to contract provisions and the health entity’s underwriting results.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding risk transfer other than reinsurance. 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 health entity’s risk transfer other than reinsurance under the specific circumstances involved.

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

- Contact the health entity seeking explanations or additional information
III. Annual Procedures – D.9. Level 2 Risk Transfer Other Than Reinsurance (Health)

- Require additional interim reporting from the health entity
- Speak to the opining actuary to determine if there were any concerns with provider contracts or financial strength
- 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 ________

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III. Quarterly Procedures – D.9. Level 2 Risk Transfer Other Than Reinsurance (Health)

1. Determine if uninsured volume or receivables is material.
   a. Are uninsured plan receivables +/-10 percent of capital and surplus?
   b. Has the uninsured receivables relating to uninsured accident and health plans increased or decreased by greater than 20 percent since last year-end?
   c. Does the health entity report any nonadmitted uninsured receivables relating to uninsured accident and health plans?
   d. If the health entity reported liabilities on page 3 of the quarterly statement for uninsured accident and health plans has the amount changed by greater than +/-25 percent from the prior year-end?
   e. If the health entity reported any nonadmitted balances in uninsured plan receivables, has the amount changed by greater than +/-25 percent from the prior year-end?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding risk transfer other than reinsurance. 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 health entity’s risk transfer other than reinsurance under the specific circumstances involved.

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Overview

Risk to health entities comes primarily from underwriting risk, which is the risk that health care costs are higher than those anticipated in premium rate development. Health care costs can be higher than anticipated because of higher than forecasted cost per service or because of a higher level of utilization of those services. Any methodology that controls the cost or utilization of services decreases the risk of misestimating health care costs. Arrangements that control costs of services may not be as effective in reducing risk, if providers increase utilization to make up for lower costs. For example, controlling the cost of a day in the hospital by contracting for fixed per diems is not effective if lengths of stay increase. Contracting for reduced inpatient care cost or changing benefit designs to reduce the use of inpatient care is not effective if providers shift to outpatient facilities and increase the cost of outpatient care.

Health entities use many types of risk transfer arrangements with outside entities to help control costs. Risk can be transferred to:

- Reinsurers
- Groups
- Insured members
- Providers/provider intermediaries

The risk transfer to reinsurers is discussed in the Reinsurance section.

Risk can be retained by the employer, trade association or other groups using administrative services only (ASO) or administrative service contract (ASC) self-insurance arrangements. In both arrangements, the group bears the underwriting risk that claim payments will exceed a predetermined level, except for any risk that is reinsured through stop-loss contracts, while the health entity bears the business risk in administration. The difference between ASO and ASC arrangements is the amount of business risk that the health entity has if the group becomes insolvent. In ASO arrangements, the health entity is exposed to minimal business risk, but with ASC arrangements, one or more possible situations may result in the health entity being exposed to the business risk for claims, if the group does not pay the claims that it is contractually obligated to pay. First, identification cards given to the member are often indistinguishable from insured member cards. (This may also be the case with ASO arrangements, which would increase their business risk.) This can create an impression on the part of the provider or member that the health entity is responsible for the claims and result in litigation. Very few group members are aware or understand that their insurance is actually self-insurance by their employer or association group and is not the responsibility of the health entity indicated on their insurance card. Second, in ASC arrangements where the health entity pays claims first and then bills the group or uses electronic funds transfer to be reimbursed for claims, they may have difficulty obtaining reimbursement if the group becomes insolvent. In addition, such risk can exist for both ASO and ASC contracts for claims in the course of settlement or claims incurred but not reported. Statutory accounting was changed under Codification to require premium income and claims expense for self-insured plans to be excluded from revenues and expenses, but rather to be included as a component of administrative expenses. SSAP No. 47, Uninsured Plans, describes the accounting for ASO and ASC arrangements. ASO and ASC administrative expenses and ASC medical expenses are included in worksheet XR019 of the Risk-Based Capital (RBC) filing.

Minimum premium arrangements, which are hybrids between insured and self-insured plans, can be used to transfer claim cost risk to groups using an alternative funding mechanism. In these arrangements, a fund is established (e.g., a bank account) and used by the health entity for the purpose of paying claims, up to a pre-determined level (stop-loss threshold). These claims are self-insured and the associated

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funding is excluded from premium revenue. In addition, the policyholder remits a minimum premium to
the health entity to cover claims in excess of the stop-loss threshold. This portion of the policyholder
payment is considered premium revenue to the health entity. Typically, there are two types of stop-loss
provisions attached to this arrangement to control the claim cost risk for the policyholder. Individual
specific stop-loss limits the risk of the policyholder to a pre-determined amount per covered individual or
claim, (e.g., $50,000) and an aggregate stop-loss cover limits the risk of the policyholder to a pre-
determined amount on an overall basis for all claims, (e.g., 120 percent of expected paid claims). The
minimum premium remitted to the health entity covers claims in excess of the stop-loss threshold, both
individual and aggregate, and for the administrative expenses of the policy. The amounts remitted in the
deposit fund vary according to the pre-determined amounts in the individual and aggregate stop-loss
provisions, and the benefit provisions of the underlying medical care plan. If claims experience is more
favorable than expected, the policyholder may reduce its payments to the deposit fund. Unused amounts
in the deposit fund at the end of the policy year revert to the policyholder.

An advantage of these arrangements to the policyholder is that they reduce the up-front cash flow in its
first year of operation, as there is no reserve funding required for self-insured claims below the stop-loss
threshold. Another advantage is that premium tax is usually not paid in the amounts paid into the deposit
funds. At cancellation of this arrangement, the policy may call for the payment by the policyholder to the
health entity of a supplemental premium for the handling of the claims incurred and not yet paid.

Another experience rating arrangement, which transfers some risk to the policyholder, is called the
Retrospective Premium Arrangement. Under such arrangement, health entity and policyholder agree to set
premiums at a lower level than determined by the health entity, (e.g., 80 percent level, with a provision
that an additional retrospective premium may be required, up to the 100 percent level, if claims
experience is unfavorable). An individual stop-loss arrangement is typically included in these plans, so as
to control the claim cost risk for the policy. These arrangements typically arise when there is some
disagreement between the health entity and the policyholder on the magnitude of a premium rate increase.
Agreement is reached on a lower level of premiums, with an arrangement for a potential retrospective
premium if required. These arrangements also can incorporate a premium stabilization reserve where
margins arising from favorable claims experience is deposited and which may be used to pay the
additional retrospective premium when claims experience is unfavorable. A premium stabilization reserve
reduces the health entity’s risk of having to absorb experience deficits in addition to rate increases.

One advantage to the policyholder of these arrangements is that they reduce the up-front cash flow as
premiums are remitted at a reduced level during the policy year. One disadvantage to the health entity is
that it may be difficult to collect the retrospective premium, if required, at the end of the policy year,
possibly leading to questions by the policyholder as to the size of the claim reserves established by the
health entity. Once a retrospective premium is billed, any amounts due more than 90 days after the due
date is treated as a non-admitted asset. At any time, if it is probable that the additional retrospective
premium is uncollectable, it must be written-off against operations in the period such a determination is
made. At termination, any fund remaining in the premium stabilization reserve is refunded to the
policyholder. However, the health entity will normally hold the rate stabilization reserve for a one-year
runoff period, before refunding the balance.

A modification to the retrospective premium arrangement is where the full 100 percent premium is billed
during the policy year, with margins arising from favorable claims experience being deposited in the
premium stabilization reserve, or remitted to the policyholder. Deficits arising from unfavorable claims
experience may be recouped from available funds in the premium stabilization reserves. Unrecouped
deficits are carried forward to the next policy year, and may be recouped from future years’ favorable
claims experience. The health entity is not totally protected from unfavorable claims experience, as the
policyholder may move the policy to another health entity, leaving the prior health entity with an unrecouped deficit. At termination, any fund remaining in the premium stabilization reserve is refunded to the policyholder after a one-year runoff period as described above.

Premium stabilization reserves are included in the reserve for rate credits or experience rating refunds on Underwriting and Investment Exhibit Part 2D line 4, with a corresponding entry to premiums. Accounting guidance for retrospectively rated contracts with return of premium provisions can be found in SSAP No. 66, *Retrospectively Rated Contracts*.

Risk transfer to insured members is accomplished through the use of deductibles, coinsurance, and co-payments (copays), which transfers some of the risk of increased cost and utilization to members. The analyst should see Section D for more information on other risk-transfer techniques that do not explicitly appear in the financial statements.

Although providers are more resistant to taking risk from health entities, there are still many types of arrangements found that transfer risk from health entities to providers. Capitation is the most common method of transferring risk. There are several types of arrangements that fall under the term capitation:

- Paid on a PMPM or percent of premium basis to a provider or provider group that covers only the services of that provider or group.
- Paid on a PMPM or percent of premium basis directly to a provider intermediary such as an Independent Practice Association (IPA) or provider group covering only the services of the providers that have a contract with the intermediary (participating providers or provider network) or provider group.
- Paid on a PMPM or percent of premium basis, covering the services of participating providers and the services of other providers (e.g., specialists and inpatient facilities).

Monthly capitations are paid for all members enrolled with the provider intermediary. Capitations can be deposited to a separate bank account that the provider intermediary then writes checks against to pay for provider services. Capitations can also be accounted for internally by the health entity, but not actually paid; rather a deduction is made from the internal account when claims are paid to providers contracting with the provider intermediary for enrolled member services. See the TPA, IPA, and MGA section for more detail on payment arrangements.

Other arrangements include withholds, bonuses and special payment arrangements. Bonus and withhold arrangements can be structured to take the risk off the provider when there is a capitation arrangement. The amount paid in bonuses and withholds associated with capitations is not included on Exhibit 7. Withholds and bonuses are discussed in the Other Provider Liabilities section.

If capitation arrangements are significant, the analyst may consider getting more information on the structure of the capitation contract and if there are any associated bonuses and withholds. In the Annual Financial Statement, capitations are broken out in Exhibit 7 – Part 1, Summary of Transactions with Providers. Since intermediaries do not provide services directly, they may be more vulnerable to financial problems if the demand for medical services is higher than anticipated. Intermediaries may pass on some risk through capitating participating providers, but they may also pay some participating providers on a fee-for-service basis. If the total of the intermediary’s incurred claims exceed the capitations that they receive from the health entity, the intermediary experiences financial losses. If this continues the intermediary may become insolvent, which can impact the ability of the health entity to maintain its network and ultimately to provide services to its members. Medical groups on the other hand provide
more of the services directly and when the demand for services is more than anticipated, they can either work longer hours (called sweat equity) or delay services until their schedule allows.

Capitations have the effect of reducing the amount of unpaid claim liability as a portion of the incurred claims, since payments are made at the beginning of the month to cover services provided in the month.

Receivables from provider contracts are subject to the analysis and reporting requirements of SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans*. In the situation where the provider contract requires payments from, as well as, to the provider, the health entity should separate ultimate results into the liability entry and the receivable entry. For additional discussion see the Other Assets section.

These amounts do not include the health entity’s liability if a contracting provider becomes insolvent. Provision for the effect of provider insolvencies should be included in the claim liability and/or premium deficiency reserve as appropriate. For further information see the Health Reserves and Liabilities section.

Special payment arrangements to provider groups can include fee schedules, discounts, and DRG payments to hospitals. See the Health Reserves and Liabilities section for a discussion of how these arrangements affect risk transfer, liabilities, and reserves.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board.

The procedures included in the Risk Transfer Other Than Reinsurance section of the Level 2 Annual Procedures are designed to identify potential areas of concern with the reporting of provider contracts, minimum premium contracts or ASO and ASC arrangements to the analyst. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.

The materiality of uninsured plans is determined by reviewing claims volume and the magnitude of uninsured receivables. Relationships of ASO/ASC claims payments are made to hospital and medical expenses to determine the relative volume of uninsured payments. Uninsured receivables are compared to capital and surplus and changes in receivables is reviewed.

The materiality of experience rated arrangements is determined by comparing the amount due from groups (from write-in for other than invested assets) and the amount due to groups (from reserve for rate credits or experience rating refunds on the Underwriting and Investment Exhibit Part 2D, Line 4) to total hospital and medical benefits paid.

The significance of capitation payments and bonuses and withholds is determined by comparing their total to hospital and medical benefits paid. Also, the percent of capitation being paid to intermediaries or “other providers” is reviewed to determine if there is a disproportionate amount being paid to these entities and the proportion of bonuses and withhold payments is reviewed for appropriateness.
The additional procedures compare RBC filing and year-to-year Annual Financial Statements to determine if there may be a problem in reporting. The analyst is also asked to make some judgments concerning the potential inaccuracy of some Annual Financial Statement reporting.

**Discussion of Level 2 Quarterly Procedures**

The Procedures included in the Risk Transfer Other Than Reinsurance section of the Level 2 Quarterly Procedures are intended to identify whether significant changes in alternate risk transfer arrangements have occurred since the prior year Annual Financial Statement.
III. Annual Procedures – D.10. Level 2 Reinsurance (Health)

1. Determine whether the health entity has a reinsurance program in place that adequately supports its risk profile. Review General Interrogatory, Part 2, #5.1. Did the health entity report they do not have stop-loss reinsurance?

If “yes,” review the health entity’s explanation and the maximum retained risk in General Interrogatory Part 2, #5.2 and #5.3. Do any concerns exist regarding the health entities lack of stop-loss coverage or the level of maximum retained risk?

Additional procedures and prospective risk considerations if further concerns exist:

   a. Review, for each line of business included in the Analysis of Operations by Lines of Business, the trends in loss ratios for indications of deteriorating underwriting results.

   b. Obtain a copy of the health entity’s A.M. Best Supplemental Ratings Questionnaire, if available, and review the reinsurance section.

   Briefly scan the individual reinsurers listed on Schedule S - Part 3 - Section 2.

   c. Determine if there are any significant new reinsurers known to engage in financial reinsurance transactions that may trigger concerns as to transfer of risk with respect to the health entity.

   d. Determine if there are specific situations noted, or overall trends that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies.

2. Determine whether the health entity’s accounting treatment for reinsurance ceded is proper and in accordance with the Annual Financial Statement Instructions.

   a. Briefly scan the individual reinsurers listed in Schedule S - Part 3 – Section 2. Do any of the reinsurers listed as authorized appear to be improperly classified as such?

   b. Briefly scan the Annual Financial Statement pages related to Assets, Liabilities, and Statement of Revenues and Expenses. Are any unusual items noted relating to write-ins or significant changes or inconsistencies from prior years regarding reinsurance activities?

Additional procedures and prospective risk considerations if further concerns exist:

   c. Select the five largest individual reinsurers based on the total reinsurance recoverables amount and determine whether they are authorized.

   d. On a test basis, as considered necessary, select a sample from among the remaining reinsurers and determine whether they are authorized.

   e. If the health entity holds a material letter of credit (LOC) securing unauthorized reinsurance recoverables, identify the amount of the LOC and the issuing bank. If “yes,” then provide the American Bankers Association rating of the bank and summarize any concerns.

   f. Review General Interrogatories, Part 1, #15.1 and 15.2.

      i. Is the reporting entity the beneficiary of a LOC that is unrelated to reinsurance with an NAIC rating of 3 or below?

      ii. If the answer to 2f(i) is “yes,” list the name of the Issuing or Confirming Bank, the circumstances that can trigger the LOC and the amount.
III. Annual Procedures – D.10. Level 2 Reinsurance (Health)

3. Determine whether amounts recoverable from reinsurers are significant and collectible.
   a. Are amounts recoverable from reinsurers greater than 10 percent of capital and surplus?
   b. Are ceded premiums written greater than 10 percent of gross premiums written?
   c. Are ceded reserve credits greater than 10 percent of capital and surplus?
   d. Review Schedule S – Part 3 – Section 2. Are any unusual items noted regarding the types of reinsurance and their relative significance, or the specific reinsurers involved?
   e. Review Notes to the Financials #23. Did the health entity report any items that cause concern regarding reinsurance balances?
   f. Review the results of the Actuarial Opinion Supplemental Procedures. Were any concerns noted regarding the collectability of reinsurance recoverables?

Additional procedures and prospective risk considerations if further concerns exist:
   g. Review the analysis and supporting documentation that is already available within the department (e.g., examination reports, recent analysis, current financial statements, etc.).
   h. Determine the current ratings of the reinsurer from the major rating agencies and investigate significant changes during the past 12 months.
   i. Review information about the reinsurer available from industry analysts and benchmark capital adequacy with top performers and peer groups.
   j. Request a copy of the health entity’s A.M. Best Supplemental Ratings Questionnaire, if available, and review the reinsurance section for unusual items.
   l. Review U.S. Securities and Exchange Commission (SEC) filings of the reinsurer if applicable, for insight regarding collectability.
   m. Obtain and review the actuarial opinion of the reinsurer for additional insight regarding collectability.
   n. Discuss any significant write-offs of reinsurance collectables during the period.
   o. Determine whether adequate levels of collateral e.g. (letters of credit, etc.) are being maintained to secure outstanding losses.
   p. Contact the domiciliary state to determine whether any regulatory actions are pending against the reinsurer.
   q. Review the reinsurer’s historical payment patterns of recoverables and comment on any findings.
   r. Review the NAIC I-SITE Regulatory Information Retrieval System (RIRS) reports and review the status of any relevant multistate insurance company departmental supervisions, conservatorships, rehabilitations, or liquidations.
   s. Determine whether the reinsurance transactions involved going “in and out” of treaties in such a manner that, in substance, the transactions are for financial reinsurance purposes.
   t. Using the Global Receivership Information Database (GRID) within I-SITE, review the status of any relevant multistate, single state or alien reinsurance company departmental...
III. Annual Procedures – D.10. Level 2 Reinsurance (Health)

or jurisdictional supervised receivership (e.g., conservatorship, rehabilitation, or liquidation proceedings).

4. Determine whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another.
   a. Are affiliated ceded premiums written greater than 10 percent of total gross premiums written?
   b. Review Schedule S – Part 2 (amounts recoverable on paid and unpaid losses for claims) and Schedule S – Part 3 – Section 2 (ceded reinsurance). Are reinsurance recoverables from affiliates greater than 10 percent of capital and surplus?
   c. Is there a significant point change in the above two ratios from the prior year of 15 points or over the past five years of 25 points?
   d. Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10 percent or controlled, either directly or indirectly, by the health entity or any representative, officer, trustee, or director of the health entity? (Notes to Financials - Note #23; Ceded Reinsurance Report - Section 1 - General Interrogatory Part 1)
      i. If “yes,” review Schedule S - Part 2 and Schedule S – Part 3 – Section 2. Are any unusual items noted regarding the nature or magnitude of non-affiliated relationships?
   e. Have any policies issued by the health entity been reinsured with an alien insurer owned or controlled, directly or indirectly, by the insured, a beneficiary, a creditor of the insured, or any other person not primarily engaged in the insurance business? (Notes to Financials – Note #23; Ceded Reinsurance Report - Section 1 - General Interrogatory Part 2)

Additional procedures and prospective risk considerations if further concerns exist:
   f. Obtain and review the underlying agreements that support the transaction(s) in question.
   g. Critically assess the substance of the transaction in terms of the following criteria:
      i. The transaction must be economic-based and at arm’s length.
      ii. The transaction must result in the transfer of risk and represent a consummated or permanent act.
      iii. Any assets transferred to an affiliate must be transferred at fair value if an economic-based transaction.
      iv. In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approvals.

5. Does the health entity have any agreements with reinsurance intermediaries or did the health entity enter into any transactions or agreements with reinsurance intermediaries during the year?

Additional procedures and prospective risk considerations if further concerns exist:
If there are concerns that transactions or agreements with reinsurance intermediaries exist, obtain and review underlying documents relating to the use of the reinsurance intermediaries.
III. Annual Procedures – D.10. Level 2 Reinsurance (Health)

6. Review Schedule S, Note to Financial Statements #23, the results of the Actuarial Opinion Supplemental Procedures and any other information available to the analyst regarding the health entities reinsurance agreements. Were any of the following types of reinsurance transactions or agreements completed during the year: portfolio transfer transactions; commutation agreements; surplus relief or financial reinsurance; bulk or assumption reinsurance; or material non-renewal, cancellation or revisions of ceded reinsurance agreements or changes in the primary reinsurers?

Additional procedures and prospective risk considerations if further concerns exist:
   a. Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief or financial reinsurance agreements.
   b. Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements.

7. Determine whether pyramiding may be occurring that could cause significant collectability risk to the health entity.
   a. Review the individual authorized reinsurers listed in Schedule S - Part 3 – Section 2. Are any of the reinsurers generally known to enter into significant retrocession agreements?
   b. If there are concerns that pyramiding exists, consider completing one or more of the following procedures, paying attention to declines in the overall quality level of reinsurers:
      i. Obtain the annual financial statement of selected, large reinsurers and determine the extent to which the reinsurer cedes business to other reinsurers.
      ii. If significant collectability concerns surface as a result of these procedures, perform the procedures to evaluate collectability.

Summary and Conclusion

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

Recommendations for further action, if any, based on the overall conclusion above:
- Contact the health entity seeking explanations or additional information
- Obtain the health entity’s business plan
- Require additional interim reporting from the health entity
- Refer concerns to examination section for targeted examination
- Engage an independent actuary or other reinsurance expert to review specific reinsurance contracts
- 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 ________

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III. Quarterly Procedures – D.10. Level 2 Reinsurance (Health)

1. Determine whether amounts recoverable from reinsurers are significant.
   a. Are amounts recoverable from reinsurers greater than 10 percent of capital and surplus?
   b. If 1.a is “yes,” have amounts recoverable from reinsurers changed by (i) greater than +/-10 percent from the prior quarter or (ii) +/-35 percent from the prior year-end?

2. Determine whether any unusual reinsurance transactions were completed during the quarter.
   a. Review Schedule S – Ceded Reinsurance. Were any new reinsurers added since the prior quarter?
   b. Review General Interrogatory, Part 1, #1.1. Did the health entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile, as required by the Model Act?
   c. If the answer to 2.b is “yes,” did the health entity fail to make the appropriate filing of a Disclosure of Material Transactions with the State of Domicile (General Interrogatory #1.2)?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

   Analyst ________________  Date __________

Comments as a result of supervisory review.

   Reviewer ________________  Date __________
Overview

Although reinsurance is not uncommon among health entities, its use is generally more limited compared to traditional life/health and property/casualty insurers. Approximately 40 percent of health entities have no ceded reinsurance premiums. Health entities that are not licensed as insurers are often not authorized to assume reinsurance. More than 95 percent of health entities have no assumed reinsurance premiums. This section is primarily designed to assist an analyst when reviewing a health entity with more significant use of reinsurance. However, this section can still be used in cases where the use of reinsurance is less pervasive and the analyst determines that only certain procedures apply.

Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the primary health entity transfers or “cedes” to another insurer (the reinsurer) all or part of the financial risk of loss for claims incurred under insurance policies sold to the policyholder or subscriber. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding company for all or part of the claims that the ceding company may sustain.

One of the basic functions of reinsurance is to spread the risk of loss and increase the amount of coverage health entities can provide. Through reinsurance, a health entity can share its risk with another insurer or insurers and limit its claims incurred under policies written. An insurance company generally limits the amount of coverage it is willing to underwrite relative to its surplus. Through reinsurance, a health entity can reduce its incurred claims by the amount of risk transferred to the reinsurer and, as a result, increase its capacity to write more business.

Health entities operating in the United States may obtain reinsurance from insurance companies that specialize in assuming reinsurance, referred to as professional reinsurers; reinsurance departments of primary insurers; and alien reinsurers (i.e., a reinsurer domiciled in another country). Generally, any health entity licensed to write accident and health insurance may assume reinsurance for that line of business unless prohibited by Statute or Regulation. Reinsurance is also available from pools, which are groups of insurers organized to jointly underwrite reinsurance. Although voluntary and intercompany pooling is somewhat uncommon among health entities, involuntary pools are used by many states to provide coverage to individuals or small groups in order to mitigate the risk of anti-selection or high cost claims. See SSAP No. 63, Underwriting Pools and Associations Including Intercompany Pools, for further discussion.

Reinsurance does not modify in any way the obligation of the primary health entity to pay policyholder or subscriber claims. Only after claims have been paid can the primary health entity seek reimbursement from a reinsurer for its share of paid claims. Generally, a reinsurer has no direct relationship or responsibility to policyholders. In the event of the ceding company’s insolvency, the policyholder or beneficiary under a contract that is reinsured has the same status as a policyholder or beneficiary with a policy that was not reinsured. Health entities may be required to file copies and receive approval of reinsurance treaties. A company may not need to be licensed in a state in order to act as a reinsurer of a domestic health entity. The domestic company may not receive full reinsurance credit on business ceded to such reinsurers. Some states require that, to be “authorized,” a reinsurer must meet certain criteria, but these may not be the same as those demanded of companies doing direct business in the state. An analyst should review their state’s criteria for licensing of reinsurers and approval of reinsurance treaties or any special exceptions the state has made specific to the health entity. Reinsurance premiums usually are not subject to premium taxes. Frequently, the reinsurer reimburses the ceding company for the premium taxes paid on that portion of the direct premium equal to the reinsurance premiums.
Health entities of various sizes have different capacities to write insurance. A health entity must determine the maximum exposure it is able to accept and retain as its own insurance business. Having made this determination, the health entity must then decide what to do with any risks presented that exceed the maximum amount it is willing to retain. It has two choices - accept the additional risk and reinsure it, or decline the extra risk.

The two most commonly used types of reinsurance for health entities are excess-of-loss (also referred to as stop-loss) and coinsurance. Excess-of-loss is the most common type of reinsurance arrangement used by managed care health entities. HMDIs also use excess-of-loss coverage and are more likely than other health entities to use coinsurance.

1. Excess-of-loss

Many managed care health entities use excess-of-loss coverage to provide for day-to-day operations. Other types of companies may use this type of coverage to provide catastrophe coverage. Excess-of-loss reinsurance is often referred to as non-proportional reinsurance or stop-loss reinsurance. Health entity’s reinsurance contracts generally operate on a per risk excess-of-loss basis with an aggregate limit per year on each risk and aggregate limit on the life of the member covered. Generally, the excess-of-loss reinsurance agreement reimburses an agreed upon percentage of claims once the ceding company reaches its retention for claims. Excess-of-loss reinsurance may reimburse on the basis of an individual claim or accumulation of claims for a particular member, occurrence or accident, or an aggregate. On a per claim basis, the ceding company recovers claims in excess of a retention that applies to each claim or series of claims for a given member. On an occurrence or accident basis, the company recovers claims in excess of a retention applied to each occurrence or accident resulting in multiple claims, regardless of the number of members involved. The aggregate basis allows the ceding company to recover claims that in the aggregate exceed retention, usually a flat amount for aggregate excess covers and a percentage of net premiums for stop-loss covers. The terms of excess-of-loss reinsurance vary considerably, so no general rules can be made.

Excess-of-loss reinsurance pays benefits to the ceding company after a claim(s) has exceeded a predetermined amount, often referred to as a deductible or retention. This predetermined amount can be either a specific dollar amount or some other amount such as a percentage. An example of a specific dollar amount would be where a contract states that if an individual claim exceeds $100,000, the reinsurance contract becomes effective and the reinsurer will reimburse the ceding company for the amount or part of the amount exceeding the established retention. Contracts that use a percentage to establish retention might state that a reinsurer shall reimburse the ceding company when a financial ratio, such as the loss ratio, exceeds a certain percentage.

Excess-of-loss premiums are typically based upon the number of members reinsured and generally paid on a per member per month basis. Unlike many other types of reinsurance, in this contract, there is no proportional relationship to the original premiums and claim. Generally, the contract reimburses an agreed upon percentage of claims in excess of the ceding company’s retention. Often times the retention amounts or the reimbursement amounts vary for in-network claims, vs. out-of-network claims or for hospital claims vs. physician claims. Hospital excess-of-loss coverage is the most common excess-of-loss coverage for managed care health entities.

Catastrophe reinsurance is also non-proportional reinsurance. Under this type of reinsurance the ceding company receives payment from the reinsurer when the ceding company’s total net retained claims that result from a single accidental event exceed the ceding company’s retention or a specified loss ratio.
2. **Coinsurance**

Under this mode, the direct writer and the reinsurer share in the risk of claims and expenses on a proportionate basis. The ceding company pays the reinsurer a proportional part of the premiums collected from the insured. In return, the reinsurer reimburses the ceding company for the proportional part of the claim payment and other benefits provided by the policy. The reinsurer may also reimburse the ceding company for its commissions and out-of-pocket expenses incurred in writing the business. This is referred to as an expense allowance.

The reinsurer must also establish the required reserves for the portion of the policy it has assumed. Coinsurance and most excess-of-loss reinsurance contracts are automatic. An automatic contract covers risks meeting the contract criteria at the set premium without specific review of individual claims by the reinsurer. Some coinsurance contracts may be facultative. A facultative contract requires the ceding company to submit the underwriting file on each individual application to the reinsurer for review. Then the reinsurer individually accepts or declines to participate in the reinstatement of that individual. Facultative reinsurance is rarely encountered in the health market.

The basic objective of reinsurance is to spread the risk of loss. Through reinsurance, a health entity can limit its claims under policies issued, as the reinsurer assumes the obligation to indemnify the health entity. There are four primary reasons why a health entity enters into reinsurance transactions.

1. **Stabilize Underwriting Results**

Reinsurance can serve to stabilize a health entity’s overall underwriting results by allowing a health entity to pass along claims to reinsurers in bad years in exchange for sharing profits in good years. Like other businesses, health entities try to avoid wide fluctuations in profits and losses from year to year. As discussed above, a health entity limits exposure to an individual risk by retaining a portion of the original risk and reinsuring the balance. To some extent, a health entity may also limit aggregate claims sustained over a specific period, such as a year, by reinsuring claims in excess of a predetermined cap.

2. **Increase Underwriting Capacity**

Reinsurance increases a health entity’s capacity to write greater amounts of policy coverage than it could cover on its own. Some risks may be too large for any health entity to insure alone. Prudent management and certain insurance regulations demand limits on any one potential claim proportionate to the size of the health entity’s surplus. For example, a health entity may issue a policy to its members with a maximum annual coverage of up to $1,000,000 per year with a lifetime limit of $2,000,000. The health entity’s retention on any one risk is based upon the total surplus, the number of members covered and how long the company has written this business. By transferring risks in excess of this prudent retention, a health entity can write policies with greater amounts of coverage without having to bear the full impact of potential claims under such policies. This function is crucial for small and medium size health entities to compete with larger health entities in meeting policyholders’/subscribers’ coverage needs.

3. **Support Point of Service Operations**

The use of reinsurance to stabilize underwriting results and increase underwriting capacity is common to all types of insurance. However, one purpose of reinsurance that is specific to health entities is driven by how a particular health entity provides a point of service product. Depending upon state preferences, a health entity may provide a point of service type of product by providing the coverage
through the health entity, but only if parts of the coverage are pick up or reinsured by an indemnity company.

4. **Provide Continuation of Coverage and Benefits in the Event of Insolvency**

Most health contracts have termination language that allows for automatic termination in the event of insolvency or cessation of operations. This feature is a critical distinction among health contracts since the health entity is presumed to be acting as the primary mechanism to deliver care to its subscribers. In the event of insolvency, a continuation of benefits clause within the reinsurance agreement will require the reinsurer to be liable for all claims incurred from the date of insolvency for a specified period of time. In addition, continuation of benefits clauses typically require that the reinsurer pay claims from the date of insolvency through the earlier of the date of discharge for a member who is confined to an impatient facility, or the date the member becomes eligible for health coverage under another plan. Continuation of benefits clauses may also contain other limitations as well. The coverage may also provide that the reinsurance company continue benefits for any member for medical services incurred for a service date subsequent to the date of insolvency provided that premium for the members are current. Historically, continuation of benefits clauses has not contained maximum limits. However, more recently, reinsurers have attempted to insert dollar limits to avoid large exposure under the provision resulting from the insolvency of a large health entity.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board.

The procedures included in the reinsurance section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. While there are many legitimate business uses for reinsurance, it can be used to mask a health entity’s financial problems or expose the health entity to significant collectability, or credit risk. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.

*Procedure #1* assists the analyst in determining whether the health entity has a reinsurance program in place that adequately supports its overall risk profile.

Additional steps may be performed if there are concerns that the reinsurer’s risk profile is not adequately supported by its reinsurance program. A particularly helpful source of information in this regard is the supporting reinsurance information the health entity prepares for the rating agencies. While this information is not a required filing to the insurance department, the major rating agencies generally require it in connection with the rating process. For example, if the health entity has elected to apply for an A.M. Best rating, a detailed questionnaire on reinsurance must be prepared. This questionnaire requires the health entity to describe each major reinsurance contract, and provide other extensive information. Questions such as these can provide excellent background information to the analyst.

*Procedure #2* assists the analyst in determining whether significant errors exist relating to the accounting for reinsurance. Generally, the major concern will relate to the manner in which the health entity accounts for credits, or reductions in, the liability for reserves relating to recognition of estimated reinsurance...
recoverables. SSAP No. 61R, *Life, Deposit-Type & Accident and Health Reinsurance* (SSAP No. 61R), defines the specific circumstances when the health entity can record such a credit, or reduction in, the liability for claim reserves. In summary, a credit for reinsurance can be recorded when the assuming insurer is authorized (i.e., licensed or approved by the ceding health entity’s state of domicile, or accredited). When the assuming insurer is unauthorized (i.e., neither licensed or approved by the ceding health entity’s state of domicile, nor accredited), then a credit for reinsurance may only be recorded when adequate security exists in the form of trust accounts, letters of credit, etc. Another accounting issue may involve the treatment of disputed amounts. Occasionally, a reinsurer will question whether an individual claim is covered under a reinsurance contract or may even attempt to nullify an entire treaty. A ceding health entity, depending upon the individual facts, may or may not choose to continue to take credit for such disputed balances. The ceding health entity may not take credit for reinsurance recoverables in dispute with an affiliate.

Additional steps may be performed if there are concerns regarding the health entity’s accounting treatment of ceded reinsurance. The analyst should consider reviewing the largest reinsurers as well as a random selection of the remaining reinsurers to determine that reinsurers are classified correctly.

Procedure #3 assists the analyst in determining whether reinsurance recoverables are significant and if so, whether the amounts involved are collectable. For example, for stop-loss reinsurance, only after claims have been paid beyond the retention level can the primary company seek reimbursement from a reinsurer for its share of paid claims. As a result, evaluating the collectability of the recoverables, as well as the overall credit-worthiness of the reinsurers, is a key concern. Evaluating the collectability of reinsurance recoverables in general requires an understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained. Reinsurance is generally obtained from one of the following categories of insurers:

1. **Professional Reinsurers** - The main business of professional reinsurers is assuming reinsurance from non-affiliated insurers. In general, the large and well-capitalized professional reinsurers will not pose a serious collectability concern.

2. **Reinsurance Departments of Primary Insurers** - Many insurers assume reinsurance from non-affiliates, but also write significant business on a direct basis. These types of insurers may pose a larger collectability concern than professional reinsurers since the specialized reinsurance expertise may not be as strong.

3. **Alien Insurers** - Reinsurers domiciled in another country generally pose the most significant collectability issues; however, health entities typically obtain reinsurance from U.S. domestic reinsurers.

Additional steps may be performed if collectability concerns exist. The fundamental issue involved with evaluating collectability is an assessment of the financial stability of the underlying reinsurers. To evaluate the collectability of reinsurance recoverables, the analyst should consider the need to collect as much financial information as possible about the reinsurers, including various regulatory and governmental filings, rating agency reports and financial analyses available from industry analysts.

The I-SITE application, **Global Receivership Information Database (GRID)**, allows the regulator to review the status of a receivership (i.e., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal, financial and reporting data. Receivables and recoverables due from companies in liquidation proceedings may be partially collected; however, collection will likely be delayed. It is practically certain
that balances due at the time a liquidation is closed (the last action date that may be entered in GRID) will never be collected. Evaluating the collectability of reinsurance recoverables requires understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained.

**Procedure #4** assists the analyst in identifying whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another. A group of affiliated insurance companies may use reinsurance as a mechanism to diversify the portfolios of individual companies and to allocate premiums, assets, liabilities, and surplus among affiliates. From an economic standpoint, reinsurance transactions between affiliated insurance companies do not reduce risk for the group, but instead shift risk among affiliates. Reinsurance between affiliates can be used effectively in lieu of moving capital in cases where there is capital capacity in affiliated companies that does not exist in the health entity. However, affiliate reinsurance can present opportunities for manipulation and potential abuse where excess capital in a health entity is removed from the regulators jurisdiction. 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.

Additional steps may be performed to determining whether pyramiding exists. The chain of reinsurance does not end once a health entity cedes business to a reinsurer. Since a reinsurer purchases reinsurance for the same reasons as a health entity, the reinsurer may, in turn, retrocede a portion of its assumed reinsurance business to another reinsurer. Each ceding company may rely on many reinsurance agreements with multiple reinsurers participating in each agreement. Therefore, retrocessions further complicate assessing how reinsurance affects a health entity’s financial condition. While a health entity remains liable for all claims filed by its policyholders before seeking reimbursement from its reinsurers, a health entity’s continued solvency may be impaired if the reinsurance chain fails.

**Procedure #5** assists the analyst in highlighting whether any transactions or agreements with reinsurance intermediaries exist. While some professional reinsurers are direct marketers, intermediaries (brokers, managers, or managing general agents) may arrange reinsurance agreements between a ceding company and a reinsurer in exchange for commissions or fees. The intermediary bears no financial risk in the event of under priced or poor underwriting or placement with a troubled reinsurer. But, poor performance by an intermediary can affect both ceding health entities and reinsurers. Refer to the TPAs, IPAs & MGAs section for more discussion on managing general agents.

**Procedure #6** assists the analyst in highlighting unusual reinsurance transactions where a review of the transfer of risk criteria may be important. The essential ingredient of a reinsurance contract is the shifting of risk. The reinsurer must indemnify the health entity in form and in fact, against loss or liability relating to the original policy in order for the health entity to account for it as a reinsurance recoverable. Determining whether a contract involves the transfer of risk requires a complete understanding of the contract between the health entity and the reinsurer. All contractual features that limit the amount of insurance risk to the reinsurer or delay the timely reimbursement of claims by the reinsurer should be thoroughly understood. A transfer of risk requires that the reinsurer assume significant insurance risk under the reinsured portions of the underlying insurance contracts and that it is reasonably possible that the reinsurer may realize a significant loss from the transaction.

Although not common in health entities, the analyst should also be alert to unusual types of transactions such as commutations, portfolio transfers, bulk reinsurance, assumption reinsurance agreements and surplus relief. A commutation is a transaction, which results in the complete and final settlement and discharge of all present and future obligations between parties to a reinsurance agreement and is more prevalent in property/casualty lines of business. A loss portfolio transfer is an agreement, applied

retroactively, in which the ceding company transfers a portfolio of claims (i.e., claim reserves) to another company along with consideration for assuming such claim reserves. Bulk reinsurance is when a health entity cedes all or part of a block of insurance business. Such bulk cessions may or may not be in the ordinary course of business and may or may not require prior regulatory approval. Assumption reinsurance agreements occur when the health entity transfers, with the consent of the policyholder, responsibility for policyholder obligations to another health entity. Surplus relief, or financial reinsurance, is a method of accelerating future profits on a block of insurance business, whereby the reinsurer normally returns the majority of the profits on a block of business, less a fee, to the health entity through an experience refund. Since surplus relief transactions merely represent a financing arrangement, SSAP No. 61 does not allow a credit to surplus until the risk has been transferred.

Additional steps may be performed if concerns for significant or unusual reinsurance transactions or agreements exist such as commutation, portfolio transfer, bulk or assumption reinsurance, and surplus relief or financial reinsurance. The analyst should review these types of transactions and agreements closely to determine whether a transfer of risk has been consummated. Even when transfer of risk has been consummated, the analyst should evaluate the impact of the transaction on future financial performance of the health entity.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Reinsurance are intended to identify 1) whether amounts recoverable are significant or 2) were any unusual reinsurance transaction completed during the quarter.
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

1. Determine whether the health entity is a member of a holding company system and, if so, whether the corporate structure, or any changes in the corporate structure, elevate concerns about affiliated transactions.  

   a. Review General Interrogatory, Part 1, #1.1  
      i. Is the health entity a member of an insurance holding company system consisting of two or more affiliates, one or more of which is a health entity or insurer? If “yes,” what is the name of the ultimate controlling person or entity as reported on the holding company system registration statement?  
      ii. Is the answer to 1.a.i. different from the prior year? If “yes,” discuss the differences.  
      iii. Review Schedule Y, Part 1 and Part 2, along with the General Interrogatories and Notes to Financial Statements. Is there any information noted that contradicts the response in 1.a.i. above?  
      iv. Is the company required to file a holding company registration statement with the insurance department?  

   If 1.a.i. through 1.a.iv. are all “no,” do not proceed with the remaining Affiliated Transactions procedures.

   b. Review General Interrogatory, Part 1, #1.2. Did the health entity fail to file a registration statement in accordance with the NAIC Insurance Holding Company System Regulatory Act (#440)?  

      i. Were there any significant changes to the corporate structure during the year (i.e., acquisitions, divestitures, mergers)?  
      ii. If the answer to 1.c.i. above is “yes,” and the change involved ownership of the health entity or a transaction with an affiliate, did the health entity fail to receive proper regulatory approvals?  
      iii. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?  
      iv. Does the health entity have an agency or brokerage subsidiary?  
      v. Are there any indications the corporate structure may include a hospital or that the reporting entity may be affiliated with any other type of medical provider(s) or provider intermediaries?  

   d. Review Schedule Y, Parts 1 and 1A – Detail of Insurance Holding Company System for the current year.  
      i. Identify the ultimate controlling entity(ies)/person(s) and summarize any financial concerns.  
      ii. If there is more than one group listed on Part 1A, summarize the interrelationship and understand the rationale for the distinct groups.

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1 Health entities have not been incorporated into the Insurance Holding Company System Regulatory Act in all states.
iii. Summarize any concerns that the analyst has with regard to non-insurance entities.

Additional procedures and prospective risk considerations if further concerns exist:

e. Obtain and review the financial statements and Audited Financial Report of the parent holding company (if available with Form B filing) in order to understand its debt and equity structure.

f. Determine the level of debt service required by the holding company and gain an understanding of its primary sources of revenue.

g. If the holding company’s primary sources of revenue are dividends and fees from the health entity, evaluate these sources to determine their validity and reasonableness.

h. Obtain and review U.S. Securities and Exchange Commission (SEC) filings, if available.

i. Request a parental guaranty from the health entity to maintain capital and surplus at a pre-determined level.

2. Identify whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.


   i. Were any unusual items noted, such as significant new affiliated transactions or modified intercompany agreements from the prior year, or significant increases in transaction amounts?

   ii. Does it appear that a different schedule is included for the other affiliates?

   iii. Has the health entity forwarded to any one affiliate funds greater than 15 percent of the health entity’s surplus?

   iv. Were management fees paid to affiliates, as identified in footnotes to the Underwriting and Investment Exhibit-Part 3, greater than 15 percent of the total incurred general expenses?

b. Review Note to Financial Statements #10 - Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties.

   i. Were any unusual items noted, such as significant new affiliated transactions from the prior year, or significant increases in transaction amounts?

   ii. Do any transactions described appear to conflict with the transactions disclosed in Schedule Y, Part 2?

   iii. Are any transactions disclosed with an affiliate that is not listed on Schedule Y, Part 2?

   iv. Do affiliated business ventures resulting in a contingent liability to the health entity involve financial exposure greater than 25 percent of surplus?

   v. Review the description of management and administrative services agreements. Is an allocation basis involved other than one designed to estimate actual cost?

   vi. If the answer to 2.b.v. above is “yes,” are the allocation or cost bases used for service charges periodically reviewed and adjusted?
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

vii. Were management and service agreements between affiliates either submitted and/or approved in conformity with regulatory requirements?
viii. Was the amount of the shareholder dividend at a level that required prior regulatory approval or notification?
ix. If the response to 2.b.viii. above is “yes,” did the health entity fail to obtain proper prior regulatory approvals?
x. Does the amount of the dividend paid differ from the amount disclosed in the Notes to Financial Statements differ from the amount reflected on Cash Flow?
xi. Did the capital contributions from the health entity to another affiliate substantially impact the financial condition of the health entity?

xii. Were non-cash capital contributions into the health entity not recorded at fair value?
xiii. Were purchases, sales, or exchanges of loans, securities, real estate, mortgage loans, or other investments, not at arms-length or not recorded at fair value?
xiv. Did any transfer of assets between insurance affiliates impact the risk-based capital calculation?
xv. Does the health entity have a parental guaranty to maintain capital and surplus at a pre-determined level?

c. Review Note to Financial Statements #13, Capital and Surplus, Stockholders’ Dividend Restrictions and Quasi-Reorganizations. Are any unusual items noted?
d. Has the health entity historically required capital contributions from its parent to offset operating losses or other decreases in capital and surplus?

Additional procedures and prospective risk considerations if further concerns exist:

e. Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
f. If the concern relates to the economic substance of the transaction, obtain and review supporting documents.
g. If the concern relates to the fair value used to record the transaction:
   i. Obtain and review an appraisal of the asset transferred.
   ii. Consider consulting an independent appraiser.

h. If the concern involves a Management Agreement or Service Contract:
   i. Determine that appropriate regulatory approvals were received and that the health entity is complying with the terms as approved.
   ii. Obtain and review the supporting contract.
   iii. Determine that the amounts involved are reasonable approximations of actual costs.
   iv. Determine that actual amounts paid are in agreement with the supporting contract.
   v. Determine if allocation bases and results are periodically reviewed and adjusted.
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

vi. For any agreement based on a cost plus formula or percentage of premiums formula, request justification from the health entity for amounts in excess of the actual cost of providing the service.

vii. For those services being performed by/for an affiliate, and which are also provided by unrelated third-party vendors (i.e., data processing, actuarial, investment management), contact such vendors or review vendor pricing schedules in order to determine the reasonableness of the intercompany transfer pricing level.

viii. Evaluate whether any portion of such fees is in substance dividends that should be evaluated in the context of dividend regulations.

3. Determine whether investments in affiliates are significant.
   a. Is the total of all investments in affiliates (Five-Year Historical Data) greater than 20 percent of capital and surplus?
   b. Has the total of all investments in affiliates changed by greater than +/- 20 percent from the prior year-end?
   c. Has there been any change in any category of affiliated investments greater than +/- 10 percent from the prior year-end?
   d. Does the company have an interest in the capital stock of another insurance company or other health entity?
      i. If the response to 3.d. above is “yes,” and if the health entity was a member of a holding company system at the end of the reporting period, did the health entity fail to properly disclose the investment on Schedule Y, Part I?
   e. Are affiliated investments in violation of state statutes?

4. Determine whether investments in affiliates are properly valued in accordance with statutory accounting practices.
   a. If investments in common stocks of parents, subsidiaries and affiliates involve publicly traded securities, is the investment valued on a basis other than market valuation?
   b. If investments in common stocks of parents, subsidiaries and affiliates do not involve publicly traded securities, is the investment valued on a basis other than the Statutory Equity of GAAP Equity methods?

Additional procedures and prospective risk considerations if further concerns exist:
   c. Review details of affiliated investments as reported in Schedules A, B, and D, and compare with prior years.
   d. Obtain an understanding of the primary business activity of the affiliate and determine that such an investment complies with regulatory requirements.
   e. Review the components of investment income reflected on the Exhibit of Net Investment Income and the Exhibit of Capital Gains (Losses).
      i. Calculate the return on investment for current and prior years.
      ii. Review the components of investment income and determine whether the source is cash or merely an increase in accrued interest income.
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

iii. If a substantial portion of investment income relates to an increase in the accrual, determine whether such revenue recognition is legitimate and reasonable.

iv. Determine whether accrued interest on investments in affiliates have grown to a significant level.

f. Obtain and review the Audited Financial Report and Annual Financial Statement of the affiliate, if available.

g. Determine the current ratings of the affiliate from the major rating agencies, if available.

h. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.

i. Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.

j. Contact the affiliate’s primary regulator (if applicable) to determine whether any regulatory actions are pending against the affiliate.

k. Using the Global Receivership Information Database (GRID) within I-Site, review the status of any relevant multi-state, single state or alien affiliated company departmental or jurisdictional supervised receivership (e.g., conservatorship, rehabilitation, or liquidation proceedings).

5. Determine whether other affiliated transactions are legitimate and properly accounted for.

a. Review the balance sheet asset receivable from parent, subsidiaries and, as well as the liability payable to parent, subsidiaries and affiliates. Are either of these items greater than 10 percent of capital and surplus?

b. Review Exhibit 5 – Amounts Due from Parent, Subsidiaries and Affiliates.

i. Are there any balances over 90 days, which are admitted?

ii. Does the exhibit otherwise suggest that the health entity may have collectability issues with its affiliates?

iii. Are any of the receivable balances from an affiliate which the health entity also reports a payable balance on Exhibit 6, and could therefore net the balances on the face of the balance sheet if the requirements of SSAP 64 were met?

iv. Is the analyst aware of any receivable balances from an affiliate, which has experienced some financial problems?

v. Are there any affiliated receivable balances from medical providers or intermediaries included on Exhibit 5?

c. Review Exhibit 6 - Amounts Due to Parent, Subsidiaries and Affiliates.

i. Are any of the balances non-current?

ii. Are any of the balances unusually large for the description or are any of the descriptions unusual?

d. Review Exhibit 7 - Summary of Transactions with Providers.

i. Is the ratio of payments made to affiliated providers to total payments greater than 50 percent?
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

ii. Has there been any indication that the amount charged by the affiliated provider is non-economic or non-arms-length?

e. Review Schedule E.

i. Were any open depositories a parent, subsidiary or affiliate?

ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the health entity?


i. Is the health entity included in a consolidated federal income tax return?

ii. If the answer to 5.f.i. is “yes,” are there any concerns about the manner in which federal income taxes are allocated to the health entity?

iii. Are federal income tax recoverables greater than 5 percent of capital and surplus?

iv. If the answer to 5.f.iii. above is “yes,” are federal income tax recoverables due from an affiliate?

g. Review General Interrogatory Part 1, #7. Does any foreign entity control 10 percent or more of the health entity, either directly or indirectly, through a holding company?

i. If the response to 5.g. above is “yes,” did the health entity fail to properly disclose the investment on Schedule Y, Part 1?

h. Review General Interrogatory Part 1, #20.11 and 20.12.

i. Did the health entity report amounts loaned during the year to directors, other officers and stockholders? If “yes,” what is the percentage of statutory net income and capital and surplus?

ii. Did the health entity report amount of loans outstanding at the end of the year to directors, officers and stockholders? If “yes,” what are the percentages of statutory net income and capital and surplus?

i. Review General Interrogatory Part 1, #18. Has the health entity failed to establish a conflict of interest disclosure policy?

j. Is there any evidence that activities of directors, officers or shareholders were in violation of state statutes?

k. Review Schedule SIS, Stockholder Information Supplement. Are any unusual items noted regarding transactions with, or compensation to, directors and officers?

Additional procedures and prospective risk considerations if further concerns exist:

l. If the concern relates to federal tax recoverables from a parent or affiliate:

i. Obtain and review the financial statements of the parent or affiliate and evaluate any collectability risk to the health entity.

ii. Review any tax-sharing agreement and verify that the terms of the tax-sharing agreement are being followed.

iii. Verify that the amount recoverable from the prior year-end has been paid.

m. Assemble a list of all affiliates and other related parties.

i. Summarize the financial impact of each transaction.
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

ii. Identify any other unusual transactions and investigate for reasonableness.

iii. Determine whether any required regulatory approvals were obtained.

n. If concern exists regarding downstream risk with affiliated provider intermediaries:
   i. Obtain and review the Audited Financial Report and Annual Financial Statement of the affiliate, if available.
   ii. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups, if available.
   iii. Obtain and review the actuarial opinion of the affiliate, if available.
   iv. Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.

Summary and Conclusion

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

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

- Contact the health entity seeking explanations or additional information
- Obtain the health entity’s business plan
- Request consolidating holding company schedules
- Require additional interim reporting from the health entity
- Refer concerns to examination section for targeted examination
- Consult an independent appraiser to evaluate specific transactions involving significant transfers of assets
- Meet with the health entity’s management
- Recommend that a cease and desist order and/or fines be issued for holding company violations that were detected during the review
- Obtain a corrective plan from the health entity
- Recommend that action be taken to reverse or modify contracts that are harmful to health entity
- Other (explain)

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
III. Quarterly Procedures – D.11. Level 2 Affiliated Transactions (Health)

1. Determine whether the health entity is a member of a holding company system and, if so, whether the corporate structure, or any changes in the corporate structure, elevate concerns about affiliated transactions.
   a. Was the health entity a member of an Insurance Holding Company System as of the prior year-end?
   b. Has the Department directed the health entity to file a Holding Company registration statement?
      i. Review Part 1 and Part 1A. Identify the ultimate controlling party(ies)/person(s) and summarize any financial concerns.
      ii. If there is more than one group listed on Part 1A, summarize the interrelationship and understand the rationale for the distinct groups.
      iii. Summarize any concerns that the analyst has with regard to non-insurance entities.
   d. Did the health entity fail to file a registration statement in accordance with the Model Holding Company System Regulatory Act?
   e. Review Schedule Y, along with the General Interrogatories. Is there any information noted that contradicts the response to 1.a above?

If the answers to 1 a. – 1 e. are no, do not proceed with the Affiliated Transactions Procedures and skip to the next financial analysis topic.

f. Review Notes to Financials. Did the health entity report a change in the health entity’s capital structure?

h. If the answer to 1.f. above is “yes,” and the change involved ownership of the health entity or a transaction with an affiliate, did the health entity fail to receive proper regulatory approvals?

i. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?

j. Does the health entity have an agency or brokerage subsidiary?

k. Are there any indications the corporate structure may include a hospital or that the reporting entity may be affiliated with any other type of medical provider(s) or provider intermediaries?

l. Review General Interrogatory #5. Have there been changes to any management agreement in terms of the agreement or principals involved?
III. Quarterly Procedures – D.11. Level 2 Affiliated Transactions (Health)

2. Determine whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.
   a. Review the Summary of Operations, capital and surplus account line item dividends to stockholders.
      i. Is the amount of the stockholder dividend at a level that required prior regulatory approval or notification?
      ii. If the answer to 2.a.i. above is “yes,” did the health entity fail to obtain proper prior regulatory approvals?
   b. Review Schedule A - Part 2, Real Estate Acquired and Additions Made During the Current Quarter, and Schedule BA - Part 1, Long-Term Invested Assets Acquired and Additions Made During the Current Quarter?
      i. Did any such acquisitions involve an affiliate, or other related party?
      ii. If the answer to 2.b.i. above is “yes,” is the amount of the acquisition greater than 5 percent of capital and surplus?
      iii. If either answer to 2.b.i. and ii. above is “yes,” is there any reason to believe the sale was recorded on a basis other than fair value?
   c. Review Schedule A – Part 3, Real Estate Disposed During the Current Quarter, and Schedule BA – Part 3, Long-Term Invested Assets Disposed, Transferred or Repaid During the Current Quarter.
      i. Did any such dispositions involve an affiliate or other related party?
      ii. If the answer to 2.c.i. above is “yes,” is the amount of the disposition greater than 5 percent of capital and surplus?
      iii. If either answer to 2.c.i. or 2.c.ii. above is “yes,” is there any reason to believe the sale was recorded on a basis other than fair market value?

   a. Is the total of all investments in affiliates greater than 20 percent of capital and surplus?
   b. Has the total of all investments in affiliates changed by greater than +/- 20 percent from the prior year-end?
   c. Has there been any change in any category of affiliated investments greater than +/- 10 percent from the prior year-end?

4. Determine whether other affiliated transactions are legitimate and properly accounted for.
   a. If federal and foreign income tax recoverables exceed 3 percent of total assets, have such recoverables changed by greater than (i) +/- 10% from the prior quarter or (ii) +/- 20 percent from the prior year-end?
   b. Is the receivable from parent, subsidiaries and affiliates greater than 10 percent of capital and surplus?
   c. Has the receivable from parent, subsidiaries and affiliates changed by greater than +/- 25 percent from the prior year-end?
   d. Is the payable to parent, subsidiaries and affiliates greater than 10 percent of capital and surplus?
III. Quarterly Procedures – D.11. Level 2 Affiliated Transactions (Health)

e. Has the payable to parent, subsidiaries and affiliates changed by greater than +/- 25 percent from the prior year-end?

f. Review Schedule E.
   i. Were any open depositories a parent, subsidiary or affiliate?
   ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the health entity?

5. Are there any indications that significant transactions or unusual transactions involve an affiliate or other related party?

Summary and Conclusion

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

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or recompleted?

Describe the rationale for this recommendation.

   Analyst _______________ Date ________

Comments as a result of supervisory review.

   Reviewer _______________ Date ________
Overview

SSAP No. 25, *Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties* (SSAP 25), defines an affiliate as an entity that is within the holding company system that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. According to SSAP 25, control is defined as possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person or entity, whether through the a) ownership of voting securities, b) by contract other than a commercial contract for goods or non-management services, c) by contract for goods or non-management services where the volume of activity results in a reliance relationship, d) by common management, or e) otherwise. Control shall be presumed to exist if a reporting entity and its affiliates directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10 percent or more of the voting interests of the entity. An analyst may also refer to the NAIC *Insurance Holding Company System Regulatory Act* for additional guidance. Not all states have incorporated health entities into the requirements of the NAIC *Insurance Holding Company System Regulatory Act*.

Affiliated relationships that are unique to health entities include not-for-profit corporations (e.g. hospitals) and other providers of medical care. Not-for-profit health entities are membership corporations that can be affiliated with other entities via common management (members or boards of directors) with other business corporations or not-for-profit corporations. Entities related in this way are often deemed to be affiliates. Further, reliance on a particular provider or provider intermediary to provide medical services to members can create an affiliate relationship pursuant to SSAP 25. Relationships such as the above can have a material impact on the way a health entity operates. In a corporate structure that includes a hospital, the health entity may exist for the primary purpose of providing a health care delivery system to a community or region. As a result, the operations and financial condition of the health entity may be secondary to other missions of the corporate structure. Also, providers that are affiliated with a health entity may be used by the health entity to mask poor underwriting results of the health entity and/or manipulate Risk-Based Capital (RBC) results. Continual losses of a provider affiliate may be the result of the health entity transferring those losses to the affiliate. Such losses may ultimately impact the health entity (See the Risk Transfer section). RBC levels of the health entity may not reflect the true nature of the underwriting risk being borne. Conversely, where the provider affiliate is periodically transferring capital to the health entity in order to keep the health entity solvent or to keep from triggering RBC events, the provider may not be able to continue making sufficient contributions. This may result in the health entity becoming financially distressed. The continuing obligations of a health entity, as in the case where capitated or other risk transfer payments are made to an affiliated provider or intermediary, but the health entity retains the ultimate obligation to provide or pay for medical services, may raise questions about the transfer of risks.

Transactions between affiliates and other companies within the same holding company system shall be fair and reasonable. Premiums shall be billed, claims paid, and expenses allocated so as to clearly maintain the identity of affiliated entities. The accounting for assets transferred between affiliates is generally determined by an analysis of the economic substance of the transaction. An economic transaction is an arm’s length transaction that results in the transfer of risks and rewards of ownership and represents a consummated act. An arm’s length transaction is defined as one in which willing parties, each being reasonably aware of all relevant facts and neither under compulsion to buy, sell or loan, would be willing to participate. Such a transaction must represent a bonafide business purpose demonstrable in measurable terms, such as the creation of a tax benefit, an improvement in cash flow position, etc. A transaction that results in the mere inflation of surplus without any other demonstrable and measurable improvement is not an economic transaction.
Compared to commercial accident and health insurers, some states require health entities, particularly Health Maintenance Organizations (HMOs) and not-for-profit health plans (HMDI or Blue Cross Blue Shield type plans) to be licensed or otherwise authorized to operate in a single state. HMOs can operate regionally or even nationally via a holding company system with an ultimate parent controlling multiple single state affiliated HMOs. In these instances there are generally administrative services provided by the parent and medical services provided by the affiliated HMOs within a geographic region. Blue Cross Blue Shield Plans may also operate in multiple states via a holding company system. Some services such as administrative services, investment management, and actuarial support may be centralized, while other services, such as marketing, may be decentralized. It is essential for the analyst to be satisfied that the identity of, and asset control by, the individual health entities are maintained. Since much of the overall financial strength can be concentrated at the holding company level rather than remaining in the health entity, understanding the consolidated financial condition of the holding company system is important.

Another holding company issue would be determining that the risks and rewards of ownership have been transferred to the buyer. This requires an examination of the underlying facts and circumstances. Although these are frequently less of an issue in dealing with most health entities, the matter should still be considered. The following circumstances from SSAP No. 25 may raise questions about the transfer of risks.

1. A continuing involvement by the seller in the transaction or in the assets transferred, such as through the exercise of managerial authority to a degree usually associated with the ownership, perhaps in the form of a remarketing agreement or a commitment to operate the property.
2. Absence of significant financial investment by the buyer in the asset transferred, as evidenced, for example, by a token down payment or by a concurrent loan to the buyer.
3. Repayment of debt that constitutes the principal consideration in the transaction dependent on the generation of sufficient funds from the asset transferred.
4. Limitations or restrictions on the purchaser’s use of the asset transferred or on the profits from it.
5. Retention of effective control of the asset by the seller.

Security swaps of similar issues between or among affiliated companies are considered non-economic transactions. Swaps of dissimilar issues accompanied by exchanges of liabilities between or among affiliates are considered non-economic transactions. The appearance of permanence is also an important criterion in establishing the economic substance of a transaction. If subsequent events or transactions reverse the effect of an earlier transaction, the question is raised as to whether economic substance existed in the case of the original transaction. In order for a transaction to have economic substance and thus warrant revenue (loss) recognition, it must appear unlikely to be reversed.

Health entities may rely on surplus notes from affiliates as a source of capital within a holding company structure. Such notes are often the method of choice for not-for-profit health entities. Surplus notes are discussed further in the Income Statement and Surplus section.

A bonafide business purpose would exist, for example, if an asset were transferred in order to create a specific advantage or benefit. The advantage or benefit must be to the benefit of the health entity. A bonafide business purpose would not exist if the transaction were initiated for the purpose of inflating (deflating) a particular health entity’s financial statement, including effects on the balance sheet or income statement.
When accounting for a specific affiliated transaction, the following valuation methods should be used, according to SSAP No. 25.

1. Economic-based transactions between affiliates should be recorded at prevailing fair values at the date of the transaction.

2. Non-economic-based transactions between affiliated health entities should be recorded at the lower of existing book/adjusted carrying values or prevailing fair values at the date of the transaction.

3. Non-economic-based transactions between a health entity and an entity that has no significant ongoing operations other than to hold assets that are primarily for the direct or indirect benefit or use of the health entity or its affiliates should be recorded at the prevailing fair value at the date of the transaction. However, to the extent that the transaction results in a gain, that gain should be deferred until such time as permanence can be verified.

4. Transactions that are designed to avoid statutory accounting practices shall be included as if the health entity continued to own the assets or to be obligated for a liability directly instead of through a subsidiary.

Assets may be valued on a different basis if held by a health entity versus a life insurer. Therefore, the regulator must take this into consideration when using the general guidelines.

In the absence of specific guidelines or where doubt exists as to the propriety of a special accounting method, the domiciliary state should be consulted.

In addition to the above valuation requirements, reporting of affiliated balances must follow the requirements set forth in SSAP No. 64, *Offsetting and Netting of Assets and Liabilities*, which provides that netting of balances can only be used when certain conditions are met.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

The Level 2 Procedures are designed to identify potential areas of concern to the analyst. The challenge to the analyst in this area is to understand, in substance, the various transactions between affiliates and recognize those transactions that are intended to circumvent existing regulations. Many of the procedures may require a prior knowledge of the health entity or a past knowledge of the holding company structure. A review of the health entity’s holding company files may assist in this regard. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.

*Procedure #1* assists the analyst in understanding the health entity’s corporate structure. Significant changes in corporate structure may materially impact the health entity’s future financial condition and generally require prior regulatory approval. The analyst should closely analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure in which the health entity operates, the analyst may be able to foresee future problems and take appropriate
action. For example, a common corporate structure the analyst may encounter involves a holding company whose only significant asset is the stock of the health entity. The holding company may have financed the acquisition of the health entity through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the health entity. This type of corporate structure warrants close attention by the analyst to ensure that dividends are valid and in compliance with your state’s applicable dividend restrictions, and that any other payments by the health entity to the holding company are legitimate, rather than dividends in disguise. The analyst should also be alert to a corporate structure that includes affiliated brokers or intermediaries that may be recording unusual or significant levels of commissions and fees. When a corporate structure is involved that includes multiple tiers of affiliates where significant levels of surplus are comprised of investments in affiliates, the analyst should focus on the level of real surplus that exists on a consolidated basis. The analyst should also be aware of corporate structures that include a hospital organization. As previously mentioned, the operations and financial condition of the health entity may be secondary to other missions of the corporate structure when a hospital or other type of medical provider is involved.

Additional steps may be performed if the health entity’s corporate structure elevates concerns about affiliated transactions. The primary objective is to understand the financial position of the parent company. By understanding the financial commitments of the parent, the analyst will be able to better understand the parent’s motivation for entering into transactions with the health entity or other affiliates. Financial statements of affiliates may reveal unauthorized transactions in progress.

Procedure #2 assists the analyst in understanding and evaluating the summary of transactions reported in Schedule Y, Part 2. Several types of affiliated transactions are reported in Schedule Y, Part 2 and explanatory comments are provided in Note to Financial Statements No. 10, Information Concerning Parent, Subsidiaries and Affiliates and Other Related Parties. The analyst should refer to both sources of information in order to develop an understanding of the underlying affiliated transactions.

The following briefly describes the key concerns to the analyst for several of the major affiliated transactions.

- For **shareholder dividends**, the major concern relates to whether the level of dividend is within the regulatory guidelines, and whether the dividend should be considered extraordinary, and therefore requires prior regulatory approval.

- For **capital contributions** from the health entity to another affiliate, the analyst should determine that such contribution does not substantially impact the financial condition of the health entity.

- For **non-cash capital contributions** into the health entity, the analyst should determine that the infusion is recorded at fair value so as to not arbitrarily inflate surplus.

- In the case of **purchases, sales, or exchanges of loans, securities, real estate, mortgage loans, or other investments**, the concern to the analyst is primarily one of valuation. These types of transfers should be at arm’s length and recorded at fair value.

- The analyst should also be alert to possible abuses regarding the **transfer of assets** between insurance affiliates merely to impact the Risk-Based Capital calculation of the affiliates.

- For **management agreements and service contracts**, the main concerns to the analyst relate to the type of service being performed and the reasonableness of the cost or allocation basis. The contract should also specify the frequency of review and adjustment of the cost or allocation basis. This is a common area for abuse when parent companies desire to withdraw
funds from the health entity, but do not want to, or would not be permitted to classify it as a shareholder dividend. The analyst should understand why the parties were motivated to enter into such contracts and particularly the benefit to the health entity.

- For guarantees by the health entity for the benefit of an affiliated entity, the analyst should be aware that if the affiliated entity is unable to perform, it could be subject to material contingent liabilities. The analyst should review Notes to Financial Statements No. 10 to determine if the health entity is subject to this type of potential exposure. For guarantees by an affiliate (usually a parent) for the benefit of the health entity, the analyst should understand the nature of guaranty. Parental Guarantees are not counted as capital, but regulators often rely on them as additional security during the development period of health entities or during implementation of impairment restoration or RBC action plans. Such guarantees should include specific provisions as to triggers and timing of capital infusions. The analyst should review the department’s internal files to obtain a better understanding of the guarantees. In reviewing the guaranty, the analyst should consider the impact that an all-purpose long-term guaranty may have on the market or competing health entities. However, the analyst should be most concerned about the ability of the guarantor to meet the requirements of the guarantee if needed.

Procedures #3 and 4 assist the analyst in determining whether investments in affiliates are significant 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 investment may be substantially overvalued.

Additional steps may be performed when investments in affiliates are significant and the valuation of such investments is a concern. In particular, the analyst should review the level of return on the investment in affiliate, including the source of the investment income (i.e., cash or merely an increase in the accrual). The analyst should not only be alert to the level of investments in affiliate, but also the level of accrued interest relating to investments in affiliate.

The I-SITE application, Global Receivership Information Database (GRID), allows the analyst to review the status of a receivership (i.e., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal, financial and reporting data. Receivables and recoverables due from companies in liquidation proceedings may be partially collected; however, collection will likely be delayed. It is practically certain that balances due at the time a liquidation is closed (the last action date that may be entered in GRID) will never be collected. Evaluating the collectability of reinsurance recoverables requires understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained.

Procedure #5 assists the analyst in evaluating all other affiliated transactions. The analyst’s primary objective in this area is to understand the substance of the transactions and to determine whether they are economic-based. The analyst should closely monitor other affiliated transactions to ensure that the health entity is not exposed to significant collectability risk.

The analyst should review the information obtained in Exhibits 5 and 6, which contain detailed information on amounts due from affiliates and amounts due to affiliates, respectively. The analyst can use the detailed information on amounts due from affiliates to help assess whether the health entity may be experiencing collectability problems. Similarly, the analyst can use the detailed information on
amounts due to affiliates to help assess whether the health entity may be experiencing some liquidity problems.

The analyst should also review the information obtained in Exhibit 7 to determine if transactions with affiliated providers are significant. Non-arm’s length transactions with affiliated providers could present a potential material area of abuse and special attention should be given if there is reason to believe the amounts paid to these particular providers are not reasonable.

The analyst should review Schedule E-Part 1-Cash, to determine if any open depositories are institutions that are affiliates of the health entity. Affiliated open depositories can present additional access and control risk to the health entity that are not present in unaffiliated open depositories.

If the health entity is included in a consolidated federal income tax return and a significant asset for Federal Income Tax Recoverable is recorded on the financial statements of the health entity, the analyst should closely review the financial statements of the parent to determine the parent’s ability to repay the receivable.

The analyst should review the extent of transactions with officers and directors to ensure that the transactions are at arm’s length and are not detrimental to the financial condition of the health entity. General Interrogatories #15 and #16, as well as, Schedule SIS, Stockholder Information Supplement should be studied to determine if there is a potential problem.

Additional steps may be performed when there are concerns that transactions with affiliates may not be economic-based or at arm’s length. For those services provided by an affiliate where a market already exists, such as data processing, actuarial, or investment management, an effective way for the analyst to determine whether an arm’s length transaction exists is to contact one of the vendors and request a proposal or fee estimate for a similar service.

**Discussion of Level 2 Quarterly Procedures**

The Level 2 Quarterly Procedures for Affiliated Transactions are intended to identify 1) significant changes in the corporate structure; 2) whether affiliated transactions that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement are economic-based; 3) whether the transactions are significant, legitimate and properly accounted for; or 4) other significant or unusual transactions with affiliates.
III. Annual Procedures – D.12. Level 2 TPAs, IPAs, and MGAs (Health)

1. Determine whether concerns exist due to a significant amount of the health entity’s direct premiums being written through Managing General Agents (MGAs) and Third Party Administrators (TPAs).
   a. Review General Interrogatories #4.1 and 4.2. Did any agent, general agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the insurer) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of either the sale of new business or renewals?
   b. Review Notes to Financial Statements #19 - Direct Premiums Written produced by Managing General Agents/Third Party Administrators. Was the aggregate amount of direct premiums written through MGAs and TPAs greater than (i) 10 percent of total direct premiums written or (ii) 5 percent of capital and surplus?

Additional procedures and prospective risk considerations if further concerns exist:
   c. Review Notes to Financial Statements #19 - Direct Premiums Written produced by Managing General Agents/Third Party Administrators (which lists individual MGAs and TPAs through which direct writings are greater than 5 percent of capital and surplus). Determine the following: 1) which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the health entity), 2) the types and amount of direct business written by the MGAs and TPAs, and 3) the types of authority granted to the MGAs and TPAs by the health entity.
   d. For the more significant MGAs and TPAs, request information from the health entity regarding commission rates and any other amounts paid to the MGAs and TPAs. Review the information for reasonableness and compare the commission rates to those paid by the health entity to other agents.
   e. For more significant MGAs and TPAs, request information from the health entity to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether the reinsurance was arranged by the MGA or TPA. If the MGA or TPA arranged for the reinsurance, determine whether the MGA or TPA is affiliated with the reinsurer and consider reviewing the reinsurance agreements to determine if the terms are reasonable.
   f. Determine whether the MGAs utilized by the health entity are properly licensed and whether the TPAs utilized by the health entity hold valid certificates of authority. (In some states, a health entity may utilize an MGA who is not licensed if biographical questionnaires have been submitted for each individual owning more than 10 percent of the MGA. If this provision is applicable and the MGA is not licensed, verify that the required biographical questionnaires have been submitted.)
   g. Request copies of the contracts between the health entity and its more significant MGAs and review to determine that the contracts include the minimum required provisions per Section 4 of the NAIC Managing General Agents Act (#225) and/or the applicable sections of the Insurance Code.
   h. Request copies of the contracts between the health entity and its more significant TPAs and review to determine that the contracts include the minimum required provisions per Sections 2, 4, 6, 7 and 8 of the NAIC Third-Party Administrator Statute (#90) and/or the applicable sections of the Insurance Code.
III. Annual Procedures – D.12. Level 2 TPAs, IPAs, and MGAs (Health)

i. For the more significant MGAs utilized by the health entity, request and review the following:
   i. The most recent independent CPA audit of the MGA. If not available, request the most recent annual report.
   ii. If, with respect to business produced by the MGA, the MGA provides the health entity with claim reserve and/or claim adjustment expense reserve estimates that are incorporated into the health entity’s financial statement, an opinion from an actuary employed or retained by the MGA attesting to the adequacy of such reserves.
   iii. Documentation supporting the health entity’s periodic (at least semi-annual) on-site review of the MGAs underwriting and claims processing operations, as well as its disaster recovery plan.

j. If there are concerns regarding the business placed with the health entity by an MGA or TPA, consider determining if other health entities are utilizing the same MGA or TPA and perform the following:
   i. Compare the contract between the health entity and the MGA or TPA with the contracts between the other health entities and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates).
   ii. Compare the health entity’s claim and claim adjustment expense ratios on the business placed by the MGA or TPA with those of the other health entities utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the health entity may be receiving a disproportionate amount of “bad” business from the MGA or TPA.
   iii. Review analyst notes or exam reports for the other companies for potential problems or adverse findings.

2. Determine whether concerns exist due to a significant amount of the claims that are preauthorized or processed by TPAs or Independent Practice Associations (IPAs).
   a. Is the ratio of direct medical expense payments made to intermediaries to total medical expense payments greater than 5 percent?

Additional procedures and prospective risk considerations if further concerns exist:
   b. Request a listing of significant TPAs and IPAs that pre-authorize or process claims for the health entity, by line of health business (e.g., pharmacy, vision, mental health) and/or provider types (Hospitals, Physicians).
   c. Determine whether the TPAs and IPAs utilized by the health entity are properly licensed to process, preauthorize or otherwise administrator claims.
   d. For the more significant TPAs or IPAs utilized by the health entity, request and review the following:
      i. Contracts between the health entity and the TPA or IPA to determine whether the contracts include minimum provisions.
      ii. The most recent independent CPA audit of the TPA or IPA. If not available, request the most recent annual report.
III. Annual Procedures – D.12. Level 2 TPAs, IPAs, and MGAs (Health)

iii. If, with respect to business produced by the TPA or IPA, the TPA or IPA provides the health entity with claim reserve and/or claim adjustment expense reserve estimates that are incorporated into the health entity’s financial statement, an opinion from an actuary employed or retained by the TPA or IPA attesting to the adequacy of such reserves.

iv. If the TPA or IPA provides paid claims data that is used by the health entity in establishing claim reserves, determine whether the health entity or the actuary providing the health entity’s claim reserve certification tested data provided by the TPA or IPA.

v. Documentation supporting the health entity’s periodic (at least semi-annual) on-site review of the TPAs or IPAs underwriting and claims processing operations, as well as its disaster recovery plan.

vi. Review analyst notes or exam reports for the other companies using the same TPA or IPA if there is reason to believe problems exist with those entities.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding whether concerns exist due to a significant reliance on TPAs, IPAs or MGAs. 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 health entity’s use of TPAs, IPAs and MGAs under the specific circumstances involved.

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

- Contact the health entity seeking explanations or additional information
- Obtain the health entity’s business plan
- Require additional interim reporting from the health entity
- Refer concerns to the examination section for targeted examination
- Refer concerns regarding a particular TPA, IPA or MGA to the examination section for examination of the TPA, IPA or MGA
- 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 ________
III. Quarterly Procedures – D.12. Level 2 TPAs, IPAs and MGAs (Health)

1. Review General Interrogatories, Part 1, #5. Have there been any significant changes regarding the terms of any agreements with MGAs or TPAs?

**Summary and Conclusion**

Develop and document an overall summary and conclusion regarding whether concerns exist due to a significant reliance on TPAs, IPAs and MGAs. 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 health entity’s use of TPAs, IPAs and MGAs under the specific circumstances involved.

Does the analyst recommend that one or more of the Additional Procedures in the annual Level 2 be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst ___________ Date ________

Comments as a result of supervisory review.

Reviewer ___________ Date ________
Overview

The importance of understanding the contractual relationship between a health entity and a subcontractor cannot be overstressed or underestimated. Health entities can utilize third party administrators (TPAs) and managing general agents (MGAs). In addition, Individual Practice Associations (IPAs) or other provider-based organizations are utilized to perform similar services, and also can add the element of risk transfer (discussed in detail in section III.D.9.). These organizations are often referred to as Risk Bearing Entities (RBEs) (discussed in section VII.). An analyst must become familiar with the various methods that health entities employ in their subcontracting arrangements. Also, the terminology used for the multiple types of subcontracting arrangements is continually changing and may vary from state to state. Each individual state, as a general rule, has approached the regulation of delegation of services and business risk differently. Therefore, regulatory attention to the transfer of various types of business functions from health entities to subcontractors is one of the most complex and serious challenges currently faced by regulators.

The NAIC Third-Party Administrator Statute (#90) (TPA Statute) defines a TPA as any person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from or adjusts or settles claims in connection with life or health insurance coverage, annuities or workers’ compensation insurance. However, the TPA Statute exempts certain persons from being considered TPAs, including, among others: insurers (or health entities), licensed agents whose activities are limited exclusively to the sale of insurance, licensed adjusters whose activities are limited to the adjustment of claims, and MGAs.

The NAIC Managing General Agents Act (#225) (MGA Act) defines an MGA as any person who 1) manages all or part of the business of a health entity (including the management of a separate division, department or underwriting office) and 2) acts as an agent for such health entity, who, with or without the authority, produces, directly or indirectly, and underwrites an amount of gross direct written premiums equal to or more than 5 percent of the health entity’s surplus in any one quarter or year and either adjusts or pays claims or negotiates reinsurance on behalf of the health entity. However, the MGA Act exempts certain persons from being considered MGAs for purposes of the Act, including employees of the health entity and underwriting managers under common control with the health entity whose compensation is not based on the volume of premiums written.

MGAs produce or solicit business for some health entities and can also provide one or more of the following services: underwriting, premium collection, enrollment changes, claims adjustment, claims payment and reinsurance negotiation. MGAs can be used by health entities to increase the volume of business written without having to expand internal staffing, and to facilitate entry into new lines of business or geographical locations. Although this may help a health entity to gain critical mass, it can also lead to rapid growth and becoming over leveraged. A written contract should be executed with each MGA and should set forth the specific responsibilities of each party.

TPAs can serve this function as well, but are more typically used in the processing or preauthorization of claims, or the administration of particular types of health business. This includes benefits for prescription drugs (pharmacy benefit managers), dental, mental health and chiropractic service for health entities that underwrite comprehensive medical coverage. In these cases, it is critical that the health entity is able to obtain timely and accurate data from the TPA in order to adjust its reserving and pricing assumptions accordingly. It should be noted that TPAs might contribute to net income of the health entity via reduced claims expenses (e.g., pharmaceutical rebates from manufacturers). TPAs are also often used to administer uninsured business (ASO/ASC) that is solicited by a health entity when such entity is either precluded by statute or regulation from acting as a TPA, or where it desires to separate this function from
its insurance operations. In these cases the TPA is often affiliated with the health entity. A health entity may also provide stop loss insurance to groups administered by TPAs. IPAs, which include other provider-based organizations, can act like TPAs but also add the element of risk transfer. In all of these arrangements it is important to identify how much of the claims cost or underwriting risk is being assumed by each entity.

The more authority that is delegated to TPAs, IPAs and MGAs, the greater the potential impact of mismanagement making it more important for the health entity to provide active ongoing oversight into the MGAs or TPAs operations. If the health entity relinquishes too much control, management may not be able to effectively guide and monitor the entity's operations. TPAs, IPAs and MGAs may have priorities or needs that conflict with those of the health entity. When MGAs are compensated based on the volume of business written, there may be incentive to write as much business as possible, without adequate underwriting controls. TPAs are also often compensated on the basis of claim volume processed, which may lead to lack of adherence to claims adjudication rules and procedures. These types of conflicts have played a significant part in the failure of several health entities. Alternatively, when TPAs or IPAs preauthorize or process claims, they can cause problems for health entities that must meet regulatory requirements for claims processing. Also, if customer service is delegated to the MGA or TPA as part of the claims payment process, the health entity retains the responsibility if regulatory requirements are not met. In some cases, these problems can result in sizable penalties imposed on the health entity. Furthermore, TPAs, IPAs and MGAs can be responsible for establishing reserves for unpaid claims, or for providing paid claims data that is used by the health entity in estimating reserves for unpaid claims. Note, in some states, IPAs need to be licensed as TPAs or claims adjusters to perform certain functions in a state.

It is important that the health entity actively supervises and monitors the financial impact that TPAs, IPAs and MGAs have on the entity, on an ongoing basis, to ensure their adequate performance. To effectively monitor TPAs, IPAs and MGAs, health entities should obtain and review annual independent financial examinations and financial reports of the TPAs, IPAs and MGAs utilized. In addition, the NAIC model acts regarding MGAs and TPAs require health entities to periodically perform on-site reviews of the underwriting and claims processing operations of each MGA and TPA utilized and these requirements should be applied to health entities. The health entity should also review membership administration and customer service processes, if they are delegated to the TPA, IPA or MGA.

**Discussion of Level 2 Annual Procedures**

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. The analyst should also consider the health entity’s corporate governance which includes the assessment of the risk environment facing the health entity in order to identify current or prospective solvency risks, oversight provided by the board of directors and the effectiveness of management, including the code of conduct established by the board of directors.

The procedures in the TPAs, IPAs and MGAs section of the Level 2 Annual Procedures are designed to assist the analyst in identifying those health entities that may have problems due to significant reliance on TPAs, IPAs and MGAs. The two procedures in the TPAs, IPAs and MGAs Annual Financial Statement Supplemental Procedures are designed to determine the extent to which TPAs, IPAs and MGAs are used to write and administer business written by the health entity. The Annual Financial Statement contains information regarding the MGAs and TPAs utilized the types and amount of direct premiums written by each, and the types of authority granted to each by the health entity. The Annual Financial Statement and
Health Risk-Based Capital (RBC) reports also contain information relative to capitated arrangements in Annual Financial Statement Exhibit 7, Part 1 – Summary of Transactions With Providers and RBC report page XR015 that can be used as a starting point to determine whether IPAs are processing claims. The Annual Financial Statement also contains information on health care receivables, which can also be indicative of TPA arrangements, particularly with regard to pharmaceutical claims. Additional procedures, including prospective risk are also available if the level of concern warrants further review as determined by the analyst.

Procedure #1 assists the analyst in determining whether a significant amount of the health entity’s direct premiums are being written through MGAs and TPAs. While the amount of direct premiums written by MGAs and TPAs is not necessarily an indication of a problem or concern, this procedure provides an indication to the analyst of the health entity’s exposure to potential abuse by MGAs and TPAs. MGAs and TPAs who had been delegated significant authority without health entity oversight have played a major role in the insolvency of several large health entities.

Additional steps may be performed if there are concerns regarding the health entity’s use of MGAs and TPAs. The analyst should consider reviewing the information in Note to Financial Statements No. 19 - Direct Premiums written by Managing General Agents/Third-Party Administrators in more detail than was done as a part of the Level 2 Annual Procedures review to determine which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the health entity), the types and amount of direct premiums written by each, and the types of authority granted to each by the health entity.

For the more significant MGAs and TPAs, the analyst should consider requesting information from the health entity to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether the MGA or TPA arranged for that reinsurance. If the MGA or TPA arranged for the reinsurance, the analyst might consider determining whether the MGA or TPA is affiliated with the reinsurer. In addition, the analyst should consider reviewing the reinsurance agreements to determine whether the terms are reasonable. For the more significant MGAs and TPAs, the analyst should also consider requesting information from the health entity regarding commission rates and any other amounts paid to the MGAs and TPAs, reviewing that information for reasonableness and comparing the commission rates to those paid by the health entity to other agents. Any arrangement involving sliding scale commissions based on loss ratios or a sharing of interim profits on business where the MGA or TPA establishes claim liabilities or controls claim payments should be reviewed closely to determine if there is potential for abuse by the MGA or TPA. In addition, the analyst might also consider determining whether the MGAs utilized by the health entity are properly licensed and whether the TPAs utilized by the health entity hold valid certificates of authority.

To evaluate the health entity’s oversight of significant MGAs and TPAs, the analyst should consider requesting from the health entity copies of its contracts with the MGAs and TPAs to determine compliance with the minimum contract provisions per the NAIC Model Managing General Agents Act and the NAIC Third-Party Administrator Statute and/or the applicable provisions of the Insurance Code. The analyst should also consider requesting from the health entity copies of financial statements for the significant MGAs and TPAs and documentation supporting the health entity’s periodic (at least semi-annual) review of the underwriting and claims processing systems. If there are concerns regarding the business placed with the health entity by an MGA or TPA, the analyst should consider determining if other health entities are utilizing the same MGA or TPA and comparing the contract between the health entity and the MGA or TPA with the contracts between the other health entities and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates). The analyst should also consider comparing the health entity’s loss and loss adjustment expense (LAE) ratios on the business placed by the MGA or TPA with those of the other health entities utilizing the same MGA or TPA to
determine whether the ratios are similar or whether it appears that the health entity may be receiving a disproportionate amount of “bad” business from the MGA or TPA.

Procedure #2 assists the analyst in determining whether a significant proportion of the health entity’s claims are being pre-authorized or processed by TPAs and IPAs. While the proportion of claims processed by TPAs or IPAs is not necessarily an indication of a problem or concern, this procedure does provide the analyst with the health entity’s possible exposure to potential regulatory penalties, unpaid claim reserve misstatement, and other financial exposures to TPAs and IPAs that can affect the solvency of the health entity.

Additional steps may be performed if there are concerns regarding the health entity’s use of TPAs and IPAs to process claims. Many of the procedures are similar to those contained in Level 3 procedure #1. Again, the more authority that is delegated to a TPA or IPA, the more important it is for the health entity to provide active ongoing oversight into the TPAs or MGAs operations. The analyst should review a listing of all significant TPAs and IPAs and verify that all are properly licensed and that the health entity’s contracts with these companies meet minimum standards. The analyst should also request from the health entity copies of financial statements for the significant TPAs and IPAs and documentation supporting the health entity’s periodic review of those companies claims processing systems.

**Discussion of Level 2 Quarterly Procedures**

The Level 2 Quarterly Procedures for TPAs, IPAs and MGAs are intended to identify any significant changes regarding the terms of any agreements with MGAs or TPAs that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.
IV. Supplemental Procedures and Analyst Reference Guide

A. Management Considerations
B. Audited Financial Report
C. Statement of Actuarial Opinion
   1. Property/Casualty and Title
   2. Life/A&H and Fraternal
   3. Health
D. Management’s Discussion and Analysis
E. Holding Company System Analysis
   1. Non-Lead State Procedures
   2. Form A Procedures
   3. Form B Procedures
   4. Form D Procedures
   5. Form E (or Other Required Information)
   6. Extraordinary Dividend/Distribution
   7. Analyst Reference Guide
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.

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.
   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.
IV. Supplemental Procedures – A. Management Considerations

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.
IV. Supplemental Procedures – A. Management Considerations

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 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.
IV. Supplemental Procedures – A. Management Considerations

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.
   f. Are there internal and/or external prospective risks that have the potential to impact the overall business plan?

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.

IV. Supplemental Procedures – A. Management Considerations

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.

Risk Management

23. 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.

24. 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.
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, that 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)*;
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.
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.

Procedures #23 and #24 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 General Interrogatory – Part 1, #10.6 for an explanation.
   b. Does the Audit Committee membership meet independence requirements of the domiciliary state insurance laws?

18. Has the insurer been granted any exemptions under Sections 7H, 14H or 17A of the NAIC Annual Financial Reporting Model Regulation? If “yes,” review General Interrogatories – Part 1, #10.1 through #10.4.

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 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 includes 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 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?
(Property/Casualty and Title)

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 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.
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 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)?
(Property/Casualty and Title)

e. Note any major risk factors or explanations discussed by the actuary. Regardless of whether the answer to Exhibit B, Item #6 is “Yes” or “No,” explanation of major 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 address material adverse deviation in his/her opinion.

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 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 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 Schedule F

23. The insurer failed the following IRIS ratios (check all that apply):
   - None.
   - One-year development (Schedule P, Part 2) divided by prior year’s Surplus (Five-Year Historical Data).
   - Two-year development (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-year and 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 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 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”; booked reserves are at or near the actuary’s point estimate and/or within the actuary’s range
   • Opinion conclusion is “Deficient”; booked reserves are materially below the actuary’s point estimate and/or below the low end of the actuary’s range
   • Opinion conclusion is “Redundant”; booked reserves are materially above the actuary’s point estimate and/or above the high end of the actuary’s range
   If the booked reserves are deficient and/or the Summary is not consistent with the Opinion, document any concerns.
(Property/Casualty and Title)

6. Did the company experience one-year development in excess of 5 percent of surplus as measured by 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? Was the discussion more detailed than in the Opinion? 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 in-house (company) 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 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 the company and its appointed actuary regarding expectations around the reported information. Section 2 provides that the Opinion should contain four clearly designated sections: Identification, Scope, Opinion, and Relevant Comments. While illustrative language is provided in the Instructions, specific language is not required, provided the information is clearly conveyed.

Section 3 (Identification) is self-explanatory. No appointed actuary should have difficulty providing clarity. The actuary is rendering his or her opinion as an individual, not the firm the actuary represents.

Section 4 (Scope) is self-explanatory. Required reserve amounts upon which the Opinion is based are consolidated into Exhibit A. Required disclosure amounts are consolidated into Exhibit B. The exhibit structure lends itself to easier identification of zero and non-zero amounts and comparison 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 see a need for immediate attention. The illustrative language is not required. The actuary is required to explicitly identify his or her opinion within one of five categories. The illustrative language is based on the most commonly rendered opinion—that the carried reserves make a reasonable provision. Should any other category 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. Then the actuary must 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 chosen to 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 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. Using 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 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:

If 10 percent 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 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, but 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

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 for the decision for further regulatory attention.

Sections 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.
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 Financial 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  Point  High</td>
<td>Low  Point  High</td>
</tr>
<tr>
<td>B. Actuary’s Estimates</td>
<td>17,000 20,000 23,000</td>
<td>21,500 25,000 28,000</td>
</tr>
<tr>
<td>C. Company Carried Reserves</td>
<td>20,000</td>
<td>25,000</td>
</tr>
<tr>
<td>D. Difference</td>
<td>3,000 0 (3,000)</td>
<td>3,500 0 (3,000)</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 that case there is no difference between the actuary’s estimate and the carried amount. There may be small variations on this case in which the actuary’s estimate is “close to” the company carried reserves. The analyst needs to determine “How close is close enough?” Because the regulatory emphasis is on financial solvency, 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  Point  High</td>
<td>Low  Point  High</td>
</tr>
<tr>
<td>B. Actuary’s Point Estimates</td>
<td>17,000 20,000 23,000</td>
<td>21,500 25,000 28,000</td>
</tr>
<tr>
<td>C. Company Carried Reserves</td>
<td>21,000</td>
<td>26,500</td>
</tr>
<tr>
<td>D. Difference</td>
<td>4,000 1,000 (2,000)</td>
<td>5,000 1,500 (1,500)</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 high 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.

When the actuary’s estimate is greater than the carried reserves, the question of “How close is close enough?” becomes more relevant. This is a more challenging situation for the analyst to evaluate.

**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></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 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

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, carrying reserves more than 5 percent (of surplus) below the actuary’s point estimate or range midpoint is concerning, 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 material adverse deviation 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 that there are significant risks for 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 carried amounts.

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 RMAD 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.

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 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 estimate 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 companies, 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 in-house actuary**

If the appointed actuary is a company employee, the analyst should consider contacting that actuary regarding any issues noted in the Opinion or the Summary.

The classes of business for which the insurer has provided coverage can greatly affect the type of liabilities that arise. Pollution 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. Construction defect claims have a 10-year reporting period in some states, making their liabilities particularly difficult to estimate. Other uncertainties can arise over asbestos or other types of mass tort claims. The analyst should consider submitting a request for additional information from the insurer if an RMAD from these types of claims is identified.

**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 Schedule P, Parts 1 and 2.
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 for 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 companies, 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

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

2. 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?

3. Does the SAO cover at least the following items and amounts: aggregate reserve for life policies and contracts (Exhibit 5); aggregate reserve for accident and health contracts (Exhibit 6); aggregate reserve for deposit-type contracts (Exhibit 7); and policy and contract claims – liability end of current year (Exhibit 8, Part 1)?

4. 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?

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

6. 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)

7. 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

8. 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**

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

10. 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.

11. 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
Summary (Life/A&H and Fraternal)

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

12. 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.

Summary (Life/A&H and Fraternal)

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)

13. 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?

14. 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.

15. 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 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

Summary (Life/A&H and Fraternal)

☐ 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: 1) aggregate reserves for life contracts (Exhibit 5), 2) aggregate reserves for accident and health contracts (Exhibit 6), 3) aggregate reserve for deposit-type contracts (Exhibit 7), and 4) policy and 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* assists 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 use the New York 7 tests. This scenario testing may highlight the impact of prolonged low interest rates. As stated above, the company actuary may perform alternative stochastic testing as some states may not require the NY7 scenarios be tested and other scenarios may be used.

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 provide a qualified health actuary means a member 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*. 

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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. 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.

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.

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2 *Accounting Practices and Procedures Manual, Appendix A-822* provides guidance for Asset Adequacy Analysis Requirements. The only companies filing the Health Annual Financial Statement that are subject to the requirements of Appendix A-822 are those licensed as life insurance companies.

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 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.
IV. Supplemental Procedures – D. Management’s Discussion and Analysis

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 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

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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.
IV. Supplemental Procedures – E.1. Non-Lead State Holding Company System Analysis

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 ____________

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 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 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 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 holding company analysis? Please document any items briefly here and communicate those findings to the Lead State.
IV. Supplemental Procedures – E.1. Non-Lead State Holding Company System Analysis

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.

- 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 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.

Recommendations for further action:

- Communicate any concerns to the Lead 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.

Certain procedures include the 2010 revisions to the Insurance Holding Company System Regulatory Act and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions. For states that have not adopted these revisions, the requirements of your own state’s laws and regulations should be applied when reviewing Form A. Changes related to the 2010 revisions are highlighted gray in the text below.

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

Determine whether the organizational chart identifies and states the relationship of every member of the insurance holding company system, except for affiliates with total assets less than 0.5 percent of the total assets of the ultimate controlling person within the 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.
IV. Supplemental Procedures – E.2. Form A

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.

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?

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

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.
- 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.

Certain procedures include the 2010 revisions to the Insurance Holding Company System Regulatory Act and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions. For states that have not adopted these revisions, the requirements of your own state’s laws and regulations should be applied when reviewing Form B. Changes related to the 2010 revisions are highlighted gray in the text below.

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, except affiliates with total assets equal to or less than 0.5 percent of the total assets of the ultimate controlling person within the holding company system.
   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).
IV. Supplemental Procedures – E.3. Form B

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 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.
IV. Supplemental Procedures – E.3. Form B

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. Non-lead Holding Company System Analysis 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 Affiliated Transactions Level 2 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_______
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
IV. Supplemental Procedures – E.4. Form D Procedures

- 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

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
IV. Supplemental Procedures – E.4. Form D Procedures

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.

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?
IV. Supplemental Procedures – E.4. Form D Procedures

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.

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.

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 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
IV. Supplemental Procedures – E.4. Form D Procedures

- 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.

Certain procedures include the 2010 revisions to the Insurance Holding Company System Regulatory Act and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions. For states that have not adopted these revisions, the requirements of your own state’s laws and regulations should be applied when reviewing Form E or other required procedures. Changes related to the 2010 revisions are highlighted gray in the text below.

1. Does Form E or other required information state the names and addresses of the persons 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 persons affiliated with the persons 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 persons 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 persons identified in questions 1 and 2 currently benefit from in this state
   - Historical market and market share data for each person 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
IV. Supplemental Procedures – E.5. Form E (or Other Required Information)

Assessment of Form E or Other Required Information

6. If the Form E or other required information identifies certain thresholds that are exceeded, indicating evidence of the transaction’s violation of the competitive standards within the state, has the applicant provided appropriate information or arguments that support the transaction does not violate the competitive standard? If “no,” explain.

7. In the department’s review of the Form E or other required information, did the Department note any concerns or risks regarding the impact of the proposed merger or acquisition on the market share or competition within the state? Explain.

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________

Non-Lead (Domestic) State Holding Company Analysis Procedures

Refer to Chapter V. Group-wide Supervisions D. Corporate Governance Risks 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 persons 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 persons, 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 December 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 December 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 December 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.

NOTE: Certain procedures include the 2010 revisions to the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). For the states that have not adopted these revisions, the requirements of your own state’s laws and regulations should be applied when reviewing these filings. Changes related to the 2010 revisions are highlighted in the procedure text.

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.

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 48 (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.
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? (See Modified Calculation of Total Adjusted Capital at the end of this chapter.)
   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 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.
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 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 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 croschecks 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 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 (Exhibit 1 following Supplemental Procedures). 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 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 General Interrogatories. Specific attention should be given to 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 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
C. Holding Company System Analysis Procedures (Lead State)
D. Corporate Governance Risks
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
Introduction

The framework for group-wide supervision within the state-based system of regulation is set forth in the NAIC’s Insurance Holding Company System Regulatory Act (#440), the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450), the NAIC 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 either 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.
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 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 the Financial Analysis Handbook (Handbook) and 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 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.

V. Group-Wide Supervision – A. Framework

- **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 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.

**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.
V. Group-Wide Supervision – A. Framework

- Phase 3 – Identify and Evaluate Risk Mitigation Strategies/Controls—These strategies/controls include management oversight, policies and procedures, risk measurement, control monitoring, and compliance with laws.

- Phase 4 – Determine Residual Risk—Once this risk is determined, the examiner can determine where to focus resources most effectively.

- Phase 5 – Establish/Conduct Detail Examination Procedures—Upon completion of risk assessment, determine nature and extent of detail examination procedures to be performed.

- 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:

- Assess 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.

- Assess 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 Lead State/Group-Wide Supervisor 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.

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.H. – Periodic Meeting with Group, 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 NAIC’s *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.

The NAIC Lead State Summary Report, located on I-SITE, within Summary Reports, provides up-to-date information on direct and gross premiums written, admitted assets, and last examination date for each company as well as contact information for communicating with all domestic states. It can be sorted on a particular NAIC group code to help states reassess the lead state for that group to the extent there has been some change in the group (e.g. acquisition or disposal of an entity or major restructure) that...
materially affects the above factors. It is not necessary to reassess the lead state on a periodic basis (e.g. every 1 to 5 years) unless there has been a material change in the group that affects the above factors.

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 domestic. To increase the effectiveness of this concept, it may be helpful for the lead state to find a means to make sure that each group for which it is the lead is aware that it is, in fact, the lead state for that group. This may include directing it to certain information or through some other communication.

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

The Model #440 adopted by all the states established 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 1) profitability; 2) leverage; 3) liquidity; and 4) overall financial condition. Although much of this analysis can be driven by information from the group’s financial statements submitted as part of the registration statement, in most cases the analysis requires further discussion with management of the group. See Section V.F. – Own risk and Solvency Assessment (ORSA) Procedures for further guidance regarding periodic meeting with group.

Completing the holding company analysis procedures as detailed in Section V.C. – Insurance Holding Company system Analysis (Lead State) is one of the roles of the lead state. These procedures are 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 group could have on the domestic insurer, which requires a basic level of understanding of the group’s risks. The lead state should determine the extent to which the development of a Group Profile Summary and a supervisory plan that is appropriate for the nature, scale and complexity of the group is necessary. For many groups, the creation of the Group Profile Summary may not be necessary and therefore, the conclusion/summary would be more appropriately documented in the holding company analysis procedures or the holding company section of the Insurer Profile Summary (IPS).

Corporate Governance Risks

The NAICs Model Regulation to Define Standards and Commissioners Authority for Companies Deemed to be in Hazardous Financial Condition (#385) specifically indicates that if an officer, director, or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position, the insurer can be deemed to be a company that is in a hazardous financial condition. Clearly, this inclusion recognizes that such a situation is a risk to a policyholder. For this reason, Model #385 specifically provides the supervisor with the authority to issue and order that insurer to correct corporate governance practice deficiencies, and adopt and use governance practices acceptable to the commissioner.

The NAIC has incorporated into its Annual Financial Reporting Model Regulation (#205) specific governance requirements as it pertains to insurers audit committees. Most notably, the regulation requires an increasing amount of independent audit committee members as the premium increases. The calculation of this independence requirement may be provided to the audit committee on an aggregate basis for insurers in the insurance holding company system. However, specific reporting is limited and instead governance is assessed with information gathered during the examination and analysis process.

Assessing the corporate governance of the group as detailed in Section V.D. – Corporate Governance Risks 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 NAIC’s 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 NAICs 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 is one of the roles of the lead state.

Market Conduct Risks

This Handbook discusses within Section I.A. – Introduction-Department Organization and Communication the need for communication with other divisions within the insurance department. This Handbook also discusses within Section I.B. – Introduction-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 upon 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
V. Group-Wide Supervision – B. Roles and Responsibilities of Lead State/Group-Wide Supervisor

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.F. – Own Risk and Solvency Assessment (ORSA) 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, since 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 since 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.G. Form F – Enterprise Risk Management Process Risks 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.

The supervisory college creates a more unified approach towards addressing global financial supervision issues. Effective and efficient regulatory scrutiny of group-wide issues occurs in the context of an organized approach with all significant regulatory parties involved, which could include regulatory agencies from countries outside of the U.S, and other state and federal agencies within the U.S.

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.
V. Group-Wide Supervision – B. Roles and Responsibilities of Lead State/Group-Wide Supervisor

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 NAIC’s 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.H. – Periodic Meeting with Group is one of the roles of the lead state.
Lead State Holding Company Analysis

Name of Insurance Holding Company System ____________________

Understand the Insurance Holding Company System

1. Evaluate and document below an understanding of the insurance holding company system. Consider using the following if available and/or applicable: statutory Schedule Y, Form B Registration Statement, Own Risk and Solvency Assessment, and financial filings of the insurance holding company system and/or person. Document an understanding of the following:

   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.).
   c. Business segments and percent of overall revenue per segment (Use segments as defined in the most current 10K).
   d. Number of insurers and respective jurisdictions.
   e. Level of international insurance activities (including branches).
   f. 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?
   g. 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.)
   h. Recent news and press releases that identify changes in the holding company or financial results.
   i. Potential risks as a result of the aforementioned considerations.
   j. 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.

Evaluate the Overall Financial Condition of the Insurance Holding Company System

For the following financial assessment procedures consider using the following, if available and/or applicable: Form B, shareholders’ report, combined financial statements, quarterly and annual Securities and Exchange Commission(SEC) filings, International Financial Reporting Standards (IFRS) filings, personal net worth statements, audited financial statements, management assessment on internal controls, auditor’s assessment on management’s assessment on internal controls, media releases, confidential information from other regulatory/supervisory bodies, and any other available sources. If the domestic insurers in an insurance holding company system consist of only run-off companies, the domestic
regulator, at his or her discretion, should determine the value, if any, of performing an insurance holding company system analysis. If it is determined that an insurance holding company system analysis would be of no added value, this determination should be documented.

2. If publicly traded, review the insurance 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.

3. Assess the insurance holding company’s sources of capital.

4. Profitability: Evaluate the insurance holding company system’s operating and net income over the past three years and document any trends as well as the primary drivers of those trends.

5. Financial Position: Evaluate the insurance holding company system’s shareholder’s equity (or equivalent), and document any negative deterioration.

6. Leverage: Review the insurance holding company system’s leverage positions, and document any negative trends and/or deteriorating ranges.

7. Liquidity: Evaluate the insurance holding company’s liquidity and document any negative trends and overall strength.

8. Derivatives: Evaluate the use of derivatives and their purpose. Are the derivatives being used for the hedging of business or to enhance investment yield? Does the level of collateral held for the derivatives contracts seem reasonable? Evaluate the trend of derivatives balances over the last two to three years and discuss any concerns.

Regulator/Supervisor Communication and Coordination and Supervisory College Considerations

9. Using the Lead State Report, identify the primary contact of other involved domestic states. Based on the analysis of the overall insurance holding company structure and the state’s preference, consider whether there is a need to request the confidential Insurer Profile Summary (IPS) report(s) from the applicable U.S. domestic states for insurers within the insurance 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 IPS are requested, identify and document any material concerns or risks that were not covered elsewhere in this analysis.

10. Identify and document any other regulated entities within the insurance 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 insurance 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.
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c. Does the size, complexity and/or interconnectivity of the entity with the insurance 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 of Insurance (DOI) and/or other domestic state(s) within the group have a memorandum of understanding (MoU) to share confidential information with the involved supervisor(s)?

e. Have any 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.

11. If applicable, identify and document contact information for federal or international involved supervisor(s).

12. 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.

13. If your state is leading or participating in a supervisory college of the insurance 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.

14. 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 on Internal Controls
   - Auditor’s Assessment on Management’s Assessment on Internal Controls

15. 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.

**Summary and Conclusion**

Develop and document the insurance holding company analysis, including a summary and conclusion. In addition to each of the previously identified items, the summary and conclusion should identify the group’s:

- Significant events.
- Overall financial condition.
- Key strengths and weaknesses.
- Material concerns.
V. Group-Wide Supervision – C. Insurance Holding Company System Analysis (Lead State)

In developing a conclusion, consider the above procedures, as well as any other procedures that, in the analyst’s judgment, are relevant to evaluating an insurance holding company system under the specific circumstances involved.

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

- Obtain the insurance holding company system’s business plan.
- Obtain the insurance holding company system’s economic capital assessment, if available.
- Meet with the insurance holding company system’s management team and/or board of directors.
- Immediately communicate any concerns to the other domestic states to determine a plan of action to address concerns.
- Contact the insurer seeking explanations of additional information.
- Require additional interim reporting from the group.
- Refer concerns to the examination section for targeted examination.
- Meet with the insurance holding company system’s management team and/or board of directors.
- Other (explain).

Summary Recommendations/Conclusion

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
Special Note: The following procedures are intended to be performed in analyzing the financial condition of the holding company, and are therefore additional procedures that the lead state may want to consider. 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. These are not intended to be performed by domestic states on individual insurers.

Additional Procedures on Key Risk Areas – Insurance Holding Company System

Invested Assets
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.
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?
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.

Non-Invested Assets
4. Review the distribution of the non-invested assets, and assess the overall collectability risk.
5. Review the level of goodwill and intangible assets. Determine the level of goodwill and intangible assets relative to the value of equity. If significant, summarize the following:
   a. Nature of intangible assets.
   b. Change or trend in goodwill.
   c. Source of goodwill.
   d. Impairment of goodwill.

Liabilities
6. Assess whether the insurance holding company system is reliant on the insurance operations for any of the following:
   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.

8. Determine the level of insurance holding company debt and its relative value-to-equity. 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 so, document the nature and outcome of those matters.
   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.


**Financial Position**

11. Review the insurance holding company’s statement of shareholders’ equity.
   a. Has equity decreased from the prior year or deteriorated over the past three years? If “yes,” describe the reason(s) for the decline.
   b. Does the net worth of the insurer(s) represent the total net worth or the majority of the net worth of the insurance holding company system?
   c. Is the net worth of the insurance holding company system less than the net worth of the insurer(s)?

12. If publicly traded, review the changes in the insurance holding company’s outstanding common stock. Document and understand the nature and business purpose of the following: new stock issuance; stock repurchase, stock split, short sales, or change in major exchange listings.

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.
   b. Compare current year extraordinary dividends to prior year dividends to identify any excessive trends in payments.
V. Group-Wide Supervision – C. Insurance Holding Company System Analysis (Lead State)

Operations / Segment Information

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?
      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?
   c. Has the volume of business increased or decreased significantly over the prior year? If “yes,” explain the reason for the change.

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
   b. Collateralization to unauthorized reinsurance
   c. Recent reinsurance transactions
   d. Credit quality of the reinsurer
   e. Collectability of recoverables
   f. Level of surplus aid

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.
   b. Document the amount of investment income by sector that is attributed to dividends received from insurance subsidiaries.
   c. Document the annual investment yield. Has the yield decreased materially over the prior year? If “yes,” explain the reason(s) for the change.
   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. Did the insurance holding company report material realized capital gains/losses? If “yes,” identify the cause of the loss.

17. Review all other sources of revenue, and note any material changes or weaknesses.
V. Group-Wide Supervision – C. Insurance Holding Company System Analysis (Lead State)

18. Review expenses.
   a. Have losses increased or decreased substantially over the prior year? If “yes,” explain the reason for the change.
   b. Have administrative and other expenses increased significantly over the prior year? If “yes,” explain the reason for the change.
   c. Summarize the loss and expense ratios by line of business for material insurance lines and review the trend.

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.

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.

Cash Flow

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.

22. Evaluate any downstream payments and explain the reason(s) for the downstream contributions.

Summary Recommendations/Conclusion

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer ________________ Date ________
## Non-Insurance Company Grid

<table>
<thead>
<tr>
<th>NAC #</th>
<th>FEIN</th>
<th>Name of Securities Exchange if Publicly Traded (U.S. or International)</th>
<th>Name of Parent, Subsidiaries or Affiliates</th>
<th>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>Moody's Rating</th>
<th>S &amp; P Rating</th>
<th>Prospective Risks</th>
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**Comments:**

...
The following information is intended to provide a narrative description of the issues/considerations for the analyst when performing insurance holding company analysis. As discussed in V.B-Roles and Responsibilities of the lead state, group-wide supervision 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.

Understanding 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 Group Profile Summary.</td>
<td>• Coordinate the completion of holding company analysis and consider 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 consider 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 consider preparing a 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>
</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 Analysis checklist represents guidance that the accreditation team will use to evaluate the sufficiency of depth and documentation considerations.</td>
<td>• Complete before Dec. 31st.</td>
<td>• Complete before Dec. 31st.</td>
<td>• If a copy of the analysis has not been received by November from the lead state, 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>• 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 communication of lead state analysis to other domestics before Oct. 31st.</td>
<td>• Complete before Dec. 31st.</td>
<td></td>
</tr>
<tr>
<td>• Complete communication of lead state analysis to other domestics before Oct. 31st.</td>
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*Each state should still review Form B for its domestic companies.
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.

Responsibilities of the Lead State

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 Forms 10Ks or 10Qs) 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.

A sophisticated/complex insurance holding company system may include the following (but not limited to):

- Both insurance and non-insurance operations
- International operations
- Multiple or diverse lines of business
- Numerous entities or segments

Documentation and Communication of Insurance Holding Company System Analysis

Documentation of the analysis work performed should include sufficient evidence of a review of the insurance holding company system. The use of a Group Profile Summary should be considered.

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 document sufficient evidence of a review of the insurance holding company system. 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.

The following analysis work should be documented:

- Review of the insurance holding company structure and operations, including an understanding of all the key business segments, international insurance activity and key entities/persons within the insurance holding company system.
- 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.
- Document an understanding of the financial strength of the insurance holding company system, including financial position, liquidity, leverage, and profitability.
• Document and provide analytical understanding of the key prospective risks within the insurance holding company system, such as financial, legal, reputational, credit, market, or catastrophic risks of regulated and non-regulated entities. For example, such documentation should include summarizing key strengths and weaknesses noted within the insurer profile reports from respective domestic regulators within the group.

• Document the review of any 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.

• Document the understanding of any rating organization changes/actions.

Responsibilities of Each Domestic State

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 Forms B and 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 summary from the lead state of the information 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 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 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. For example, if a lead state did not provide the insurance holding company analysis work papers to a domestic within a group, the analyst could schedule a call to verbally discuss the review. The respective domestic’s states would be expected to document the aforementioned items. If a state relies on the insurance holding company analysis of another regulator communication the lead state should complete such by Oct. 31.

Understanding the Insurance Holding Company System

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.

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 Statutory Annual 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-insurers 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 since 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 since 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 since 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.

Organizational Structure

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.
V. Group-Wide Supervision – D. Corporate Governance Risks

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 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.

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 of this Handbook.

The MD&A and Audited Financial Statement 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.

The Audited Financial Statement provides background, operational information, affiliated transactions, mergers and subsidiary holdings. 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.

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.

**Other Sources of Information for Understanding the Holding Company**

There are many sources of information available to assist the analyst in analyzing holding companies. The most useful sources include consolidated statutory financial statements for property/casualty (P/C) insurers, and the holding company’s annual shareholder’s report. However, other external sources of information exist, including rating reports and analysis from Credit Rating Providers, press releases from the insurance holding company system, and news and other analytical profiles from various financial and news organizations.

Combined statutory financial statements are required for P/C insurers only. These statements have been adjusted for intercompany transactions and affiliated investments.
Shareholders’ reports 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.

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.

The NAIC database and I-SITE provides information primarily on the insurance companies, rather than the insurance holding company system, with the exception of the property and casualty combined annual 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.

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 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.

Specific Procedures in Completing the Insurance Holding Company Analysis

Core Analysis Procedures

The insurance holding company analysis performed by either the lead state, or an agreed upon other designated state(s) is not required to follow any particular form. However, a narrative may be seen as the best form.

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.

Procedures #2–8 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. 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. This 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 #4 assists the analyst in evaluating the profitability of the group. 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 return on equity (ROE) (net income/stockholders equity) over a five-year period. The use of ROE is the most 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, in simple terms, every investor will make a decision to invest, or continue to invest, based upon
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.

Procedure #5 assists the analyst in evaluating the overall financial condition of the group. As discussed within procedure #3, evaluating the adequacy of the overall financial condition, or stockholders’ equity, or capital as it is often referred, within the regulatory environment typically begins with an evaluation of profitability. As noted within that procedure, generally speaking, everything in terms of how a corporate entity operates begins with this understanding. This includes, as a starting point, evaluating the variability in profitability. Some industries carry little to no variability in their profitability. This is typically driven by the business model of the industry itself and the risks that are associated with carrying out that business model. All business models carry risk, although the business of insurance may be one of the few for which its sole purpose is to transfer risk, or assume risk. As insurance regulators well know, some insurance products carry more risk than others, and with that, their profitability is subject to more variability. This is not to suggest that variability in historical profits is the best measure of prospective risk but the point is made because stakeholders, including regulators, often consider such past volatility a starting point for discussion until management presents information that suggests the efforts that have been made to modify that expected pattern and specific risk measures they use to track the success of such efforts. In completing procedure #4, the analyst must begin with first evaluating the variability in the group’s profitability, and from that, establish the normal levels and the extent of variability and drivers of such variability. When performing this procedure, it is also necessary for the analyst to consider the requirement to obtain and understand the nature and function of all non-insurance entities within the
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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 since 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 historical 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 discuss management’s view of the adequacy of the capital for its business and help the analyst better make an appropriate assessment in this area.

Procedure #6 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 eluded 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-insurers within the group. Consistent with procedure #4, 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 don’t 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. 5 years). The following presents different gauges for evaluating this ratio.

<table>
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<tr>
<th>Interest Coverage</th>
<th>Benchmarks</th>
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<tr>
<td>Extremely strong</td>
<td>10 to 1 and higher</td>
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<tr>
<td>Strong</td>
<td>5 to 1</td>
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<td>Adequate</td>
<td>4 to 1</td>
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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 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 higher possibility that shareholders would be left with less value in a bankruptcy since 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 since investors may not be attracted to such groups.

Procedure #7 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 very 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 similar to much of the above, can generally only be conducted through understanding information developed by the group. Information such as this is obtained in the risk-focused examination, but it is likely that the analyst may need to periodically obtain updated information in order to be able to continue to make such an evaluation. Such 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.

Procedures #9 - 12 assists 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.

Procedure #14 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.

Additional/ Supplemental Procedures
The procedures may be completed in part or in total 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. Additional procedures may be appropriate, including those to address possible prospective risks, if such risks warrant such further review as determined by the analyst.
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.

**Assets**

*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.

**Liabilities**

*Procedures #6 - 10* assist 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.

**Financial Position**

*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.

**Operations / Segment Information**

*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 the 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 if 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 that 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.

**Profitability**

*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.

Cash Flow and Liquidity

*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.

Other Considerations

Recent News and Rating Information

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 Capital Markets reports available to 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 investor’s page of publicly held international holding companies’ websites will provide the best source of financial information.

The regulation of international holding companies varies according to the laws of its country of origin. For most European Economic Community 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**

Form 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
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*Reporting Forms and Instructions* (#450). See supplemental procedures for holding company considerations for domestic and non-lead states.
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.
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 \textit{Own Risk and Solvency Assessment Guidance Manual} followed by a narrative that supports the assessment.

A. \textbf{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.

\begin{itemize}
\item \textbullet\hspace{1cm} 5
\item \textbullet\hspace{1cm} 4
\item \textbullet\hspace{1cm} 3
\item \textbullet\hspace{1cm} 2
\item \textbullet\hspace{1cm} 1
\end{itemize}

\textit{Supporting Narrative}

B. \textbf{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.

\begin{itemize}
\item \textbullet\hspace{1cm} 5
\item \textbullet\hspace{1cm} 4
\item \textbullet\hspace{1cm} 3
\item \textbullet\hspace{1cm} 2
\item \textbullet\hspace{1cm} 1
\end{itemize}

\textit{Supporting Narrative}

C. \textbf{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 \textit{(e.g., relationship between risk tolerances and the amount and quality of risk capital)}.

\begin{itemize}
\item \textbullet\hspace{1cm} 5
\item \textbullet\hspace{1cm} 4
\item \textbullet\hspace{1cm} 3
\item \textbullet\hspace{1cm} 2
\item \textbullet\hspace{1cm} 1
\end{itemize}

\textit{Supporting Narrative}

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

\begin{itemize}
\item \textbullet\hspace{1cm} 5
\item \textbullet\hspace{1cm} 4
\item \textbullet\hspace{1cm} 3
\item \textbullet\hspace{1cm} 2
\item \textbullet\hspace{1cm} 1
\end{itemize}

\textit{Supporting Narrative}

E. \textbf{Risk Reporting and Communication} - Provides key constituents with transparency into the risk-management processes and facilitates active, informal decisions on risk-taking and management \textit{(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)}

\begin{itemize}
\item \textbullet\hspace{1cm} 5
\item \textbullet\hspace{1cm} 4
\item \textbullet\hspace{1cm} 3
\item \textbullet\hspace{1cm} 2
\item \textbullet\hspace{1cm} 1
\end{itemize}

\textit{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

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):
Suggested Additional Verification/Areas of Focus for the Financial

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Purpose</th>
</tr>
</thead>
<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.

Form F procedures are included in the 2010 revisions to the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). The following procedures are applicable for states that have adopted the 2010 revisions for Form F.

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% 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, 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 with the results from the Form F review.
- The analyst should update the Group Profile Summary and Supervisory Plan with the 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________

Reviewer _______________ Date________

Comments as a result of supervision review.

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V. Group-Wide Supervision – H. Periodic Meeting with Group

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 upon 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
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.
- The analyst should update the Group Profile Summary and Supervisory Plan.
- 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________
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 Risks 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.

☐ The analyst should update the Group Profile Summary and Supervisory Plan.

Analyst ________________ Date________

Comments as a result of supervision review.

Reviewer ________________ Date_______
Special Note: The following procedures do not supersede state regulation, but are merely additional guidance an analyst may consider useful.

On Nov. 12, 2009 the Group Solvency Issues (E) Working Group (the Working Group) of the Solvency Modernization Initiative (E) Task Force endorsed as guidance the International Association of Insurance Supervisors (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.

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 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.

International Expectations

In the wake of the 2008 global financial crisis, insurance regulators worldwide determined that increased levels of communication, coordination and cooperation among regulators at supervisory colleges is vital to understanding risk trends that could affect domestic insurers and policyholders in an increasing global insurance market. Although insurance companies and policyholders fared reasonably well during the recent global financial crisis, global policymakers see the enhancement of information exchange, cooperation and coordination amongst relevant supervisors as a key component for enhancing the supervision of cross-border financial institutions.¹

In April 2008, the Financial Stability Forum (now the Financial Stability Board, or 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.²

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

¹ 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."

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.

ICP 23-Group-Wide Supervision requires among other things, the following:

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

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.”

U.S. Approach to Supervisory Colleges

The U.S. approach to group solvency assessment is discussed within the Holding Company Systems Analysis chapter of the NAIC’s Financial Analysis Handbook (Handbook) Holding Company Systems Analysis chapter. This section contemplates a written summary analysis that considers any information available on the group, especially information from the 10K and 10Q Securities and Exchange Commissioner Filings for public companies (or similar financial information on non-public insurance groups). States looking for best practices in this area may wish to contact the NAIC Financial Analysis staff. Among other things, this section of the Handbook requires the lead state of all insurance groups operating in the U.S. to obtain an understanding of the entire insurance holding company system; and evaluate the overall financial condition of the entire insurance holding company system.

The evaluation of the overall financial condition of the entire insurance holding company system includes assessing the profitability, leverage, liquidity and overall equity position of the entire insurance holding company system. This analysis places equal importance on each of these items as opposed to placing a higher emphasis on particular items. The equal importance is considered appropriate given that capital markets typically consider each of these elements equally in their consideration of a group. The perspective of the capital markets is considered appropriate because the regulator must understand the limitations and risks within the insurer’s business and financing strategy (i.e., how much capital can be accessed from the capital markets based upon their view of the group) to develop an approach for dealing with any concerns regarding the group. State insurance regulators analyze and examine separately the capital of the group. This is commonly completed within the context of the prospective risk assessment during an examination. Such assessment is typically based upon the examiner’s review of the insurance group’s risk management process and internal capital models where available. Through testing, the examiner is able to determine the appropriateness and effectiveness of such strategies, and make an overall assessment of the group’s risk management processes. Similar assessments are made by state insurance regulators regarding the group’s governance and internal controls. Some states update these assessments through periodic meetings with management when they inquire regarding strategic changes. The documentation of these assessments is formalized in the Group Profile Summary which will be updated once state insurance regulators begin to receive the Holding Company Form F report and Own Risk and Solvency Assessments (ORSA) Summary Report. However, state insurance regulators do not approve or deny the use of such strategies or models, but rather understand and consider them in their overall assessment of the risk of the group. State insurance regulators view the use of such strategies or models as management’s decision, and although the regulator may make recommendations for improvements, including potentially missing elements or inappropriate assumptions, they generally do not require the group to use other methods unless the group’s processes and risks are deemed hazardous to policyholders.

State insurance regulators should be prepared to discuss the details of their examination of the group’s governance, risk management and internal controls processes; including their assessment of the risks inherent in the group’s processes. However, state insurance regulators have found that it’s equally important for the insurance group to provide its own overview of its processes so that all members of the
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college are familiar with the same general information. State insurance regulators find that specific discussion regarding regulators views of these risks is more beneficial to the supervisory college.

Organizational Procedures Performed Before Conducting a Supervisory College

The above bullets under the heading 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 does not materially differ from the criteria contained within this Handbook for determining the lead state. Hence, the below is taken from the IAIS guidance paper and represents a summary of some of the factors to consider.

Determination of the 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 is a state insurance regulator, discussion with the insurance group should place and the state insurance supervisor 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.

In addition, once the state regulator has been determined to be the group-wide supervisor it may publish the determination and that it was endorsed by the supervisory college for the group on its website.

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. The determined state insurance regulator/supervisor should begin to consider who the appropriate members of the college are.

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 regulator should also consider requesting feedback from the insurance group regarding who it believes should be included in the “Tier 1,” since 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 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.

**Information Sharing Agreements**

One of the most important tasks and typically one of the first actions that must be undertaken by the group-wide supervisor before a supervisory college meets to discuss specific issues with an insurance group is creating information sharing agreements. Having one information sharing agreement is preferred.

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 both 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 and therefore, state insurance regulators should take action to complete these information sharing agreements as soon as possible.

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\(^3\) to be able to request from and provide to any other signatory authority having a legitimate interest, information on all issues relevant to regulated insurance companies (including licensing, ongoing supervision and winding-up where necessary) and to other regulated entities such as insurance intermediaries, where appropriate. The MMoU is essentially designed as an alternative vehicle for having every jurisdiction sign a bilateral confidentiality agreement with every other jurisdiction. Further, it facilitates the exchange of confidential information in the supervisory college context. If all members of a supervisory college are also signatory authorities of the IAIS MMoU, it would effectively eliminate the need for every supervisory college member to enter into a bilateral agreement with every other supervisory college member and/or the drafting of a supervisory college specific agreement in order to ensure that confidential information can be freely exchanged

\(^3\) 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.
between supervisory college members. This mechanism has the potential to significantly improve and expedite the cross-border exchange of information between supervisors.

**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 functions and expectations 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 the specific expectations of each supervisor through discussions in the first supervisory college of the group. 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. It also can include clarification on why a particular supervisor was determined to be the lead supervisor(s), group membership, agreement on frequency and location of meetings and finally, the role and responsibilities of the group-wide supervisor. 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” is included in the appendix to this section.

**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 that are being considered for any supervisory college. There can be important and significant differences amongst regulatory bodies that 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.

**Understanding the Group Risks from the View Point of Each Supervisory College Member**

As discussed previously, the terms of reference document is intended to capture the specific expectations of each supervisor. 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 one of the very first colleges where each college member is afforded the time to discuss their perspective of the group. The following is a list of the things that the college may want to ask each member to provide, perhaps in a 5 to 10-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.
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- 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.
- Main risk to which the entity is exposed.
- Exposure to other entities within the group.
- Any other material risks.

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 reorganizations.
- Any regulatory action.

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:

- Setting the date for the meeting (See below for further discussion)
- Setting the agenda for the meeting and distributing at least one week in advance (See below for further ideas)
- Recording outcomes that are achieved at each meeting including: 1) points arising from the meeting; and 2) 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
- Serving as a liaison with insurer management in obtaining information, their participation in the college and any related correspondence
- Developing a preliminary crisis management plan (see below for further discussion)
- Preparing and updating a coordinated work plan (Consider using U.S. Supervisory Plan as starting point)
- Preparing, updating and circulating as changes occur, a contact list of members
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- Requiring a periodic self-assessment of the effectiveness of the college (See below for further discussion)

**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 and 90 days should represent the minimum 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.

Experienced regulators have also noted that the length of the meeting should be specific, and consideration should be given to allow 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).

**Planning other Logistical Aspects for the Meeting**

Many state insurance regulators suggest that a supervisory college only be scheduled during the spring or the fall to avoid potential weather-related cancelations. 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 the entire time that the college is taking place. Most state insurance regulators believe that it is critical that the CEO, chief financial officer (CFO), chief risk officer (CRO) and chief legal counsel are all available to the college during the college. 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 are established with the insurance group officials, immediate steps should be taken to reserve a space for the meetings. Most state insurance regulators believe that strong consideration should be given for using the insurance group’s facilities. Most large insurance groups have facilities that are designed for these types of meetings. This would allow for immediate access to insurance group officials within a short notice to respond to questions that arise. The college must be set up that allows meals and refreshments to be brought into the meeting, thus preventing the possibility that supervisors go in different directions to find local eateries. The college must also be set up in a way that does allow individual supervisors to break for short periods to make short calls in private. Most suggest at least three breakout rooms be available for such use, with a phone and computer, but that can also be used for subgroup meetings if 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.

Once the location of the meeting is identified, the state insurance regulator should immediately proceed to obtain one hotel that can support all of the attendees and is in close proximity to the meeting location. State insurance regulators suggest the use of a hotel that provides for a portal website that gives each participant the ability to make their reservations online throughout the world. It is suggested that the hotel dates available to attendees give them the ability to come into the college a couple days before and after the college, to allow for personal time around the meeting dates.

Once the hotel is identified, it is recommended that a group dinner for at least one night be organized for all of the attendees to allow individuals the opportunity to better acquaint themselves with each other, thus maximizing the ability to have an engaging 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 for 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.

One final issue that is extremely important to understand is the process under which non-lead states will be able to recoup expenses for attending the supervisory college. Although the Insurance Holding Company System Regulatory Act (#440) provides the authority for a state to recoup its expenses related to a supervisory college, the process for collecting may be handled differently by each lead state since states may have different processes for settling expenses with employees as well as billing such amounts to insurers. It is suggested the lead state 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.

**Setting the Agenda**

In the initial college, the focus will be on establishing the college, the group-wide supervisor, the membership, Terms of Reference, and related details. Some state 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 since 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 that the chair 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

- Make introductions.
- Vote on the group-wide supervisor.
- Discuss and vote on the supervisory college membership.
- Begin initial discussion regarding frequency and location of meetings.
- Individual college members’ views regarding role and responsibilities of the group-wide supervisor.
- Discuss plans for documenting agreements into a Terms of Reference document.
- Discuss/establish a crisis management plan.
- Hear an initial high-level presentation from the insurance group regarding its business structure, significant operations and interconnectivity (including non-insurance affiliates), including ownership and management structure and overall operating results.
- Begin to discuss material risks of the group and format for future discussion.
- Set the date and time for the next meeting.

Next Meeting of Supervisory College Agenda Topics

- Make introductions.
- Review and vote on Terms of Reference document.
- Recap discussions regarding material risks of the group.
- Hear a secondary presentation/deeper dive from the insurance group regarding its business plan.
- This should include the group’s financing strategy as well as perceived risks and risk mitigation strategies. Consider requesting specific presentations regarding:
  - Underwriting strategies.
  - Investment strategy.
  - Reinsurance strategy and program.
  - Capital adequacy at group level including 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.
- Consider a closed session with external auditors regarding discussion of their audit approach, and material risks (Obtain clearance from the insurance group before proceeding).
- Conduct initial discussions from the group-wide supervisor regarding their assessment of the group.
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- Share views and assessments of both specific insurers and 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.
- 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.
- 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

- Make introductions.
- Recap discussions and follow up from past meeting.
- Invite group-wide supervisor to share their 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.
- Continue ongoing presentation from the insurance group regarding its risks and changes.
- 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 (i.e., internal audit, actuarial function or risk management processes).
- 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 from Each Meeting

Most state insurance regulators agree that it is important that each participant of a supervisory college 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. The college should also consider requesting that all participants provide their name, title, phone number and e-mail address (or bring their business card), so that a listing of such information can be provided to all participants of the college subsequent to the meeting. State insurance regulators may want to consider providing such information to the insurance group so they can tabulate such information to minimize the resource impact of this effort. This information can be used for different uses, including announcing information from the group (e.g., date, time and/or directions to listen to next investor call) or announcing information from the regulators such as the next scheduled examination.

Crisis Management Plan – (Note: 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 that they could 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 as these are 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.

Develop and document an overall summary and conclusion regarding the college.

- Coordinate and communicate any important information to the non-lead states.
- The analyst should update the Insurance Holding Company System Analysis.
- The analyst should update the supervisory plan.
- The analyst should communicate to the examiner-in-charge any prospective risks identified.
Possible Terms of Reference document for the Group

TERMS OF REFERENCE

[COMPANY NAME] 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.

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 its members in possible future coordinated supervisory actions and arrangements when deemed suitable.

Membership: Supervisory college membership will change over time due to modifications 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 modifications 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 subgroup 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. The chair need not be a specific person as the chair could be a particular jurisdiction or title of a position within the jurisdiction.

Scope of Activities: The supervisory college will aim for 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, supervisory college members will discuss possible procedures for dealing with issues when relevant; such as breaches of solvency positions and the crystallizing of risk exposures.
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The supervisory college will attempt to reference the applicable information of the stated overall strategic plan(s) of [COMPANY NAME] and its insurance subsidiary.

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 negotiate meeting dates and locations that will ensure the involvement of as many of the members as possible. When it is unfeasible for supervisors to be present at a meeting, a best attempt will be made to allow participation via conference calls or web broadcasting. Tier I members will plan to meet every quarter prospectively; one meeting will be held in person annually tentatively. Tier I members may call a meeting together on short notice in the event of an emergency situation. Participation or involvement or both of Tier II and Tier III members will be addressed annually at minimum.

A sample Crisis Management Plan is included in Section V.J.1 – Crisis Management Plan Sample.
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
to the college members.
- 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:
  o The company
  o The regulator
  o The marketplace
  o 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. Additional guidance is anticipated in future editions of this Handbook.

- 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.
VI. Guidance for Notes to Financial Statements
Note 1 – Summary of Significant Accounting Policies

This Note is split into three 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. 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.

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
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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.

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 parts 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 Extraordinary 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 three primary sections. Section (A) focuses on statutory purchases, section (B) focuses on statutory mergers, and section (C) focuses on impairment losses.
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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.

As described above, the analyst should use the information in the first two parts of this Note to obtain a greater understanding of the business combinations into which the insurer has entered. The analyst should use the information in those parts to determine if the value of any unamortized goodwill appears reasonable, but should also use the information in section (C) 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 five different sections, and each requires the insurer to report certain information on discontinued operations. The analyst should use the information provided in the Note to obtain a greater understanding of the operations that have been discontinued and determine the effect that the decision to discontinue could have on the current and future periods. 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, (i.e., no separate line item presentation).

The first section requires an insurer to identify the segment of business that has been or will be discontinued. The second section requires an insurer to disclose the date of disposal, and the third section requires the insurer to disclose the manner of disposal. 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 company is exposed. Generally, an
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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.

As noted above, although the run-off of certain lines of business can alleviate certain problems of an insurer, it might not always be in the best interests of all policyholders. The analyst should consider the type of business being discontinued and the geographic locations of the business to better understand the potential problems that could develop from the run-off. Generally, run-off of business with longer tails represents a greater risk to insurers and should be reviewed more closely. However, run-off of shorter tail business still represents a risk to insurers because, in some cases, the run-off can lead to greater utilization such as that which is experienced in accident and health business. In all cases, the analyst should understand the assumptions used and the work that was performed to ensure that the assets will be sufficient to run-off outstanding losses, such as that performed by a consulting actuary. However, in some cases, where an independent review of the payout pattern was not performed, the insurer might have obtained an irrevocable guarantee from its parent. The insurer may have also arranged for a portfolio transfer of the business through a reinsurance arrangement.

The fourth section requires an insurer to describe the remaining assets and liabilities of the segment at the balance sheet date. The fifth section requires an insurer to quantify the effect on the financial statements, including the balance sheet and the income statement. The analyst should use the information provided in these sections to better understand the potential impact on the insurer. By using this information, the analyst will be able to determine if the business being discontinued is significant in terms of premium volume and reserve levels. Using this information, the analyst might be able to determine if the results of the discontinued operations will be positive or negative. The analyst should not only consider the positive impact that the discontinued operations might have on the profitability of the insurer, but also the impact that the decision will have on cash flow and liquidity. In making this determination, the analyst should also understand how the insurer has accounted for the transaction. As noted above, SSAP No. 24 requires that discontinued operations be reported with an insurer’s continuing operations. In addition, the risk the insurer is exposed to under the discontinuance is of utmost importance and should be considered as part of the financial impact.

Note 5 – Investments

This Note is split into eleven 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 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
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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*. All eleven 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 analyst should review the activity in the allowance for credit losses account, including the balance in the allowance for credit losses account at the beginning and end of each period, additions charged to operations, direct write-downs charged against the allowance, and recoveries of amounts previously charged off.

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.
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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 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 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.

**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
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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, nonadmitted 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 nonadmitting 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 nonadmits 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.

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. 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
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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 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:

<table>
<thead>
<tr>
<th>Deferred Acquisition Costs</th>
<th>Stat</th>
<th>Tax</th>
<th>Diff</th>
<th>DTA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$6,745,000</td>
<td>$6,745,000</td>
<td>$2,360,750</td>
</tr>
</tbody>
</table>

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 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.

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
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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 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 nonadmitted DTAs by tax character, total DTLs by tax character as well as the net change during the year by component, total nonadmitted 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
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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 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 twelve 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 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 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*
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*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) focuses on multi-employer plans and is required by SSAP No. 102 and SSAP No. 92. Section (I) 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 of future absences in
accordance with SSAP No. 11 because the amount cannot be reasonably estimated, that fact and the
reasons shall be disclosed in the Notes to Financial Statements. The analyst should evaluate the type of
benefits disclosed and the reasons they could not be estimated 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
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.
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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, *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, gain contingencies 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.
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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.

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.

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-lessor'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. Lessor 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.

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 and represents a new disclosure 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 and represents a new disclosure 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 recourses 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.
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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 reinsur ance 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 seven 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 extraordinary 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). 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 of any extraordinary items. Under SSAP No. 24, an insurer is required to account for an extraordinary 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 extraordinary item has 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.

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...
VI. Guidance for Notes to Financial Statements

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 insurance 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.

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 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 as of the annual reporting date as if it had been reported on the balance sheet date. The reporting entity should also provide a response and statement as to whether an RBC action level would have been triggered had the fee been reported as of
the balance sheet date. The analyst should review the health care chapter in Section III – Annual Procedures – Level 2 Health Care Pursuant to Public Health Service Act.

**Note 23 – Reinsurance**

This Note is split into nine primary sections. Section (A) requires the insurer to report certain information (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. 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 (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. Sections D through H are for Property/Casualty and Sections D through G are for Title insurers only. Section (D) requires the insurer to report certain information on uncollectable reinsurance that was written off during the year. Section (E) requires the insurer to report certain information on commutation of ceded reinsurance. Section (F) requires the insurer to report certain information on the use of retroactive reinsurance. Section (G) requires the insurer to report certain information on reinsurance accounted for as a deposit. Section (H) requires the insurer to disclose transfer of property and casualty run-off agreements.

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.

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 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.

**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.
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 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.

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
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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 that the company is contingently liable should be disclosed, because there is some exposure under these types of settlements. The name, state of domicile, location of the insurance company, and the aggregate statement value of annuities due from life insurers should be disclosed. A quick check on the financial rating of the life insurer might provide the analyst with some assurance that the insurer has the ability to meet its payments.

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.)
VI. Guidance for Notes to Financial Statements

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 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>
VI. Guidance for Notes to Financial Statements

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
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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.
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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.

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
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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.

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.
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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
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.
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 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.
VI. Guidance for Notes to Financial Statements

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
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 is 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 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.
VII. Health Insurance Industry – A. Medical Insurance Markets

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 advertising. 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.
VII. Health Insurance Industry – 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
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
VII. Health Insurance Industry – B. Health Lines of Business

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/work place. 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).
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,
- Providing incentives to patients to use outpatient rather than inpatient facilities,
- Moving patients to less intensive settings or into home health care, and
- Limiting access to specialists.
VII. Health Insurance Industry – C. Product Types

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 withhold 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 HMOs 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.
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 exemptions 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, 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

\[\text{RBC requirements will generally increase for the same number of covered lives because of medical trend increases.}\]
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.
VII. Health Insurance Industry – E. Types of Ownership Structures

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 arrangements has been reduced recently with the influence of and the push back from providers and patients.
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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 under-pricing. 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 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 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:

- The “normal” level of statutory surplus strain from above average levels of new business;

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3 Diagnosis Related Groups (DRGs) are categories of diagnosis used 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 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. Holding Company and Supervisory College Best Practices

B. References
Holding Company and Supervisory College Best Practices

Created by the
NAIC Group Solvency Issues Working Group
of the Solvency Modernization Initiatives (EX) Task Force
INTRODUCTION

A. 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.

HOLDING COMPANY BEST PRACTICES

A. 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 Appendix B 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 Appendix B, 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:
VII. Appendix – A. Holding Company and Supervisory College Best Practices

- 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, following the guidelines of the Supervisory Best Practices.

**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. Therefore, states are encouraged to notify NAIC Financial Analysis staff any time contact information changes for persons listed from their state whether it be due to a shift in responsibilities or a change in a company’s domestic regulator, so that the report is always current and relevant. 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 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.
VII. Appendix – A. Holding Company and Supervisory College Best Practices

- 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.

B. 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.
VII. Appendix – A. Holding Company and Supervisory College Best Practices

- 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 regulator 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 Model Act. If the proposed acquisition of control will require the approval of more than one commissioner, Model Act #440 provides that a public hearing may be held on a consolidated basis upon request of the person filing. Such person shall file the statement with the NAIC within five (5) business days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten (10) 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.
C. 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 Insurance Holding Company Model Act (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.

D. 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 arms 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 arms 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 arms 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 arms 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. **REULATOR 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.

**BEST PRACTICES FOR PARTICIPATING IN INTERNATIONAL SUPERVISORY COLLEGES**


The following provides additional reference on how the IAIS key features regarding supervisory college participation might work in the US Framework:

- A supervisory college is a regulatory tool which 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 attempts to create 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 US, and other state and federal agencies within the US.

**A. LEAD STATE – COORDINATION/COMMUNICATION OF INFORMATION**

The following are suggestions relating to the role of the lead U.S. state to function as the U.S. contact for parent holding companies domiciled in other countries.

- Consistent communication with applicable international regulators through the voluntary submission of information via the web-based NAIC International Supervisory Colleges Request Form.
- The lead state should be available to attend supervisory colleges and for informal conference calls;
- Consistency in who participates in the supervisory college is recommended for continued building of international relationships;
- Lead state should gather all applicable material from non-lead domestic states in preparing for international meetings/calls including a conference call with all applicable domestic regulators; (see the section on state-to-state communication process)
- Within a reasonable time period after attending the supervisory college, the lead state should initiate a conference call with all non-lead domestic regulators, summarizing the supervisory meeting and any effects on the domestic companies;
The U.S. lead state plays a key role in coordinating communication to and from the international holding companies to the non-lead states.

Lead state’s financial review of the international holding companies:

- 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.

Lead state coordination among the international holding companies, international regulators and non-lead states:

- Serve as the lead to coordinate communication among the international holding companies, the international regulators and the non-lead states.
- Maintain open communication to address issues/concerns from the non-lead states.
- Provide assistance to the non-lead states in securing documents from the international holding companies.
- Initiate multi-states conference call through the NAIC to update the non-lead states on issues/concerns/events of the international holding companies.
- Collect and share issues/concerns among all non-lead states.

B. OTHER CONSIDERATIONS NOT ADDRESSED BY THE IAIS GUIDANCE PAPER ON THE USE OF SUPERVISORY COLLEGES IN GROUP-WIDE SUPERVISION

No additional best practices other than those captured in the October 2009 IAIS Guidance Paper on the Use of Supervisory Colleges in Group-wide Supervision. The following provides additional reference on how the IAIS key features might work in the US framework:

A Supervisory College is a tool which is incorporated into the existing Risk-Focused Surveillance approach and designed to work in conjunction with a regulatory agency’s analytical, examination and legal efforts.

The Supervisory College attempts to create a more unified approach towards addressing global financial supervision issues. Effective and efficient regulatory scrutiny of group-wide issues should occur in the context of an organized approach with all significant regulatory parties involved which could include regulatory agencies from countries outside of the United States, and other state and federal agencies within the United States.

The Supervisory College allows its participating members to routinely communicate on matters such as the following: possible enterprise risk, material activities, changes in controlling interest, corporate governance, recent filings, and examinations.
A Supervisory College establishes a routine for establishing a regular communication channel with the appropriate company personnel which can be beneficial in identifying the appropriate company contacts quickly in the event of a crisis.

A Supervisory College is a commitment towards cooperation in making advanced preparations for dealing with financial crisis events and in managing crises. A Supervisory College further encourages a company’s identification and implementation of contingency plans and procedures. A Supervisory College allows its regulatory member participants to better understand the differing approaches which are utilized by each participant in their attempts to regulate matters. The better understanding of differing regulatory approaches prior to a crisis situation can assist in avoiding undue concerns and/or unwarranted emphasis on unnecessary items and helps focus attention in a more timely and effective manner if a crisis should occur.

APPENDICES

A. REFERENCES

IAIS Guidance Paper on the Use of Supervisory Colleges in Group-Wide Supervision [October 2009]
## B. **Federal Agency Holding Company Regulation**

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<thead>
<tr>
<th>Agency</th>
<th>Form</th>
<th>Report Title</th>
<th>Info</th>
<th>Contact</th>
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<tbody>
<tr>
<td>SEC</td>
<td>S-4EF</td>
<td>Auto effective registration statement for securities issued in connection with the formation of a bank or savings and loan holding company in compliance with General Instruction G</td>
<td>These and all other forms available at: <a href="http://sec.gov/about/forms/secforms.htm">http://sec.gov/about/forms/secforms.htm</a></td>
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<td>Forms 3, 4, 5</td>
<td>Corporate Insiders and Beneficial Owners</td>
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<td>Form 8-K</td>
<td>Current Report</td>
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<td>Form 10-K</td>
<td>Annual Report</td>
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<td>Form 10-Q</td>
<td>Quarterly Report</td>
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<td>Form 13-F</td>
<td>Inst. Investment Managers</td>
<td>Must be filed by Institutional Investment managers who exercise investment discretion over $100 million or more.</td>
<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>Form D</td>
<td>Form D</td>
<td>Filed by those exempted from Regulation D</td>
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<td>FFIEC</td>
<td>FFEIC 031 and 041</td>
<td>Report of Condition and Income</td>
<td>This is an FFIEC Report form require by the FDIC, Fed, and OCC depending on charter of the respondent bank. The FFIEC 031 is filed by an institution with domestic and foreign offices. The FFIEC 041 is filed by an institution with domestic offices only. <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 101</td>
<td>Regulatory Capital Reporting for Institutions Subject to the Advanced Capital Adequacy</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>
<td></td>
</tr>
</tbody>
</table>
### VII. Appendix – A. Holding Company and Supervisory College Best Practices

<table>
<thead>
<tr>
<th>Framework</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFIEC 009</td>
<td>Country Exposure Report&lt;br&gt;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>
</tr>
<tr>
<td>FFIEC 009a</td>
<td>Country Exposure Information Report&lt;br&gt;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>
</tr>
<tr>
<td>Home Mortgage Disclosure Act Filings</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>
</tr>
<tr>
<td>FR 2320</td>
<td>Quarterly Savings and Loan Holding Company Report&lt;br&gt;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>
</tr>
<tr>
<td>FR Y-8</td>
<td>The Bank Holding Company Report of Insured Depository Institutions’ Section 23A&lt;br&gt;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>
</tr>
</tbody>
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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).

#### VII. Appendix – A. Holding Company and Supervisory College Best Practices

<table>
<thead>
<tr>
<th>Transactions with Affiliates</th>
<th>Transactions with Affiliates</th>
</tr>
</thead>
<tbody>
<tr>
<td>FR Y-9C</td>
<td>Consolidated Financial Statements for Holding Companies</td>
</tr>
<tr>
<td></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.</td>
</tr>
<tr>
<td>FR Y-9LP</td>
<td>Parent Company Only Financial Statements for Large Holding Companies</td>
</tr>
<tr>
<td></td>
<td>All BHCs, SLHCs, and SHCs with a parent that files the FR Y-9C must file this parent company only report.</td>
</tr>
<tr>
<td>FR Y-9SP</td>
<td>Parent Company Only Financial Statements for Small Holding Companies</td>
</tr>
<tr>
<td></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.</td>
</tr>
<tr>
<td>FR Y-9ES</td>
<td>Financial Statements for Employee Stock Ownership Plan Holding Companies</td>
</tr>
<tr>
<td></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.</td>
</tr>
<tr>
<td>FR Y-11</td>
<td>Financial Statements of U.S. Nonbank Subsidiaries of U.S. Holding Companies</td>
</tr>
<tr>
<td></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 total assets of $500 million or more and less than $1 billion.</td>
</tr>
</tbody>
</table>
## VII. Appendix – A. Holding Company and Supervisory College Best Practices

<table>
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<tr>
<th>Reporting Form</th>
<th>Description</th>
<th>Notes</th>
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</thead>
<tbody>
<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>
</tr>
<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>
</tr>
<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>
</tr>
<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...</td>
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</tbody>
</table>
### VII. Appendix – A. Holding Company and Supervisory College Best Practices

<table>
<thead>
<tr>
<th>Financial Report</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FR Y-15 Banking Organization Systemic Risk Report</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. <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-16 Annual Company-Run Stress Test Report</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. <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-20 Financial Statements for a Bank Holding Company Subsidiary Engaged in Bank-Ineligible Securities Underwriting and Dealing</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. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
</tr>
<tr>
<td>FR 2314 Financial Statements of Foreign Subsidiaries of U.S. Banking Organizations</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. <a href="http://www.federalreserve.gov/apps/reportforms/default.aspx">http://www.federalreserve.gov/apps/reportforms/default.aspx</a></td>
</tr>
<tr>
<td>FR 2314S Abbreviated Financial</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</td>
</tr>
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</table>
### VII. Appendix – A. Holding Company and Supervisory College Best Practices

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<tr>
<th>Form</th>
<th>Description</th>
<th>Reporting Requirements</th>
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</thead>
<tbody>
<tr>
<td>FR Y-6</td>
<td>Annual Report of Holding Companies</td>
<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.</td>
</tr>
<tr>
<td>FR Y-10</td>
<td>Report of Changes in Organizational Structure</td>
<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.</td>
</tr>
</tbody>
</table>

A 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. [Link](http://www.federalreserve.gov/apps/reportforms/default.aspx)
VII. Appendix – A. Holding Company and Supervisory College Best Practices

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<thead>
<tr>
<th>Agency</th>
<th>Form</th>
<th>Report Title</th>
<th>Info</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEC</td>
<td>S-4EF</td>
<td>Auto effective registration statement for securities issued in connection with the formation of a bank or savings and loan holding company in compliance with General Instruction G</td>
<td>These and all other forms available at: <a href="http://sec.gov/about/forms/secforms.htm">http://sec.gov/about/forms/secforms.htm</a></td>
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<tr>
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<td>Telephone: <a href="http://sec.gov/contact/phone.htm">http://sec.gov/contact/phone.htm</a></td>
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<td>Mailing: <a href="http://sec.gov/contact/addresses.htm">http://sec.gov/contact/addresses.htm</a></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Denver Regional Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Donald Hoerl, Regional Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1801 California Street, Suite 1500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Denver, CO 80202-2656</td>
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<td></td>
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<td></td>
<td>(303) 844-1000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>e-mail: <a href="mailto:denver@sec.gov">denver@sec.gov</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>State jurisdiction: Colorado, Kansas, Nebraska, New Mexico, North Dakota, South Dakota, Wyoming</td>
</tr>
<tr>
<td>Forms 3, 4, 5</td>
<td>Corporate Insiders and Beneficial Owners</td>
<td></td>
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</tr>
<tr>
<td>Form 8-K</td>
<td>Current Report</td>
<td></td>
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<tr>
<td>Form 10-K</td>
<td>Annual Report</td>
<td></td>
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<tr>
<td>Form 10-Q</td>
<td>Quarterly Report</td>
<td></td>
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</tr>
<tr>
<td>Form 13-F</td>
<td>Inst. Investment Managers</td>
<td>Must be filed by Institutional Investment managers who exercise investment discretion over $100 million or more.</td>
<td></td>
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</tr>
<tr>
<td>Form D</td>
<td>Filed by those exempted from Regulation D</td>
<td></td>
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</tr>
<tr>
<td>Form ID</td>
<td>Edgar Application</td>
<td>Application for access codes to Edgar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FFIEC</td>
<td>FFEIC 031 and 041</td>
<td>Report of Condition and Income</td>
<td>This is an FFIEC Report form require by the FDIC, Fed, and OCC depending on charter of the respondent bank. The FFIEC 031 is filed by an institution with domestic and foreign offices. The FFIEC 041 is filed by an institution with domestic offices only. <a href="http://www.ffiec.gov/ffiec_report_forms.htm">http://www.ffiec.gov/ffiec_report_forms.htm</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FFEIC 101</td>
<td>Regulatory Capital Reporting for Institutions Subject to the Advanced Capital Adequacy Framework</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>
<td></td>
</tr>
</tbody>
</table>
VII. Appendix – B. References

Publications

Accounting Practices and Procedures Manual, NAIC
Annual Statement Instructions Property/Casualty, NAIC
Annual Statement Instructions Title, NAIC
Financial Condition Examiners Handbook, NAIC
Insurance Regulatory Information System (IRIS) Ratio Results, NAIC
Practice Note: Statements of Actuarial Opinion on Property and Casualty Loss Reserves, American Academy of Actuaries
Purposes and Procedures Manual of the NAIC Investment Analysis Office, NAIC
Regulation Regarding Proxies, Consents, and Authorizations of Domestic Stock Insurers (#490), NAIC
Troubled Insurance Company Handbook, NAIC

Model Laws

An Act Concerning Insider Trading of Domestic Stock Insurance Company Equity Securities (#460), NAIC
Annual Financial Reporting Model Regulation (#205), NAIC
Business Transacted with Producer Controlled Property/Casualty Insurer Act (#325), NAIC
Credit for Reinsurance Model Act, (#785) NAIC
Disclosure of Material Transactions Model Act (#285), NAIC
Insurance Holding Company System Regulatory Act (#440), NAIC
Managing General Agents Act (#225), NAIC
Regulation Regarding Proxies, Consents, and Authorizations of Domestic Stock Insurers (#490), NAIC
Reinsurance Intermediary Model Act (#790), NAIC
Risk-Based Capital for Insurers Model Act (#312), NAIC
Risk Management and Own Risk and Solvency Assessment Model Act (#505), NAIC
Stockholders Information Supplement (Schedule SIS) (#500), NAIC
Third-Party Administrator Statute (#1090), NAIC