NAIC Financial Analysis Solvency Tools

Financial Analysis Handbook
2016 Annual/2017 Quarterly
Volume 1

2017
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ISBN: 978-1-59917-947-6

Printed in the United States of America

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

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

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

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

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

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

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

If you have questions regarding the Financial Analysis Handbook, contact Ralph Villegas, Life/A&H Financial Analysis Manager at (816) 783-8411, rvillegas@naic.org, or Rodney Good, Property/Casualty Financial Analysis Manager at (816) 786-8430, rgood@naic.org, or Bill Rivers, Health Financial Analysis Program Manager at (816) 783-8142, wrivers@naic.org.
Financial Analysis Handbook Proposed Revision Form

**INSTRUCTIONS**

1. Complete this form for EACH Handbook proposal. Under "Identification of Item(s) to be Changed," include section & page number, line or item identifier.
2. All attachments should be presented in a format wherein new language is underscored and deletions struck through.
3. Please consider whether this revision proposal is also addressed elsewhere in the Handbook.
4. CAUTION: before completing this form, please read additional instructions on reverse side of this form.

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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)

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

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Additional Instructions and Information

The Financial Analysis Handbook (E) Working Group meets via conference call throughout the year to consider proposed changes to the NAIC Financial Analysis Handbook (Handbook). Suggestions to the Handbook should be submitted by June 1, 2017. They will be reviewed by the Working Group and considered for adoption and implementation in the next Handbook edition. Send proposals via email to Ralph Villegas, Life/Health Financial Analysis Manager, rvillegas@naic.org, or fax to 816-460-7563; or send to Rodney Good, Property/Casualty Financial Analysis Manager, rgood@naic.org, or fax to 816-460-0176. Original copies may be sent to:

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

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

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

Proposed Procedure Revisions
During the Working Group’s review, changes proposed via this form will be considered along with an analysis conducted by the NAIC Financial Analysis & Examination Unit of the effectiveness of procedures. This analysis encompasses the effectiveness of ratio limits as well as the language of procedures. Additionally, the general usefulness of procedures is considered. Specific proposals from states relative to procedures are welcome and should include detailed analysis.

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

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

** This section must be completed on all forms.  
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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**
A general overview concerning regulatory organization, communication, and prioritization is covered within these chapters.

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

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

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

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

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

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

Appendix – References
This document provides references to other NAIC publications and NAIC Model Laws and Regulations that are applicable to the analysis process.
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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

- Commissioner of Insurance
  - Financial Condition Examinations
  - Market Conduct Examinations
  - Financial Analysis
  - Company Licensing & Admissions
  - Consumer Affairs
  - Enforcement
  - Policy/Forms Analysis
  - Rate Filings
  - Agent Licensing
  - Legal

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.
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
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 as well as the insurer’s exposure to branded risks, which include prospective risks. Analysts should meet with the examiner to 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. Such information may be shared by providing and discussing the current Insurer Profile Summary, as well as other supporting analysis documentation as necessary. 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.

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

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

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.
I. Introduction – C. External Information

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.
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](http://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
I. Introduction – C. External Information

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 18 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 16 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 and surplus, and operations.

**IRIS Ratio Application**

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

The IRIS ratio application uses key financial data from the Annual Financial Statement to calculate ratio results. There are 13 IRIS ratios calculated for 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
I. Introduction – D. NAIC Information

- 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 Investment Analysis 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.
I. Introduction – E. SAP vs. GAAP

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*, 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*, 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.

<table>
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<tr>
<th>Procedure Description</th>
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<th>Complete if further concern</th>
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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.

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...
II. Financial Analysis Framework

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.

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
II. Financial Analysis Framework

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 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
II. Financial Analysis Framework

procedures in this section. The analyst is also asked to update the Insurer Profile Summary, and supervisory plan if applicable. In addition, at the conclusion of an analysis, a management report (i.e., the Insurer Profile Summary) 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.

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 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.
II. Financial Analysis Framework

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. The analyst is also asked to update the Insurer Profile Summary, and supervisory plan, if applicable. In addition, at the conclusion of an analysis, a management report (i.e., the Insurer Profile Summary) 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 business by June 1 and August 1 of each year as of the 12 months ended December 31 of the previous year.
II. Financial Analysis Framework

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.
II. Financial Analysis Framework

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?

  No further analysis is required.

  Yes

* 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?

  No further analysis is required.

  Yes

* 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?

  No further analysis is required.

  Yes

  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

  No

* 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

Are there any new or unresolved concerns as a result of the completion of the Statement of Actuarial Opinion & Actuarial Opinion Summary or RAAIS Supplemental Procedures?

No

- No further analysis is required.

Yes

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

Management's Discussion & 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?

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 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?

- **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**
  - No further analysis is required

* Received by June 1.
II. Financial Analysis Framework

Holding Company System Analysis

The Holding Company System Analysis 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 Group-wide Supervision – Insurance Holding Company System Analysis Guidance. The Insurance Holding Company System Analysis encompasses the following analysis areas:

- Non-Lead State Procedures
- Supplemental Forms

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

**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, 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.

INSURANCE HOLDING COMPANY SYSTEM ANALYSIS DOCUMENTED IN THE GROUP PROFILE SUMMARY (LEAD STATE)
- Understanding the holding company system (lead state)
- Addressing lead state analysis considerations
- Evaluating the overall financial condition of the holding company system by completing a detailed analysis through the group’s exposure to each of the nine branded risk classifications
- Assessing corporate governance and enterprise risk management
- Documenting material concerns or conditions in the group that impact the lead state’s domestic companies
- Perform additional procedures on key risk areas, as needed

The following procedures are also included in the Group-wide Supervision Procedures:

Corporate Governance Disclosure Procedures
The Corporate Governance Annual Disclosure Model Act (#305) and Corporate Governance Annual Disclosure Model Regulation (#306) requires an insurer, or an insurance group, to file a summary of an insurer or insurance group’s corporate governance structure, policies and practices with the commissioner by June 1 of each calendar year. As of the date of this publication, most states had not adopted such legislation. These procedures are applicable to only those states that have adopted such legislation.

Own Risk and Solvency Assessment (ORSA) Procedures
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.
II. Financial Analysis Framework

Form F Procedures
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).

Periodic Meeting with the Group Procedures
The periodic meeting with the Group procedures are intended to demonstrate the type of potential questions a lead state may want to consider when it conducts a periodic meeting with the group.

Targeted Examination Procedures
The targeted examination procedures provide examples of potential risk areas where the lead state may want to perform certain limited examination procedures as part of the continual risk assessment process.

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

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 Example

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
III. Annual Procedures – A. Level 1 (All Statement Types)

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.

If, upon completion of the Level 1 procedures and a review of additional sources of information available to the department (e.g., Management’s Discussion and Analysis, filed business plans, recent examination reports, etc.), additional information is required to effectively understand the insurer, refer to the Level 1 Analyst Reference Guide section, “Understanding the Insurer in Risk-Focused Financial Analysis,” for further guidance.

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 the Annual Financial Statement, 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 the Annual Financial Statement, 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
III. Annual Procedures – A. Level 1 (All Statement Types)

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?

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.
III. Annual Procedures – A. Level 1 (All Statement Types)

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)?

   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 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.

   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.
III. Annual Procedures – A. Level 1 (All Statement Types)

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)?
   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 the Annual Financial Statement, 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 (property/casualty and title), Summary of Operations (life/A&H and fraternal), and Statement of Revenue and Expenses (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?
III. Annual Procedures – A. Level 1 (All Statement Types)

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 absolute value of the current or prior year 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-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. Is the absolute value of net unrealized capital gains/(losses) more than 10 percent (5 percent for health entities) 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 the Annual Financial Statement, Schedule F, Part 3 - Ceded Reinsurance (for property/casualty and title insurers), and the Annual Financial Statement, Schedule S, Part 3 - Reinsurance Ceded (for life/A&H insurers, health entities and fraternal societies). Also, review all the Annual Financial Statement, General Interrogatories and Notes to Financials pertaining to reinsurance and note any areas of concern.
III. Annual Procedures – A. Level 1 (All Statement Types)

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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 Annual 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?
III. Annual Procedures – A. Level 1 (All Statement Types)

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. If a financial examination is currently being planned, meet with the assigned examiner-in-charge or examination supervisor to:
   a. Discuss information on risks and concerns provided in the Insurer Profile Summary as well as additional information on the company’s financial condition, operating results since the last examination, and reasons for any unusual trends, abnormal ratios and transactions that are not easily discernible;
   b. Communicate and provide access to relevant information that has already been obtained by the analyst function and is available to the department. It may be helpful for the analyst to review the Examiner’s Exhibit B questionnaire and note specific items that have already been accumulated and available to the examiner.

26. Review the Annual Financial Statement, General Interrogatories, Part 1, #3 and determine if a financial examination report was released by the domiciliary state since the last review.
   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?
III. Annual Procedures – A. Level 1 (All Statement Types)

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 26.d or 26.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.

27. 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?

28. 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

29. 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.

30. 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.

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

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

33. 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

34. 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.
III. Annual Procedures – A. Level 1 (All Statement Types)

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

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

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 and Fraternal)
   - Management’s Discussion & Analysis
   - Captives and/or Insurers Filing on U.S. GAAP (P&C)

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

At the completion of any Level 2 or additional procedures, or 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 holding company analysis, and 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.

Update the Insurer Profile Summary, including the Supervisor 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.

If, upon completion of the Level 1 procedures and a review of additional sources of information available to the department (e.g., Quarterly Financial Statement, filed business plans, recent examination reports, etc.), additional information is required to effectively understand the insurer, refer to the Analyst Reference Guide section, “Understanding the Insurer in Risk-Focused Financial Analysis,” for further guidance.

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:

    | State’s Priority Designation | PYE | PQTD | CQ |
    |------------------------------|-----|------|----|
    | 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 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)
III. Quarterly Procedures – A. Level 1 (excludes Title)

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.

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 the Quarterly Financial Statement, 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 the Quarterly Financial Statement, 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
- 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/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?

Display the percentage change from the prior year-end and the current quarter balance.

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

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).

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

11. Review the Quarterly Financial Statement, Statement of Income (property/casualty), Summary of Operations (life/A&H and fraternal), and Statement of Revenue and Expenses (health).

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

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

Display the percentage change from the prior year-to-date and the current quarter balance.

b. Has any individual income or expense category, for which the absolute value of 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 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. Is the absolute value of net unrealized capital gains/(losses) greater than 10 percent of prior year-end capital and surplus?

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. Is the absolute value of 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 result, 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? Display 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 the Quarterly Financial Statement, Schedule D, Part 1B - Acquisitions, Dispositions and Non-Trading Activity During the Current Quarter for all Bonds and Preferred Stock by Rating Class.
III. Quarterly Procedures – A. Level 1 (excludes Title)

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?

Review ofDisclosures


Assessment of Latest Examination Report and Results

18. Review the Quarterly Financial Statement, General Interrogatories, Part 1, #6 and determine if a Financial Examination Report was released by the domiciliary state since the last review.

   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?
   f. If the answer to either 18.d or 18.e is “yes,” follow-up with the insurer regarding the implementation of recommendations in the Financial Examination Report.

19. 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.

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

Assessment of Results from Prioritization & Analytical Tools

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

22. 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.
III. Quarterly Procedures – A. Level 1 (excludes Title)

23. 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.

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:

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
   - Cash Flow and Liquidity
   - Risk Transfer Other Than Reinsurance (Health)
   - Reinsurance
   - Affiliated Transactions
   - MGAs, TPAs and IPAs
   - Separate Accounts (Life/A&H)

B. Perform Supplemental Procedures:
   - Management Considerations
   - Annual Audited Financial Report
   - Actuarial Opinion/Summary (and RAAIS for Life/A&H and Fraternal)
   - Management’s Discussion & Analysis
   - Captives and/or Insurers Filing on GAAP (P&C)

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

At the completion of any Level 2 Procedures, or 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 holding company analysis, and 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. 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.
III. Quarterly Procedures – A. Level 1 Non-Troubled Insurers (excludes Title)

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, make decisions, allocate resources or 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. 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></td>
</tr>
<tr>
<td>• Overall, the insurer is profitable, reported increasing surplus and is a non-priority.</td>
<td></td>
</tr>
<tr>
<td>• 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>• The potential for continued and worsening claims experience, which will strain capital.</td>
<td></td>
</tr>
<tr>
<td>• Other profitable lines that may not be able to continue to offset losses.</td>
<td></td>
</tr>
<tr>
<td>• Underwriting and reserving standards might not be appropriate on the unprofitable line.</td>
<td></td>
</tr>
<tr>
<td>Example #2 - Surrender Benefits</td>
<td></td>
</tr>
<tr>
<td>• The ratio of surrenders to net premiums is trending upward but not yet in an unusual range.</td>
<td></td>
</tr>
<tr>
<td>• The insurer has a high percentage of policies that are withdrawable with little or no fee.</td>
<td></td>
</tr>
<tr>
<td>• Negative impact of continued increasing surrenders.</td>
<td></td>
</tr>
<tr>
<td>• Market decline results in the need for policyholder cash, resulting in the potential negative impact or a “run on the bank” scenario.</td>
<td></td>
</tr>
<tr>
<td>• That liquid assets are insufficient to meet surrender benefits resulting in insufficient cash from operations.</td>
<td></td>
</tr>
<tr>
<td>• Poor asset-liability matching and the potential negative impact.</td>
<td></td>
</tr>
<tr>
<td>Example #3 - Reinsurance</td>
<td></td>
</tr>
<tr>
<td>• Insurer cedes via quota share to only two reinsurers.</td>
<td></td>
</tr>
<tr>
<td>• Ceded premium written to gross premium written exceeds 50%.</td>
<td></td>
</tr>
<tr>
<td>• Well capitalized insurer.</td>
<td></td>
</tr>
<tr>
<td>• Diminishing credit quality of the reinsurer.</td>
<td></td>
</tr>
<tr>
<td>• Collectability of recoverables.</td>
<td></td>
</tr>
<tr>
<td>• Changes in collateral are inadequate.</td>
<td></td>
</tr>
<tr>
<td>• If the reinsurance contract is terminated, any reliance on surplus aid would have a negative impact on capital.</td>
<td></td>
</tr>
</tbody>
</table>
Scenario | Prospective Risks Identified
---|---
Example #4 - Underwriting/Written Premiums
- Insurer utilizes only one MGA/TPA that underwrites more than 50% of the Company’s business. | • 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 #5 - 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. | • Catastrophe exposure.

Example #6 - 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. | • 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 #7 - 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. | • 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 document the prospective risks that were identified, update the Insurer Profile Summary and communicate the analysis findings 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 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. For additional guidance, the Insurer Profile Summary Sound Practices document is available on StateNet.

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 StateNet.

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):
XX DEPARTMENT OF INSURANCE
INSURER PROFILE SUMMARY
COMPANY NAME
As of 12/31/20XX
Updated as of XX/XX/20XX

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

ABC is an independently owned property and casualty insurance organization based in state X that specializes primarily in 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
Discuss any significant actions taken against the company, permitted practices, issues of non-compliance, results from the most recent financial examination, etc.

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

FINANCIAL SNAPSHOT (SUMMARY DATA) – OPTIONAL

<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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIABILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance reserves</td>
</tr>
<tr>
<td>Other liabilities</td>
</tr>
<tr>
<td>TOTAL LIABILITIES</td>
</tr>
<tr>
<td>Capital and Surplus</td>
</tr>
<tr>
<td>TOTAL LIABILITIES AND C&amp;S</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operations</th>
<th>20XX</th>
<th>20XX</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOSSES, BENEFITS AND EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policyholder Benefits</td>
</tr>
<tr>
<td>Expenses</td>
</tr>
<tr>
<td>Total losses, benefits and expenses</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>NET INCOME</td>
</tr>
</tbody>
</table>

III. Analyst Reference Guide – A. Level 1

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.
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>Reinsurance Recoverable</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>CY</th>
<th>PY</th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
</tr>
</thead>
<tbody>
<tr>
<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>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Rate Adequacy</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
</tbody>
</table>

**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>
</tr>
</thead>
<tbody>
<tr>
<td>Agent Fraud</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
<tr>
<td>Market Conduct</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
<tr>
<td>Findings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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>Two Year Develop</th>
<th>CY</th>
<th>PY</th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss &amp; LAE/C&amp;S</td>
<td>53.4%</td>
<td>8.0%</td>
<td>-20.3%</td>
<td>25.7%</td>
<td>100.1%</td>
</tr>
<tr>
<td>Loss Development</td>
<td>204.1%</td>
<td>132.3%</td>
<td>168.0%</td>
<td>235.2%</td>
<td>496.9%</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>Lines of Business</td>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Loss Development</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
</tbody>
</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>
<td></td>
<td>↑</td>
</tr>
<tr>
<td>Profitability/capital concerns</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
</tbody>
</table>

Overall Strategic Assessment: Significant Concern

Overall Trend: ↑
III. Analyst Reference Guide – A. Level 1

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>Lack of knowledge or laws</td>
<td></td>
<td>↑</td>
</tr>
</tbody>
</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. Other risks from the non-insurers is not significant. See Holding Company System Analysis (Non-Lead States) 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.
III. Analyst Reference Guide – A. Level 1

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 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.

Understanding the Insurer in Risk-Focused Financial Analysis

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

Regulators should first review existing sources of information available to the insurance department (e.g., annual and quarterly financial statements, Notes to Financial Statements and General Interrogatories, Management’s Discussion and Analysis, filed business plans, recent examination results, etc.). Additionally, if the insurer is part of a holding company group and the insurance department is not the lead state, the regulator should contact the Lead State to obtain analysis already prepared by the lead state for additional holding company group information (e.g., holding company analysis, Own Risk and Solvency Assessment (ORSA) Summary Report analysis, Form F – Enterprise Risk Report, and Corporate Governance Annual Disclosure analysis). Contacting the lead state first will help eliminate the duplicate requests for holding company group level information.

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

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

<table>
<thead>
<tr>
<th>General Topic and Description</th>
<th>Primary Branded Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underwriting Strategy – Understand the insurer’s overall underwriting strategy and goals, including its target market(s), geographic locations, products/lines of business, profitability challenges and distribution channels.</td>
<td>PR/UW, RV</td>
</tr>
<tr>
<td>Reinsurance Strategy – Understand the insurer’s overall reinsurance strategy, including its identification and modeling of risk exposure and concentrations, reinsurance program structure (affiliated and non-affiliated), reinsurer selection and quality.</td>
<td>CR, PR/UW, LQ</td>
</tr>
<tr>
<td>Investment Strategy – Understand the insurer’s investment strategy and goals, including its policies and guidelines that specify the type, credit quality and maturity of investments to be held. In addition, understand roles and responsibilities related to investment decision making, oversight and reporting.</td>
<td>CR, MK, LQ</td>
</tr>
</tbody>
</table>
### III. Analyst Reference Guide – A. Level 1

<table>
<thead>
<tr>
<th>General Topic and Description</th>
<th>Primary Branded Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Legal and Regulatory Issues</strong> – Understand significant legal, ethical and regulatory issues affecting the insurer’s current and prospective solvency, including the status or results of ongoing/recent regulatory investigations, pending/upcoming regulatory filings (e.g. rate filings, Form D, etc.), material ongoing litigation and violations of the insurer’s code of ethics.</td>
<td>LG, RP</td>
</tr>
<tr>
<td><strong>IT Systems</strong> – Understand significant changes made to IT systems since the last examination, including related implementation and transition plans, cybersecurity measures, etc.</td>
<td>OP, LG</td>
</tr>
<tr>
<td><strong>Outsourcing of Functions</strong> – Understand the significant functions outsourced by the insurer to third parties, including the insurer’s use and oversight of MGAs/TPAs, investment advisers, producers, custodians and affiliated service providers.</td>
<td>OP, RP, LG</td>
</tr>
<tr>
<td><strong>Risk Management</strong> (for non-ORSA filers) – Understand the overall risk management practices in place at the insurer, including how material and relevant risks are identified, assessed, monitored, managed and reported.</td>
<td>ST, OP</td>
</tr>
<tr>
<td><strong>Business Plans</strong> – Understand the insurer’s overall business plans, including its historical performance against projections, as well as current/future goals and initiatives.</td>
<td>ST, OP</td>
</tr>
<tr>
<td><strong>Overall Strengths and Weaknesses</strong> – Understand the insurer’s view of its overall strengths and weaknesses, including market position, financial resources, reputation and competition.</td>
<td>ST, OP, RP</td>
</tr>
</tbody>
</table>

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

### 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.
III. Analyst Reference Guide – A. Level 1

- 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) highlighted in the Insurer Profile Summary, as well as the company’s financial condition and operating results since the last examination. The analyst should be prepared to explain during this discussion the reasons for any unusual trends, abnormal ratios and transactions that are not easily discernible. This discussion should occur through a meeting (in-person or via conference call), rather than only through e-mail exchanges, which are not deemed sufficient to achieve the expectation of a planning meeting with the examiner. During the course of this discussion, the analyst should communicate and provide access to relevant information that has already been obtained by the analyst function and is available to the department. It may be specifically helpful for the analyst to review the Exhibit B questionnaire and note specific items that have already been accumulated and available to the examiner. Follow-up meetings/calls to discuss analysis of subsequent filings may also be helpful to the examination process. Finally, at the end of the examination, the analyst should meet with the examiners again to understand any material examination findings that in turn may help the analysts to focus their next review. This may include, but may not be limited to, follow-up on information collected during the examination.

**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 the Annual Financial Statement, 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 in 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 Annual Financial Statement, 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 Annual Financial Statement, 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 enforce, premium, and claims for certain lines of business.

Procedure #15 requires the analyst to identify material ceded reinsurance as reported in the Annual Financial Statement, 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 the Annual Financial Statement, 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 Annual Financial Statement, 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 the Annual
III. Analyst Reference Guide – A. Level 1

Financial Statement, Notes to Financial Statements, Note #1 - Summary of Significant Accounting Policies, Section A.

Procedure #20 requires the analyst to review the Annual 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 Annual Financial Statement, Notes to Financial Statements to assist in identifying any relevant quantitative and qualitative information.

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

Assessment of Latest Examination Report and Results

Procedures #25, #26, #27, and #28 assist the analyst in participation in the planning of upcoming examination activities and gathering specific information related to the insurer’s most recently completed financial examination. Communication between the analyst and the examiner in preparation of an examination should include a thorough discussion of key risks and concerns highlighted in the Insurer Profile Summary, as well as additional information on the company’s financial condition and operating results since the last examination. In following up on completed examinations, 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 #29 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 #30 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 #31 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 #32 requires the analyst to review the Annual Financial Profile Report, which can assist in identifying unusual trends and results.

Procedure #33 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 #34 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 #35 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 #36 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.

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 (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.

III. Annual 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. 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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?

III. Annual Procedures - B.1. Level 2 Investments (Property/Casualty)

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 Annual Financial Statement, 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 percent of surplus?
   
ii. Review the Annual Financial Statement, Notes to Financial Statements, Note #5 - Investments and Schedule D, Part 1 - Long-Term Bonds Owned, 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 the Annual Financial Statement, General Interrogatories, Part 1, #12.1. Does the insurer own any securities of a real estate holding company or otherwise hold real estate indirectly?
iii. 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 (Annual Financial Statement, 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 the Annual Financial Statement, Schedule BA, Part 1 - Other Long-Term Invested Assets Owned to determine the amount and types of other invested assets owned and identify if the insurer’s exposure to certain classes of BA assets are significant (e.g., hedge funds, private equity funds, etc.).
   A. Review Line 21 and Line 22 and determine whether concerns exist regarding the insurer’s exposure to non-traditional investments (e.g., hedge funds, private equity funds), as compared to surplus and impact on liquidity.

III. Annual Procedures - B.1. Level 2 Investments (Property/Casualty)

B. Review the experience of the insurer with respect to investing in non-traditional investments.

C. Obtain and review cash flow projections to ensure that the insurer understands the cash flow characteristics of non-traditional investments.

D. Inquire of the insurer regarding the liquidity of non-traditional investments to ensure that limitations in this area are understood.

E. Perform procedures to test the accuracy of reporting for non-traditional investments.

F. Ensure that senior management and the board of directors the insurer have explicitly signed off on non-traditional investments.

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 (e.g., 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.

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 the Annual Financial Statement, Schedule E, Part 3 - Special Deposits.

a. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 Annual Financial Statement, Notes to Financial Statements, Note #5-H - Restricted Assets. 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 any concerns exist regarding third party investment advisers and associated contractual arrangements.

a. Review the Annual Financial Statement, General Interrogatories, Part 1, #28.05. Does the insurer utilize third-party investment advisers, broker-dealers or individuals acting on behalf of the insurer with access to its investment accounts?

If the answer to 4a is “yes,” consider the following procedures:

b. Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners. Did the examination identify any issues with regard to investment advisers and associated contractual arrangements that require follow-up analysis or communication with the insurer? If “yes,” document the follow-up work performed.

c. Compare the Annual Financial Statement, General Interrogatories, Part 1, #28.05 for the current year to the prior year to determine if there have been any changes in advisers.

If the answer to 4c is “yes,”

i. Consider obtaining an explanation for the change from the insurer.

ii. Consider obtaining a copy of the new investment adviser agreement and review it for appropriate provisions.

4. 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*?
III. Annual Procedures - B.1. Level 2 Investments (Property/Casualty)

ii. If the answer to 5a.i is “yes,” document the exceptions listed in the Annual Financial Statement, General Interrogatories, Part 1, #32.2.

b. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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.

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

a. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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 Credit Rating Provider (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.

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

a. Review the Annual Financial Statement, 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 7a is “yes,” is the difference greater than 10 percent of surplus?

b. Review the Annual Financial Statement, 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 7b 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 the Annual Financial Statement, 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.
III. Annual Procedures - B.1. Level 2 Investments (Property/Casualty)

8. Determine whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year.
   a. Review the Annual Financial Statement, 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 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 the Annual Financial Statement, 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 8a and 8c 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 the Annual Financial Statement, 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.

9. Determine whether concerns exist due to significant turnover of long-term bonds, preferred stocks, or common stocks during the year.
   a. Review the Annual Financial Statement, 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.

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.

10. Determine whether there are concerns due to the level of investment in derivative instruments.
      If the answer to 10a 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 the Annual Financial Statement, Schedule DB, Parts A, B, and C, Section 1. Is the total book/adjusted carrying value at year-end greater than 10 percent or less 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 Annual Financial Statement, Exhibit of Net Investment Income. Is the ratio of derivative investment income to net investment income greater than 5 percent or less than -5 percent?
   d. Review the Annual Financial Statement, 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 the answer to 10d.i above is “yes,” is the amount of realized capital loss attributed to derivatives greater than 10 percent of surplus?
   e. Review the Annual Financial Statement, Schedule DB - Part A, Section 2, Options, Caps, Floors, Collars, Swaps and Forwards Terminated During the Current Year, columns 22, 23, and 24, and Schedule DB - Part B, Section 2, Future Contracts Terminated December 31 of Current Year, 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 the Annual Financial Statement, 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.

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

h. Review the Annual Financial Statement, 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 the Quarterly Financial Statement, 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 the Quarterly Financial Statement, 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.
c. Review the Quarterly Financial Statement, 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 the Quarterly Financial Statement, 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 the Quarterly Financial Statement, Schedule DB differs from other information provided by the insurer, request further clarifying information from the reporting entity.

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

4. Determine whether all securities owned are under the control of the insurer and in the insurer’s possession. Review the Quarterly Financial Statement, 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.
      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 5a.i is “yes,” document the exceptions listed in the Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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 the Annual Financial Statement, Schedule D, Part 1A—Quality and Maturity Distribution of All Bonds Owned, 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 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 NAIC Investment Analysis 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 No. 43R, but instead are valued in accordance with SSAP No. 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 (Annual Financial Statement, 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 the Annual Financial Statement, 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.

Procedure #2f.iii includes further additional procedures that assist the analyst in monitoring the insurer’s exposure to non-traditional investments by carefully reviewing holdings and requesting additional information, as necessary, to understand exposure. For smaller and mid-tier insurers, with respect to investments held in private equity funds and hedge funds, focus on exposure for individual companies as a percentage of surplus and consider the effects of the exposure on the company’s liquidity. Most private equity and hedge funds investments are reported on Schedule BA, Part 1, under Joint Ventures – Common Stock, Joint Ventures – Other, Partnerships, or LLC categories (Line 21 and Line 22). These lines of Schedule BA have generally consisted of mostly hedge funds investments; however, state analysts should conduct their own analysis of amounts reported on these lines to confirm.

The profile and characteristics of non-traditional investments can be very different especially as it relates to the volatility of returns and the potential for these types of investments to be illiquid. Returns for private equity and hedge funds have, in past years, been less attractive than those on traditional investments, and they may be relatively volatile. Structured notes (as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office), for example, on the surface appear to be structured like traditional corporate bonds (e.g., issuer obligations); while they are issuer obligations, the cash flow characteristics can vary dramatically. Many alternative investments are highly customized, and their analytics are very difficult to understand. Given the nature of non-traditional investments, they should represent a small percentage of overall invested assets and should not reflect a substantial percentage of surplus.

In addition to the steps for the types of investments included in procedure #2, the analyst should review procedure #3 and procedure #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 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. Annual Financial Statement, General Interrogatories, Part 1, #16 indicates whether this has been done. Annual Financial Statement, 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. Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 concerns exist regarding the use of third-party investment advisers. As investments and investment strategies grow in complexity, insurers may consider the use of unaffiliated third-party investment advisers to manage their investment strategy. Investment advisers may operate independently or as part of an investment company. Investment advisers and companies are subject to regulation by the U.S. Securities and Exchange Commission (SEC) and/or by the states in which they operate generally based on the size of their business. In certain situations, insurers may use a broker-dealer for investment advice. Broker-dealers are subject to regulation by the Financial Industry Regulatory Authority (FINRA). Regardless, most broker-dealers and investment advisers will register with the SEC and annually update a Form ADV–Uniform Application for Investment Adviser Registration and Report Form by Exempt Reporting Advisers which provides extensive information about the nature of the organization’s operations. To locate these forms, the analyst can go to www.adviserinfo.sec.gov and perform a search based on the company name.
Key information provided on a Form ADV includes:

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

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

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

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

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

It is important to note that the information provided on Form ADV is self-reported and is subject to limited regulatory oversight. However, the information may be valuable to analysts in assessing the suitability and capability of investment advisers providing advisory services to insurers.

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

The analyst should determine if changes have occurred in the insurer’s use of investment advisers that may prospectively impact the insurer’s investment strategy and overall management of the investment portfolio. If changes have occurred the analyst may consider asking the insurer for an explanation for the change in investment advisers and obtain a copy of the new adviser agreement to gain an understanding of the provisions, including the advisor’s authority; specific reference to compliance with the insurer’s investment strategy and/or policy statements, as well as state investment laws; conflicts of interest; fiduciary responsibilities; fees; and the insurer’s review of the adviser’s performance. (Refer to the Financial Condition Examiners Handbook for further guidance.)

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

Procedure #5 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 #6 assists the analyst in determining whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value. Annual Financial Statement, 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 the Annual Financial Statement, 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
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securities with an “AV” (amortized value) designation in the rate used to obtain the fair value column in the Annual Financial Statement, 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 #7 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 #8 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 the Annual Financial Statement, 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 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 that would have occurred with the insurer’s lower rated investment portfolio.
Procedure #9 assists the analyst in determining whether concerns exist due to the level of investment turnover. The analyst can identify significant turnover by reviewing Annual Financial Statement, Schedule D, Part 3—Long-Term Bonds and Stocks Acquired During Current Year; Annual Financial Statement, Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year; and Annual Financial Statement, Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During 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 #10 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 its 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.
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**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 stike/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
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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 the Annual Financial Statement, Schedule DB. 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.

The Annual Financial Statement, 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.

The Annual Financial Statement, Schedule DB – Part C – Section 1 contains the underlying detail of replicated assets owned at the end of the year. The Annual Financial Statement, 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.

The Annual Financial Statement, 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. The Annual Financial Statement, Schedule DB – Part A – Section 1 lists the insurer’s open options, caps, floors, collars, swaps and forwards. Open futures are reported in the Annual Financial Statement, 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
o Limitations on the use of derivatives
o Asset and liability management practices
o 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 Annual Financial Statement, 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-and two-year development in incurred net losses and defense and cost containment expenses by accident year reflected in the Annual Financial Statement, 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-and two-year development in incurred losses and defense and cost containment expenses by accident year reflected in the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, Schedule P – Part 3 and comment on any unusual fluctuations or aberrations in loss and expense payment patterns between accident years.

p. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 Annual Financial Statement, 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.

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 the Annual Financial Statement, 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 the Annual Financial Statement, Schedule P – Part 1 to determine which lines of business have unpaid losses and LAE that have been reduced due to consideration of anticipated salvage and subrogation.

d. For the more significant lines of business, review the Annual Financial Statement, 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 the Quarterly Financial Statement, 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 the Quarterly Financial Statement, 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 the Quarterly Financial Statement, 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?
III. Quarterly Procedures – B.2. Level 2 Unpaid Losses and LAE (Property/Casualty)

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 Annual Level 2 Additional Procedures 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 Annual Financial Statement, 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 the Annual Financial Statement, Schedule P, Part 2 to determine which lines of business are developing adversely; and incurred loss and LAE ratios per the Annual Financial Statement, Schedule P, Part 1 to determine any unusual fluctuations between years. 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 a 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 the Annual Financial Statement, Schedule P, Part 3 to determine whether there were any unusual fluctuations or aberrations in payment patterns between accident years. The review of the Annual Financial Statement, 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 the Annual Financial Statement, 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. 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 Annual Financial Statement, 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 Annual Financial Statement, 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 the Annual Financial Statement, 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 percent 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 percent 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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.

s. 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.

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

u. Review the write-ins for underwriting deductions in the Annual Financial Statement, 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.

v. Review the detail of investment income in the Annual Financial Statement, Exhibit of Net Investment Income and the detail of realized gains (losses) in the Annual Financial Statement, Exhibit of Capital Gains (Losses) for reasonableness.

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

x. 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.
III. Annual Procedures – B.3. Level 2 Income Statement and Surplus (Property/Casualty)

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 writings leverage ratio (IRIS ratio #1) greater than 900 percent?
   b. Is the net writings leverage 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 writings leverage 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).

III. Annual Procedures – B.3. Level 2 Income Statement and Surplus (Property/Casualty)

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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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
III. Annual Procedures – B.3. Level 2 Income Statement and Surplus (Property/Casualty)

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

Analyst ________________ Date ________

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 the Quarterly Financial Statement, 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 the Quarterly Financial Statement, 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 the Quarterly Financial Statement, 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 writings leverage (rolling year) ratio greater than 900 percent?
   b. Is the net writings leverage (rolling year) 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 6a is “yes,” is the amount at a level that required prior regulatory approval or notification?
      ii. If the answer to 6a.i 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 Annual Level 2 Procedures 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 writings leverage 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 Annual Financial Statement, 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 Annual Financial Statement, 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 the Annual Financial Statement, 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 and net writings leverage measure the extent to which that capacity is being utilized and the adequacy of the insurer’s surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross writings leverage ratio result greater than 900 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 writings leverage ratio 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 and net writings leverage to industry averages to help evaluate the insurer’s leverage. If the insurer is a member of an affiliated group of insurers, the analyst might want to compute the net and gross writings leverage ratios on a consolidated basis to help evaluate whether the affiliated group of insurers is excessively leveraged. If the net and gross writings leverage ratios results are high, 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 #5), 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 Annual Financial Statement, Notes to Financial Statements #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. Is the RBC ratio less than or equal to 300 percent?
   b. 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?
   c. Has there been a downward trend in the RBC ratio over the past two years? If “yes,” document the cause(s) of the decline. If a broader trend (e.g., five or more years decline) has been noted, document how the insurer plans to mitigate this continued decline.

2. Determine if the change in the insurer’s RBC ratio was due to the Total Adjusted Capital.
   a. Has Total Adjusted Capital declined by 10 percent or greater from the prior year? If “yes,” explain the cause(s) of the decline.
   b. If the insurer reported an increase in Total Adjusted Capital due to special surplus or capital infusions, etc., document the source and plan for continued support.

3. Determine if the change in the insurer’s RBC ratio was due to the Authorized Control Level.
   a. Has Authorized Control Level increased by 10 percent or greater from the prior year?
   b. Review the RBC risk component(s) and document the underlying causes of the changes.

4. Did the insurer trigger the RBC Trend Test? If “yes,” review and document the reason(s).

5. If the insurer has triggered an RBC Action Level event and if authorized by state statute, obtain and review a copy of the insurer’s RBC plan and monitor the overall progress.

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 for 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
- Implement state-mandated action
- 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 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. Model #312 supplements the system of absolute minimums and considers the risk profile of each individual insurer.

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:

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 200%</td>
<td>No Action Level</td>
</tr>
<tr>
<td>&gt; 200 to &lt; 300% and a Combined Ratio of &gt; 120%</td>
<td>Trend Test</td>
</tr>
<tr>
<td>≥ 150 to ≤ 200%</td>
<td>Company Action Level</td>
</tr>
<tr>
<td>&gt; 100 to &lt; 150%</td>
<td>Regulatory Action Level</td>
</tr>
<tr>
<td>≥ 70 to &lt; 100%</td>
<td>Authorized Control Level</td>
</tr>
<tr>
<td>&lt; 70%</td>
<td>Mandatory Control Level</td>
</tr>
</tbody>
</table>

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. 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 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 and a broader trend (e.g., five or more years decline) and the insurer’s plans to mitigate. If a downward trend is identified, the analyst should review the insurer’s projections and document its plan to improve the capital position.

**Procedure #2** determines if the change in the insurer’s RBC ratio was due to Total Adjusted Capital. Total Adjusted Capital is computed by subtracting the value of any reserving discounts from policyholders’ surplus and adjusting for AVR and half of any dividend liability of the insurer’s life insurance affiliates in addition to applying credit for capital notes.

**Procedure #3** determines if the change in the insurer’s RBC ratio was due to the Authorized Control Level. The components of the Authorized Control Level are factored to apply the level of risk. There are five major categories of risk as detailed below:

**Asset Risk - Subsidiary Insurance Companies**
This risk focuses on the default of certain affiliated investments. This represents the RBC requirement of the downstream insurance subsidiaries owned by the insurer. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the carrying value. There are several categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items (e.g., non-controlled assets, guarantees for affiliates, contingent liabilities, etc.) are included in this risk component.

**Asset Risk - Fixed Income**
This risk focuses on the default of debt assets. Fixed income assets include bonds, mortgages, short-term investments, etc. For property/casualty insurers, the risk associated with fixed income assets and equity assets is not correlated, so there are two separate components of risk. Each category of assets is assigned a risk factor that increases with the perceived risk (quality) of the asset. For example, high-quality bond investments are assigned a low factor, and non-investment grade bonds are assigned a high factor. An asset concentration factor also exists to reflect the additional risk of high concentrations in single exposures represented, for example, by an issuer of a bond or a holder of a mortgage.

**Asset Risk - Equity**
This risk focuses on the loss in fair value for equity assets. Equity assets include common and preferred stock, real estate, long-term assets, etc. Each category of assets is assigned a risk factor that increases with the perceived risk (quality) of the asset.
Asset Risk - Credit Risk
Credit risk attempts to measure the risk of defaults by agents, reinsurers, and other creditors. Ceded reinsurance balances, including recoverable from paid losses, case and incurred but not reported losses, and unearned premiums, are all assigned a risk factor. Some ceded reinsurance balances, such as recoverable from affiliates and from mandatory pools and associations, are exempt.

Underwriting Risk - Reserves and Premiums
There are two components to underwriting risk: reserve risk and premium risk.

Reserve risk attempts to measure the risk of adverse development in excess of expected investment income from loss reserves. Because reserves for the various types of business possess different frequency and severity characteristics, there are separate factors for each major line of business. The loss reserve calculation depends significantly on the development of overall industry loss reserves modified for the insurer’s actual experience. The resulting insurer’s loss reserve factor is adjusted for expected investment income and applied to its unpaid loss and LAE reserves.

Premium or pricing risk attempts to measure the risk of inadequate rates on business to be written over the coming year (premiums charged are not sufficient to pay future losses). Medium to long-tail lines of coverage are generally more volatile and, therefore, carry higher risk factors than short-tail lines. Similar to the loss reserve component, the pricing risk calculation depends significantly on the industry’s loss experience as modified for an insurer’s experience. The resulting company loss ratio is then adjusted for expected investment income and the insurer’s overall expense ratio on a line of business basis. The factor is applied to the previous year’s written premium. Thus, the formula establishes a minimum capital standard that requires for the industry as a whole to have sufficient capital to survive a repeat of historically poor underwriting experience. The factors for reserves and premiums are modified to increase the RBC required for lines with relatively favorable historical experience and lower the RBC required for lines with relatively adverse historical experience. This recognizes that particularly favorable or unfavorable historical experience will not necessarily repeat itself in the future.

Procedure #4 determines whether the insurer triggered the RBC Trend Test. The RBC Trend Test is triggered when an insurer has an RBC ratio between 200 percent and 300 percent and a combined ratio greater than 120 percent. A state could place the insurer in RBC Company Action Level if it has adopted the RBC trend test.

Procedure #5 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.
III. Annual Procedures – B.5. Level 2 Cash Flow and Liquidity (Property/Casualty)

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 the Annual Financial Statement, 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 Annual 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 Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, Schedule P – Analysis of Losses and Loss Expenses, the trends in accident year loss ratios, on both a gross and net basis, for indications of deteriorating underwriting results.

  k. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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.

III. Annual Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, Schedule F, Part 7 – Provision for Overdue Authorized Reinsurance and determine whether the provision for overdue authorized reinsurance was calculated properly.

   d. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 Annual Financial Statement, 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 the Annual Financial Statement, Schedule F, Part 5 – Provision for Unauthorized Reinsurance.
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.

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.

   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 the Annual Financial Statement, Schedule F, Part 3 – Ceded Reinsurance. Are reinsurance recoverables from affiliates greater than 20 percent of surplus?

c. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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.

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 the Annual Financial Statement, 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 the Annual Financial Statement, 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?

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 Annual Financial Statement, 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 the Annual Financial Statement, 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?
III. Annual Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

e. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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 regards 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 the Annual Financial Statement, 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.
III. Annual Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

h. Review the Annual Financial Statement, 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 the Annual Financial Statement, General Interrogatories, Part 2, #8.1. Were there any agreements to release reinsurers from liability during the year? If “yes,” explain.

j. Review the Annual Financial Statement, 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.


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.
   
   iii. Determine whether there is a trend of annual commutations and if a trend is identified, obtain a detailed rationale for the transactions.
   
   iv. If annual trending of commutations is noted, determine any favorable/unfavorable financial impact on the insurer.

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.
III. Annual Procedures – B.6. Level 2 Reinsurance (Property/Casualty)

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.

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 ________
   
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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 the Quarterly Financial Statement, 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 the Quarterly Financial Statement, General Interrogatories, Part 2, #1. If the Company is a member of a pooling arrangement, did the agreement or the Company’s participation change?
      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 as required by the Model Act?

4. Determine whether any unusual reinsurance transactions were completed during the quarter.
   a. Review the Quarterly Financial Statement, General Interrogatories, Part 2, #2. Were there any agreements to release reinsurers from liability during the quarter?
   b. Review the Quarterly Financial Statement, General Interrogatories, Part 2, #3.1. Were there any cancellations of primary reinsurance contracts during the quarter?
   c. Review the Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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 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. With regard to commutation agreements, the present value of the reinsurer’s estimated ultimate losses is paid by the reinsurer to the ceding insurer. The ceding insurer immediately establishes the ultimate loss reserve liability and the cash received as a negative paid loss, thus creating a reduction in surplus equal to the difference between the ultimate and present value of the loss reserve. The reasons for commutations differ from insurer to insurer, however, some of the key reasons include:

- **Exit of Business:** The cedant may strategically exit a specific line of business or the reinsurer may withdraw from the reinsurance marketplace.
- **Perceived Financial Instability:** The cedant or reinsurer may have concerns regarding the other party’s solvency. Commutation in this case would reduce credit risk, provide immediate cash infusions to cedant and/or allow the reinsurer to avoid future issues with the assigned liquidator.
- **Disputes:** The cedant and reinsurer may have significantly different evaluations of ultimate loss costs, claims resolution, or contract provisions and would prefer a single negotiation over commutation then continued disputes over issues.
- **Underwriting Risk:** The reinsurer may wish to eliminate underwriting and pricing risks relating to the cedants underwriting practices. Or, the reinsurer may determine that the price of the commutation is less than carried reserves and the commutation improves the reinsurer’s underwriting results.
Commutations require a thorough financial and actuarial review of the business being commuted. The cedant will need to have a clear understanding of the book of business to ensure that it receives adequate settlement from the reinsurer to pay all future claims and expenses and not lose the original value of the reinsurance and commutation agreements.

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 the Annual Financial Statement, 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 the Annual Financial Statement, Schedule Y, Part 1 – Organizational Chart and Part 2 – Summary of Insurer’s Transactions With Any Affiliate, along with the Annual Financial Statement, General Interrogatories and Notes to Financial Statements. Is there any information noted that contradicts the above answer to 1a.i?

      iv. Is the company required to file a holding company registration statement with the insurance department?

   b. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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 1c.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 the Annual Financial Statement, Schedule Y, Part 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.

      iii. Summarize any concerns that the analyst has with regard to non-insurance entities.

If the answers to 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.
III. Annual Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

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 Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 Annual Financial Statement, 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 answer to 2c.i is “yes,” did the insurer fail to obtain proper prior regulatory approvals?

III. Annual Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

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.

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 the Annual Financial Statement, 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?
III. Annual Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

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 Annual Financial Statement, 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?

   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. 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 Annual Financial Statement, 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 the Annual Financial Statement, 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 answer to 5e.ii is “yes,” review the Articles of Agreement.
III. Annual Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

f. Review the Annual Financial Statement, 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 answer to 5f.i is “yes,” did the insurer fail to properly disclose the investment on the Annual Financial Statement, Schedule Y, Part 2 - Summary of Insurer’s Transactions with Any Affiliates?

g. Review the Annual Financial Statement, 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?

h. Review the Annual Financial Statement, 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 the Annual 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
III. Annual Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

- 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 the Quarterly Financial Statement, Schedule Y - Information Concerning Activities of Insurer Members of a Holding Company Group, along with the Quarterly Financial Statement, General Interrogatories. Is there any information noted that contradicts the answer to the above question?
      ii. Review the Quarterly Financial Statement, Schedule Y, Part 1A - Detail of Insurance Holding Company System for the current year.
         A. 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 1a.i through 1c are all “no,” do not proceed with the remaining Affiliated Transactions Procedures.

   d. Review the Quarterly Financial Statement, General Interrogatories, Part 1, #2.1. Has there been a change in the insurer’s capital structure?
   e. Review the Quarterly Financial Statement, 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 the Quarterly Financial Statement, 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 Quarterly Financial Statement, Statement of Income, capital and surplus line item dividends to stockholders.
III. Quarterly Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

i. Is the amount of the stockholder dividend at a level that required prior regulatory approval or notification?

ii. If the answer to 2a.i is “yes,” did the insurer fail to obtain proper prior regulatory approvals?

b. Review the Quarterly Financial Statement, Schedule A, Part 2 - Real Estate Acquired and Additions Made During the Current Quarter and the Quarterly Financial Statement, 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 2b.i and 2b.ii are “yes,” is there any reason to believe that the acquisition was recorded on a basis other than fair value?

c. Review the Quarterly Financial Statement, Schedule A, Part 3 - Real Estate Disposed During the Current Quarter and the Quarterly Financial Statement, 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 2c.i and 2c.ii 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?

c. Has there been a shift in any affiliated investment category of more than +/- 10 percent from the prior year-end?

4. Determine whether other affiliated transactions are legitimate and properly accounted for.

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 the Quarterly Financial Statement, 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?
III. Quarterly Procedures – B.7. Level 2 Affiliated Transactions (Property/Casualty)

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 Annual Level 2 Additional Procedures 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 the Annual Financial Statement, Schedule Y, Part 2 – Summary of Insurer’s Transactions with Affiliates. Several types of affiliated transactions are reported in the Annual Financial Statement, Schedule Y, Part 2 – Summary of Insurer’s Transaction with Affiliates, and explanatory comments are provided in the Annual Financial Statement, 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.
III. Annual Procedures – B.8. Level 2 MGAs and TPAs (Property/Casualty)

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 the Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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. Annual Procedures – B.8. Level 2 MGAs and TPAs (Property/Casualty)

i. 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.

j. Request copies of the contracts between the insurer 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 Registration and Regulation of Third-Party Administrators (#1090) and/or the applicable sections of the insurance code.

k. For the more significant MGAs utilized by the insurer, request and review the following:
   i. The most recent independent CPA audit of the MGA.
   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.

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 (#225) 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 the Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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 (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 Registration and Regulation of Third-Party Administrators (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 Annual Financial Statement, 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.
III. Annual 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 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 mortgaged-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.
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 the Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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.
III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

  g. If the insurer has securities under its exclusive control that are not in its actual possession, review Annual Financial Statement, 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 Annual Financial Statement, 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 any concerns exist regarding third party investment advisers and associated contractual arrangements.

   a. Review Annual Financial Statement, General Interrogatories, Part 1, #28.05. Does the insurer utilize third party investment advisors, broker/dealer or individuals acting on behalf of the insurer with access to its investment accounts?

      If the answer to 3a is “yes”, consider the following procedures:

   b. Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners. Did the examination identify any issues with regard to investment advisers and associated contractual arrangements that require follow-up analysis or communication with the insurer? If yes, document the follow-up work performed.

   c. Compare Annual Financial Statement, General Interrogatories, Part 1, #28.05 for the current year to the prior year to determine if there have been any changes in advisors.

      If the answer to 3c is “yes”,

      i. Consider obtaining an explanation for the change from the insurer.

      ii. Consider obtaining a copy of the new investment advisor agreement and review it for appropriate provisions.

   d. Using the information reported in Annual Financial Statement, General Interrogatories, Part 1, #28.05, obtain and review SEC Form ADV (if available), to determine if the investment advisor is in good standing with the SEC. If not in good standing, contact the insurer to request an explanation.

   e. If agreements with third party investment advisers are affiliated, have the appropriate Form D–Prior Notice of Transactions been filed and approved by the department? Were any concerns noted or follow-up monitoring recommended?

4. 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 *Purpose and Procedures Manual of the NAIC Investment Analysis Office*?

      ii. If the answer to 4a(i) is “yes,” document the exceptions listed in Annual Financial Statement, General Interrogatories, Part 1, #32.2.

   b. Review Annual Financial Statement, 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
III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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.

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

a. Review Annual Financial Statement, 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 Annual Financial Statement, 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.
III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

ii. If filing exempt, determine the current rating by a Credit Rating Provider (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.

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

a. Review Annual Financial Statement, 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 6.a. is “yes,” is the difference greater than 10 percent of capital and surplus?

b. Review Annual Financial Statement, 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 6.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 Annual Financial Statement, 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?

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

a. Review Annual Financial Statement, 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
III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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.

e. Review Annual Financial Statement, 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 7.d. and 7.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).

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

a. Review Annual Financial Statement, 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?
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b. Review Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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.

9. 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 Annual Financial Statement, 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).
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 Credit Rating Provider (e.g., Moody’s Investors Service, Standard & Poor’s, A.M. Best or Fitch Ratings).

10. Review Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, Schedule D – Part 1 - Bonds 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.

11. 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 Annual Financial Statement, 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. 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.

12. 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 Annual Financial Statement, 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?
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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?

13. 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 Annual Financial Statement, Schedule A – Part 1 - Real Estate Owned, identify if real estate owned is concentrated in one or a few geographical areas?

e. Review Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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.

III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

ii. Request information from the insurer regarding any increases by adjustment in book/adjusted carrying value during the year.

k. Review Annual Financial Statement, 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 Annual Financial Statement, 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.

14. 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 Annual Financial Statement, Schedule BA - Other Invested Assets Owned, to determine the amount and types of other invested assets owned and identify if the insurer’s exposure to certain classes of BA assets are significant (e.g. hedge funds, private equity funds, etc.).
     i. Review Annual Financial Statement, Schedule BA - Part 1 (Lines 21 & 22) and determine whether concerns exist regarding the insurer’s exposure to non-traditional investments, i.e. hedge funds and private equity funds, as compared to capital and surplus and impact on liquidity.
     ii. Review the experience of the insurer with respect to investing in alternative investments such as hedge funds and private equity funds.
     iii. Obtain and review cash flow projections to ensure that the insurer understands the cash flow characteristics of such investments.
     iv. Inquire of the insurer regarding the liquidity of non-traditional investments to ensure that limitations in this area are understood.
     v. Perform procedures to test the accuracy of reporting for non-traditional investments.
     vi. Ensure that senior management and the Board of the insurer have explicitly signed off on non-traditional investments.
III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

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.

15. 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 Annual Financial Statement, 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.

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

a. Review the Annual Financial Statement, 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 Annual Financial Statement, 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

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III. Annual Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

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 Annual Financial Statement, 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 Annual Financial Statement, 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 16e.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 Annual Financial Statement, Schedule DB – Part A – Section 2, columns 22, 23, and 24, and Schedule DB – Part B – Section 2, columns 16, 17, and 18. If 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Quarterly Financial Statement, 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 Quarterly Financial Statement, Schedule DB – Part A – Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open as of Current Statement Date and
III. Quarterly Procedures – C.1. Level 2 Investments (Life/A&H and Fraternal)

Schedule DB – Part B – Section 1 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 Annual Level 2 Additional Procedures 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 Annual Financial Statement, 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 Annual Financial Statement, General Interrogatory #16
indicates whether this has been done. Annual Financial Statement, 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. Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 concerns exist regarding the use of third-party
investment advisers. As investments and investment strategies grow in complexity, insurers may consider
the use of unaffiliated third-party investment advisers to manage their investment strategy. Investment
advisers may operate independently or as part of an investment company. Investment advisers and
companies are subject to regulation by the U.S. Securities and Exchange Commission (SEC) and/or by
the states in which they operate, generally based on the size of their business. In certain situations,
insurers may use a broker-dealer for investment advice. Broker-dealers are subject to regulation by the
Financial Industry Regulatory Authority (FINRA). Regardless, most broker dealers and investment
advisers will register with the SEC and annually update a Form ADV–Uniform Application for
Investment Adviser Registration and Report Form by Exempt Reporting Advisers, which provides
extensive information about the nature of the organization’s operations. To locate these forms, the analyst
can go to www.adviserinfo.sec.gov and perform a search based on the company name.
Key information provided on a Form ADV includes:

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

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

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

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

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

It is important to note that the information provided on Form ADV is self-reported and is subject to limited regulatory oversight. However, the information may be valuable to analysts in assessing the suitability and capability of investment advisers providing advisory services to insurers.

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

The analyst should determine if changes have occurred in the insurer’s use of investment advisers that may prospectively impact the insurer’s investment strategy and overall management of the investment portfolio. If changes have occurred the analyst may consider asking the insurer for an explanation for the change in investment advisers and obtain a copy of the new adviser agreement to gain an understanding of the provisions including the advisor’s authority, specific reference to compliance with the insurer’s investment strategy and/or policy statements, as well as state investment laws; conflicts of interest; fiduciary responsibilities; fees; and the insurer’s review of the adviser’s performance. (Refer to the Financial Condition Examiners Handbook for further guidance)

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

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 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 has been disposed. In addition, the analyst should review Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 #5 assists the analyst in determining whether the statement value of bonds and sinking fund preferred stocks is significantly greater than fair value. Annual Financial Statement, 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 Annual Financial Statement, 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 #6 assists the analyst in determining whether the cost of common stocks is significantly greater than fair value. Annual Financial Statement, 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 Annual Financial Statement, 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 #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 Annual Financial Statement, 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 Annual Financial Statement, 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 #8 assists the analyst in determining whether concerns exist due to the level of investment turnover. The analyst can identify significant turnover by reviewing Annual Financial Statement, 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 Annual Financial Statement, 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 #9-15 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 #9 through 15, the analyst should review procedures #4 and 5 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 #9-15, the analyst should consider reviewing Procedures #4 and #5 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 #9 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 Annual Financial Statement, 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 #10 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 Annual Financial Statement, 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 #11 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 Annual Financial Statement, 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 #12 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 #13 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 Annual Financial Statement, 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 Annual Financial Statement, 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 #14 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 Annual Financial Statement, 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 #14c assists the analyst in monitoring the insurer’s exposure to non-traditional investments by carefully reviewing holdings and requesting additional information, as necessary to understand exposure. For smaller and mid-tier insurers, with respect to the investments held in private equity funds and hedge funds, focus on exposure for individual companies as a percentage of capital and surplus and consider the effects of the exposure on the company’s liquidity. Most private equity and hedge fund investments are reported on Schedule BA, Part 1, under the Joint Ventures – Common Stock, Joint Ventures – Other, Partnerships, or LLC categories (Lines 21 & 22). These lines of Schedule BA have generally consisted of mostly hedge fund investments; however, state analysts should conduct their own analysis of amounts reported on these lines to confirm.

The profile and characteristics of alternative investments can be very different especially as it relates to the volatility of returns and the potential for these types of investments to be illiquid. Returns for private equity and hedge funds have, in past years, been less attractive than those on traditional investments, and they may be relatively volatile. Structured notes (as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office), for example, on the surface appear to be structured like traditional corporate bonds (i.e. issuer obligation); while they are issuer obligations, the cash flow characteristics can vary dramatically. Many alternative investments are highly customized, and their analytics are very difficult to understand. Given the nature of alternative investments, they should represent a small percent of overall invested assets and should not reflect a substantial percent of capital and surplus.

Procedure #15 assists the analyst in determining whether concerns exist due to the level of investment in collateral loans. The analyst should review Annual Financial Statement, 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 Annual Financial Statement, 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 #16* 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 publically 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 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 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 that 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, Exhibit 5A - Changes in Bases of Valuation During the Year, and determine that individual changes in specific mortality tables, interest rates, or valuation methods meet the minimum statutory valuation standards.
   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?
III. Annual Procedures – C.2. Level 2 Life Reserves (Life/A&H)

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 Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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 a: 1) given mortality table; 2) maximum rate of interest; and 3) valuation method. The valuation method used to define minimum life reserves for statutory accounting purposes is referred to as the Commissioners Reserve Valuation Method (CRVM). The mortality rate assumptions are substantially higher than what the insurer can expect to realize from medically underwritten insurance policies. The interest rate assumptions are intended to be significantly lower than current money and capital market yields. Thus, the life reserves developed are generally conservative.

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-
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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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.

III. Annual Procedures – C.3. Level 2 Accident and Health Reserves (Life/A&H)

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.

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 Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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 ________
III. Analyst Reference Guide – C.3. Level 2 Accident and Health Reserves (Life/A&H)

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 Annual Financial Statement, Schedule H – Accident and Health Exhibit to determine which A&H lines of business are being written and which A&H lines of business had positive development in reserves during the year. 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, *Minimum Reserve Standards For Individual and Group Health Insurance Contracts*, 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 (the amount by which the A&H reserves originally established have proved to be understated based on subsequent activity). If the insurer’s ratio results consistently show additional development, this could be an indication that the insurer is intentionally understating its A&H reserves. The A&H loss ratio is also reviewed as a part of this procedure. Significant increases in this ratio might be indicative of additional A&H reserves being established due to prior understatements while significant decreases might be indicative of current A&H reserve understatements. Other steps included in this procedure include the review of Exhibit 5A – Changes in Bases of Valuation During the Year, of the Annual Financial Statement to determine whether there has been a change in the valuation basis of the A&H policies during the year which resulted in a decrease in A&H reserves in an amount greater than 5 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, Exhibit 5A – Changes in Bases of Valuation During the Year, – and determine that individual changes in specific mortality tables, interest rates, or valuation methods meet the minimum statutory valuation standards.
   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 Annual Financial Statements, 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 Quarterly Financial Statement, 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 Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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 wherein a predetermined future benefit stream is desired. Reserves are determined using the CARVM method with special actuarial guidelines that prescribe specialized mortality tables and govern the use of lump sum balloon payments.

5. **Variable Annuities**

Variable annuities are annuities where the amount of each benefit payment is not specified in the annuity contract, but rather fluctuates according to the earnings of a separate account fund. The primary concern relating to variable annuities reserves relates to the treatment of the CARVM expense allowance in the general account. The CARVM method is generally used, but the current thinking is that CARVM may not be appropriate for certain types of variable annuities that do not include guaranteed benefits.

Due to the complexity in determining annuity reserves, insurers must rely on actuaries to assist with valuation of these reserves. Insurers are required to annually obtain an opinion regarding the reasonableness of the reserves by a qualified actuary. In the aggregate, policy reserves for all annuity policies that are reported in the statutory financial statements must equal or exceed reserves calculated by using the assumptions and methods that produce the minimum standard valuation.

**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.
III. Annual Procedures – C.5. Level 2 Income Statement and Surplus (Life/A&H)

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 Annual Financial Statement, 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 Annual Financial Statement, Exhibit of Net Investment Income and the detail of realized gains or (losses) in the Exhibit of Capital Gains (Losses) for reasonableness.

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?
III. Annual Procedures – C.5. Level 2 Income Statement and Surplus (Life/A&H)

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 Annual Financial Statement, Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written.

f. Review Annual Financial Statement, 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?

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?

k. Review footnote (h) in the Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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.
III. Annual Procedures – C.5. Level 2 Income Statement and Surplus (Life/A&H)

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.

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 Annual Financial Statement, 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 Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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 premium 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 premium 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 Annual Financial Statement, Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written, determine whether the A&H lines of business have historically been profitable for the insurer, and determine whether A&H loss reserve adequacy has been maintained. As noted previously, an insurer that has historically written primarily A&H business might not be considered excessively leveraged, even though it has higher leverage ratio results, because the risk of significant underpricing or adverse underwriting results is less than for an insurer that has just begun writing A&H business.

Procedure #4 assists the analyst in evaluating the underwriting performance of the Medicare Part D Prescription Drug coverage. The procedures utilize data in the Annual Financial Statement, Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 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. Did the insurer write accident and health insurance premium that is subject to the federal Affordable Care Act (ACA)? If “yes” disclose the following financial impact of an assessment to the insurer.
   a. The ACA fee assessment payable for the upcoming year.
   b. The premium amount that is subject to the ACA assessment.
   c. Total Adjusted Capital after surplus adjustment.
   d. Adjusted control level.
   e. Would reporting the ACA assessment as of December 31, 2015, have triggered an RBC Action Level?

2. Were the Supplemental Health Care Exhibit (SHCE) and the SHCE’s Expense Allocation Report filed in accordance with the Annual Statement Instructions?

3. 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)
III. Annual Procedures – C.6. Level 2 Health Care Pursuant to Public Health Service Act (Life/A&H)

- 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.

4. 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.

5. Review the liability for rebate as reported in the Annual Financial Statement, 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 (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.

6. Did the insurer write accident and health insurance premium that is subject to the ACA risk-sharing provision?

a. What is the net receivable/payable effect of the Risk Adjustment, Reinsurance and Risk Corridors (3R’s) programs and what was the impact on capital and surplus?

b. Determine the impact of the risk-sharing provision on RBC.
III. Annual Procedures – C.6. Level 2 Health Care Pursuant to Public Health Service Act (Life/A&H)

7. 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.

8. 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. Review the 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 Annual Level 2 Additional Procedures 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 October 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 *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 Model #190, which contains its recommendations regarding the uniform definitions and standard methodologies to HHS on October 27, 2010. On December 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 SSAP No. 66 – Retrospectively Rated Contracts. Beginning in 2011, MLR rebate disclosures are included as an inset to various liability lines of the Annual Financial 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

1 Federal Interim Final Regulation 45 CFR 158-120(d)(3)
2 Federal Interim Final Regulation 45 CFR 158.120(d)(4)
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 January 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 Premium Stabilization Programs

Due to uncertainties created by the ACA, state insurance departments may perform Level 2 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 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 January 1, 2014. An insurance company’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 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 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 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 billion in 2014 to cover the required $10 billion in reinsurance payments, the $2 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 billion in 2014, $6 billion in 2015 and $4 billion in 2016, plus disbursements to the U.S. Treasury of $2.0 billion, $2.0 billion and $1 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 December 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 2015, 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 2015 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.** Because the regulations do not require interim settlements, an issuer will be recording an accrual at December 31 for the full year's reinsurance recovery.

- **Potential valuation allowance on reinsurance recoverable.** Because 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.

**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 whether the insurer wrote accident and health insurance premium that is subject to Section 9010 of the federal Affordable Care Act. If so, the procedure asks the analyst to review the Annual Financial Statement, Notes to Financial Statements, Note #22 for an insurer subject to the assessment of the assessment payable in the upcoming year consistent with the guidance provided under _SSAP No. 9—Subsequent Events_ for a Type II subsequent event. The disclosure should 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. The analyst should review the estimated amount of the assessment payable for the upcoming year (current and prior year), amount of the assessment paid (current and prior year) and written premium (current and prior year) that is the basis for the determination of the Section 9010 fee assessment to be paid in the subsequent year (net assessable premium). The analyst should also review the Total Adjusted Capital before and after adjustment and Authorized Control Level to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The analyst should also determine whether the reporting entity provided a response as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

Procedure #2 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 percent 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 #3 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 #3a. 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 #3 and #4. 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 December 31 of the Statement...
Year and March 31 of the following year. The second and far more important reason is that the ACA MLR includes a credibility adjustment that is based on the number of covered lives and certain benefit provisions of the coverages provided. The adjustment takes the form of an addition of percentage points to the calculated MLR. The ACA MLR is then used to determine if a rebate is due and to calculate the amount of the rebate. If the ACA MLR is greater than the relevant MLR standard no rebate is due. If the ACA MLR is less than the relevant MLR standard the rebate is calculated by multiplying the difference between the ACA MLR and the standard MLR by earned premium. Except for very large blocks of business (75,000 lives or more), the ACA MLR will always be larger than the Preliminary MLR. Conversely, for very small blocks of business (under 1,000 lives) the ACA MLR is not calculated since no rebate is due.

Despite the differences, the validity and reasonableness of the ACA MLR calculation, and therefore of the rebate calculation can be assessed using the data from the 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 #4 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 #5 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 #6 asks whether the insurer wrote accident and health insurance premium that is subject to the federal Affordable Care Act risk-sharing provision. If so, the procedure asks the analyst to review the Annual Financial Statement, Notes to Financial Statements, Note #24E for an insurer subject to the disclosure. The disclosure should provide information regarding the admitted assets, liabilities, and revenue by program regarding the risk-sharing provision of the ACA for the reporting periods that are impacted by the programs.

The analyst should review the net receivable/payable effect of the Risk Adjustment, Reinsurance and Risk Corridors programs and determine what impact they would have on capital and surplus. Also determine what the impact would be on the company’s RBC.

Procedure #7 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

It is recommended to consider the following procedures in reviewing insurers who write health insurance as they pertain to the ACA.

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 the Annual Financial Statement, Notes to Financial Statements, Note #22 – Events Subsequent 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 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 the Annual Financial Statement, Notes to Financial Statements, 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 December 31, 2013 and thereafter, an insurer subject to the ACA assessment will provide a disclosure in the Annual Financial Statement, Notes to Financial Statements, Note #22 – Subsequent Events 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 December 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 the Annual Financial Statement, Notes to Financial Statements, 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. Is the RBC ratio less than or equal to 300 percent?
   b. 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?
   c. Has there been a downward trend in the RBC ratio over the past two years? If “yes,” document the cause(s) of the decline. If a broader trend (e.g., five or more years decline) has been noted, document how the insurer plans to mitigate this continued decline.

2. Determine if the change in the insurer’s RBC ratio was due to the Total Adjusted Capital.
   a. Has Total Adjusted Capital declined by 10 percent or greater from the prior year?
   b. If the insurer reported an increase in Total Adjusted Capital due to special surplus or capital infusions, etc., document the source and plan for continued support.

3. Determine if the change in the insurer’s RBC ratio was due to the Authorized Control Level.
   a. Has Authorized Control Level increased by 10 percent or greater from the prior year?
   b. Review the RBC risk component(s) and document the underlying causes of the changes.

4. Did the insurer trigger the RBC Trend Test? If “yes,” review and document the reason(s).

5. If the insurer has triggered an RBC Action Level event and, if authorized by state statute, obtain and review a copy of the insurer’s RBC plan and monitor the overall progress.

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 for 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
- Implement state mandated action
- 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 (Model #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 generally did not consider the risk profile of the insurer. Model #312 supplements the system of absolute minimums and considers the risk profile of each individual insurer.

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:

\[
\begin{align*}
&\geq 250\% \text{ (or } 300\%) & \text{No action level} \\
&\geq 200\% \text{ to } < 250\% \text{ (or } 300\%) & \text{Trend test level} \\
&\geq 150\% \text{ to } < 200\% & \text{Company action level} \\
&\geq 100\% \text{ to } < 150\% & \text{Regulatory action level} \\
&\geq 70\% \text{ to } < 100\% & \text{Authorized control level} \\
&< 70\% & \text{Mandatory control level}
\end{align*}
\]

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 and a broader trend (e.g., five or more years decline) and the insurer’s plans to mitigate. If a downward trend is identified, the analyst should review the insurer’s projections and document its plan to improve the capital position.

Procedure #2 determines if the change in the insurer’s RBC ratio was due to Total Adjusted Capital. Total Adjusted Capital is computed by subtracting the value of any reserving discounts from capital and surplus and adjusting for AVR and half of any dividend liability of the insurer’s property/casualty affiliates, in addition to applying credit for capital notes.

Procedure #3 determines if the change in the insurer’s RBC ratio was due to Total Authorized Control Level. The components of the Authorized Control Level are factored to apply the level of risk. There are five major categories of risk as detailed below:

**Asset Risk – Affiliates**

This is the risk of assets’ default for certain affiliated investments. This represents the RBC requirement of the downstream insurance subsidiaries owned by the insurer. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the carrying value. There are thirteen categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items (e.g., non-controlled assets, guarantees for affiliates, contingent liabilities, etc.) are included in this risk component, such as non-controlled assets, guarantees for affiliates, contingent liabilities, etc.

**Asset Risk – Other**

Asset risk attempts to measure the risk that an insurer’s assets will default or will decline in fair value. Each category of assets is assigned a risk requirement factor that increases with the perceived risk level of the asset. For example, high quality bond investments are assigned a low factor and noninvestment-grade bonds are assigned a high factor. Similar factors are assigned to other asset categories.

**Insurance Risk**

Insurance risk represents the risk associated with unfavorable and/or improper assumptions used by an insurer in the mortality, morbidity, persistency and investment income components of insurance underwriting. The risk factors target the net amount of insurance at risk, net of reinsurance. The higher the level of insurance in-force, the lower the relative factor. Health insurance premiums and reserves are also targeted in the insurance risk factor.
Interest Rate Risk 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.

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.

Procedure #4 determines whether the insurer triggered 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 be placed in a Company Action Level if the state has adopted the RBC 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 #5 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.

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.
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 Annual Financial Statement, 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 Annual Financial Statement, 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.

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 a rehabilitation.

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 Annual Financial Statement, 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 Quarterly Financial Statement, 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 one or more of the Annual Level 2 Additional Procedures 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 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 Annual Financial Statement, Schedule S – Part 3 – Section 1 - Reinsurance Ceded Life and Annuities and Schedule S – Part 3 – Section 2 - Reinsurance Ceded Accident and Health. Do any of the reinsurers classified as authorized appear to be improperly classified as such?
   b. Review Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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.
III. Annual Procedures – C.9. Level 2 Reinsurance (Life/A&H)

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 Annual Financial Statement, Schedule S – Part 3 – Section 1 - Reinsurance Ceded Life and Annuities and Schedule S – Part 3 – Section 2 - Reinsurance Ceded Accident and Health. 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 Annual Financial Statement, 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).

III. Annual Procedures – C.9. Level 2 Reinsurance (Life/A&H)

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.

3. Determine whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another.


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)?


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)?


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 Annual Financial Statement, 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 (Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 (Annual Financial Statement, Notes to Financial Statement, Note #22A – Events Subsequent, Ceded Reinsurance Report – Section 1 – General Interrogatories, Part 2)?
III. Annual Procedures – C.9. Level 2 Reinsurance (Life/A&H)

Statement, Notes 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.

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 (Annual Financial Statement, 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 Annual Financial Statement, 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.
III. Annual Procedures – C.9. Level 2 Reinsurance (Life/A&H)

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 standard exemptions identified in Part 1. If there are reinsurance transactions reported in Part 2, complete the following:

a. For all transactions listed in Part 2A, 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 2B 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.

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)
III. Annual Procedures – C.9. Level 2 Reinsurance (Life/A&H)

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 Quarterly Financial Statement, 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 (Quarterly Financial Statement, 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 (Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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. Frequently, the reinsurer reimburses the ceding insurer for the premium taxes paid on that portion of the direct premium equal to the reinsurance premiums.

In formulating its rules for accepting applications for insurance, an insurer must decide upon three areas of action: retaining, reinsuring or declining the risks presented. Insurers of various sizes have different capacities to write insurance on a single life. An insurer must determine the maximum exposure it is able to accept and retain as its own insurance business. Having made this determination, the insurer must then decide what to do with any risks 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 credit-
worthiness 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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?
      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 Annual Financial Statement, Schedule Y – Part 2?
      iii. Are any transactions disclosed with an affiliate that is not listed on Annual Financial Statement, 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 Annual Financial Statement, 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/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.
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 Annual Financial Statement, 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 Annual Financial Statement, 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?

      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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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
III. Annual Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

- Refer concerns to examination section for targeted examination
- Consult an independent appraiser to evaluate specific transactions involving significant 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 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 Quarterly Financial Statement, Schedule Y along with the General Interrogatories. Is there any information noted that contradicts the response to 1.a.?
   e. Review Quarterly Financial Statement, 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 Quarterly Financial Statement, Notes to Financial Statements. Did the insurer report a change in its capital structure?
   g. Review Quarterly Financial Statement, 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 Quarterly Financial Statement, 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 Quarterly Financial Statement, 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?
III. Quarterly Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

ii. If the answer to 2.a.i. is “yes,” did the insurer fail to obtain proper prior regulatory approvals?

b. Review Quarterly Financial Statement, 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 Quarterly Financial Statement, 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?
III. Quarterly Procedures – C.10. Level 2 Affiliated Transactions (Life/A&H)

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. 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 Annual Level 2 Additional Procedures 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 Annual Financial Statement, Schedule Y – Part 2. Several types of affiliated transactions are reported in Schedule Y – Part 2 and explanatory comments are provided in Annual Financial Statement, 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 dividends is within the regulatory guidelines, and whether the dividends 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, 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.
III. Annual Procedures – C.11. Level 2 MGAs and TPAs (Life/A&H)

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.
   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 ________

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III. Annual Procedures – C.11. Level 2 MGAs and TPAs (Life/A&H)

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 Annual Level 2 Additional Procedures 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 insurer, including 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, Notes to the Financial Statements and the Separate Accounts Annual Financial Statement, 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 Annual Financial Statement, 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.
III. Annual Procedures – C.12. Level 2 Separate Accounts (Life/A&H)

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.

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 Annual Financial Statement, 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 Annual Financial Statement, 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.
III. Annual Procedures – C.12. Level 2 Separate Accounts (Life/A&H)

i. Review the insurer’s response to Annual Financial Statement, 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.

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 Quarterly Financial Statement, 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 Quarterly Financial Statement, 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 Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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 Annual Financial Statement, 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 Annual Financial Statement, 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 Annual Financial Statement, General Interrogatory #2.2 and guarantees paid in Separate Accounts General Interrogatory #2.3, but does not report risk charges paid in Separate Accounts General Interrogatory #2.7, 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 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 Annual Financial Statement through the item Net Transfers to or from Separate Accounts (referred to as “above the line” activity). Once the premiums have been moved to the separate accounts, all direct investment activity and reserve changes are recorded on the Separate Accounts Annual Financial Statement. Seed money is “contributed to or withdrawn from” the Separate Accounts Annual Financial Statement through the item Surplus (contributed to) withdrawn from Separate Accounts during the period (referred to as “below the line” activity).

Additional procedures assist 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.
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.

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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. Is 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.
III. Annual Procedures – D.1. Level 2 Investments (Health)

p. Review the maturity distribution of bonds in the Annual Financial Statement, 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.

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 the Annual Financial Statement, 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.
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 the Annual Financial Statement, 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 the Annual Financial Statement, 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.


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?
III. Annual Procedures – D.1. Level 2 Investments (Health)

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 the Annual Financial Statement, 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 Annual Financial Statement, Notes to Financial Statements, Note #5 - Investments and Schedule D - Part 1 - Long-Term Bonds Owned, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 - Other Assets.

i. Is the ratio of Schedule BA - Other Invested Assets to capital and surplus greater than 10 percent?

ii. If total Schedule BA - Other Invested 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 the Annual Financial Statement, Schedule BA - Other Invested Assets Owned, to determine the amount and types of other invested assets owned and identify if the insurer’s exposure to certain classes of BA assets are significant (e.g. hedge funds, private equity funds, etc.)
III. Annual Procedures – D.1. Level 2 Investments (Health)

A. Review Annual Financial Statement, Schedule BA - Part 1 (Lines 21 & 22) and determine whether concerns exist regarding the insurer’s exposure to non-traditional investments, i.e. hedge funds and private equity funds, as compared to capital and surplus and impact on liquidity.

B. Review the experience of the insurer with respect to investing in alternative investments such as hedge funds and private equity funds.

C. Obtain and review cash flow projections to ensure that the insurer understands the cash flow characteristics of such investments.

D. Inquire of the insurer regarding the liquidity of non-traditional investments to ensure that limitations in this area are understood.

E. Perform procedures to test the accuracy of reporting for non-traditional investments.

F. Ensure that senior management and the Board of the insurer have explicitly signed off on non-traditional investments.

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

a. Review the Annual Financial Statement, General Interrogatories, Part 1, #28.05. Does the insurer utilize third party investment advisors, broker-dealers or individuals acting on behalf of the insurer with access to its investment accounts?

If the answer to 3a is “yes,” consider the following procedures:

b. Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners. Did the examination identify any issues with regard to investment advisors and associated contractual arrangements that require follow-up analysis or communication with the insurer? If yes, document the follow-up performed.

c. Compare General Interrogatories, Part 1, #28.05 for the current year to the prior year to determine if there have been any changes in advisors.

If the answer to 3c is “yes,”

i. Consider obtaining an explanation for the change from the insurer.

ii. Consider obtaining a copy of the new investment advisor agreement and review it for appropriate provisions.
III. Annual Procedures – D.1. Level 2 Investments (Health)

d. Using the information reported in General Interrogatories, Part 1, #28.05, obtain and review SEC Form ADV (if available), to determine if the investment advisor is in good standing with the SEC. If not, contact the insurer to request an explanation.

e. If agreements with third party investment advisors are affiliated have the appropriate form D-Prior Notice of Transaction been filed and approved by the department? Were any concerns noted or follow-up monitoring recommended?

4. 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 health entity and in the health entity’s possession.

a. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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.

5. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Investment Analysis Office.

III. Annual Procedures – D.1. Level 2 Investments (Health)

i. Has the health entity failed to follow the filing requirements of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*?

ii. If the answer to 5.a.i is “yes,” document the exceptions listed in General Interrogatories, Part 1, #32.2.

b. Review the Annual Financial Statement, Schedule D - Part 1 - Long-Term Bonds Owned 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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.

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

a. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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.

ii. If filing exempt, determine the current rating by an NAIC Credit Rating Provider (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.

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

a. Review the Annual Financial Statement, 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 7.a. is “yes,” is the difference greater than 5 percent of capital and surplus?

b. Review the Annual Financial Statement, 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 7.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 the Annual Financial Statement, 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?

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

a. Review the Annual Financial Statement, 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, Capital and Surplus page. Is payable for securities greater than 3 percent of invested assets?

c. Review the Annual Financial Statement, 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 page. Is receivable for securities greater than 3 percent of invested assets?

e. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D -
III. Annual Procedures – D.1. Level 2 Investments (Health)

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 8a and 8c. 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).

9. 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 Annual Financial Statement, Exhibit of Capital Gains (Losses) to determine the degree of reliance on capital gains to increase surplus or to offset underwriting losses.
III. Annual Procedures – D.1. Level 2 Investments (Health)

10. Determine whether there are concerns due to investments in derivative instruments. Review the Annual Financial Statement, Notes to Financial Statements, Note #1 - Summary of Significant Accounting Policies and Note #8 - Derivative Instruments; 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:
   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 the Annual Financial Statement, 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
III. Annual Procedures – D.1. Level 2 Investments (Health)

☐ 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 the Quarterly Financial Statement, Schedule DB, all Parts, the write-ins for assets and liabilities, General Interrogatory #15.1 and #15.2, Notes to the Financial Statements, Note #1 and Note #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 the Quarterly Financial Statement, 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.
III. Quarterly Procedures – D.1. Level 2 Investments (Health)

a. Review the Quarterly Financial Statement, 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?

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 Annual Level 2 Additional Procedures 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 the health entity’s size and level of capital and surplus. In some cases, a small or thinly capitalized health entity may need to maintain additional liquidity and therefore hold mostly cash or cash equivalents. Other health entities, such as Hospital, Medical and Dental Services or Indemnities (HMDIs), may be able to maintain sufficient liquidity while holding some long-term investments. A significant portion of most health entities’ invested assets is maintained in cash and short-term investments. Most health entities also hold the majority of remaining invested assets in investment grade bonds with somewhat short-term maturities. Although most health entities will maintain a fairly liquid asset mix, 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 the Annual Financial Statement, 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 procedure #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 cash 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 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 the Annual Financial Statement, 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
III. Analyst Reference Guide – D.1. Level 2 Investments (Health)

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 the Annual Financial Statement, 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 the Annual Financial Statement, 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

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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 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 #2f.iii assists the analyst in monitoring the insurer’s exposure to non-traditional investments by carefully reviewing holdings and requesting additional information, as necessary to understand exposure. For smaller and mid-tier insurers, with respect to the investments held in private equity funds and hedge funds, focus on exposure for individual companies as a percentage of capital and surplus and consider the effects of the exposure on the company’s liquidity. Most private equity and hedge fund investments are reported on Schedule BA, Part 1, under the Joint Ventures – Common Stock, Joint Ventures – Other, Partnerships, or LLC categories (Lines 21 & 22). These lines of Schedule BA have generally consisted of mostly hedge fund investments; however, state analysts should conduct their own analysis of amounts reported on these lines to confirm.

The profile and characteristics of alternative investments can be very different especially as it relates to the volatility of returns and the potential for these types of investments to be illiquid. Returns for private
equity and hedge funds have, in the past years, been less attractive than those on traditional investments, and they may be relatively volatile. Structured Notes (as defined in the *Purposes & Procedures Manual of the NAIC Investment Analysis Office*), for example, on the surface appear to be structured like traditional corporate bonds (i.e. issuer obligations); while they are issuer obligations, the cash flow characteristics can vary dramatically. Many alternative investments are highly customized and their analytics are very difficult to understand. Given the nature of alternative investments, they should represent a small percent of overall invested assets and should not reflect a substantial percent of capital of surplus.

Procedure #3 assists the analyst in determining whether concerns exist regarding the use of third-party investment advisors. As investments and investment strategies grow in complexity, insurers may consider the use of unaffiliated third-party investment advisers to manage their investment strategy. Investment advisers may operate independently or as part of an investment company. Investment advisers and companies are subject to regulation by the U.S. Securities and Exchange Commission (SEC) and/or by the states in which they operate, generally based on the size of their business. In certain situations insurers may use a broker-dealer for investment advice. Broker dealers are subject to regulation by the Financial Industry Regulatory Authority (FINRA). Regardless, most broker dealers and investment advisers will register with the SEC and annually update a Form ADV-Uniform Application for Investment Adviser Registration and Report Form by Exempt Reporting Advisers which provides extensive information about the nature of the organizations operations. To locate these forms, the analyst can go to [www.adviserinfo.sec.gov](http://www.adviserinfo.sec.gov) and perform a search based on the company name.

Key Information provided on a Form ADV includes:

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

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

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

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

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

It is important to note that the information provided on Form ADV is self-reported and is subject to limited regulatory oversight. However the information may be valuable to analysts in assessing the suitability and capability of investment advisers providing advisory services to insurers.

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

The analyst should determine if changes have occurred in the insurer’s use of investment advisers that may prospectively impact the insurer’s investment strategy and overall management of the investment portfolio. If changes have occurred the analyst may consider asking the insurer for an explanation for the change in investment advisers and obtain a copy of the new adviser agreement to gain an understanding of the provisions including the adviser’s authority, specific reference to compliance with the insurer’s investment strategy and/or policy statements, as well as state investment laws; conflicts of interest;
The analyst should determine if the investment adviser is in good standing with the SEC. The SEC does not officially use the term “good standing”; however, for this analysis, the term is used to mean a firm that is registered as an investment adviser with the SEC and does not report disciplinary actions or criminal records in Item 11 of the form ADV.

Procedure #4 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 December 31 of the current year, over which the health entity has 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. The Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 #5 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 a valuation or that the securities have been disposed of. In addition, the analyst should review the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 #6 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 reviewing the Annual Financial Statement: 1) Schedule D - Part 1 - Long-Term Bonds; 2) 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 #7 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 the Annual Financial Statement, 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 #8 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 the Annual Financial Statement: 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 FullyDisposed 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 #9 assists the analyst in determining whether concerns exist due to the level of investment turnover. The analyst can identify significant turnover by reviewing the Annual Financial Statement: 1) Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year; and 2) Annual Financial Statement, 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 the Annual Financial Statement: 1) Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired During Current Year; 2) Annual Financial Statement, Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed Of During Current Year; and 3) Annual Financial Statement, 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 #10 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 details provided in Schedule DB columns for Hedge Effectiveness at Inception and at Year-End, and 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.

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 non-admitted uncollected premiums?
   f. If the answer to 1.e. above is “yes,” do non-admitted 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 details 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 non-admitted 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 non-admitted health care receivable balances?

III. Annual Procedures – D.2. Level 2 Other Assets (Health)

e. If the answer to 2.d. above is “yes,” do non-admitted 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 non-admitted 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.

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 the Annual Financial Statement, Notes to Financial Statements, Note #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?

Additional procedures and prospective risk considerations if further concerns exist:

c. Review the Annual Financial Statement, 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 non-admitted 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.

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 Annual Level 2 Additional Procedures 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 Non-admitted 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 non-admitted under a 90-day rule. Remaining amounts that are determined to be uncollectable must be written off. Generally, if a contract with an agent permits offsetting, amounts payable to an agent may be offset against a receivable from that agent. Agents’ balances carry credit risk and can have a material impact on the net income and capital and surplus of a health entity if the balances are significant. Significant or growing balances can also lead to liquidity problems if the health entity is unable to convert the receivables into cash to be used to pay claims.

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

The balance for uncollected premium may also result from amounts due from the Centers for Medicare and Medicaid Services or other government plans. Although coverage periods on this type of business are usually the same as comprehensive group business, the payment cycle can be much different due to the longer settlement periods experienced under government contracts. However, collectability of balances associated with government plans is usually not an issue. Because of this, the 90-day rule that is applied to other receivables is not applicable to receivables from these types of government plans.

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

Despite the efforts to mitigate the impact of uncollected premiums and agent’s balances, write-offs and non-admitted unpaid premium assets can still have a material impact on the net income and capital and surplus of a health entity. These issues can lead to liquidity problems if the health entity is unable to convert the receivable into cash to be used to pay claims. 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.
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 non-admitted.

Analysis of these assets should consist primarily of ongoing monitoring of the balances, the relative change, and the relationship of that change with what is expected based upon other trends/activity within the health entity.

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 non-admitted asset. EDP equipment and software depreciated for a period not to exceed three years using methods detailed in SSAP No. 19, *Furniture, Fixtures 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.
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 non-admitted, 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 Annual Financial Statement, Underwriting and Investment Exhibit - Part 2B - Analysis of Claims Unpaid - Prior Year - Net of Reinsurance.
      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 - Development of Paid and Incurred Health Claims. 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 - Prior Year - Net of Reinsurance and Part 2C - Development of Paid and Incurred Health Claims. 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 to Financial Statements, 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
- 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 Quarterly Financial Statement, 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 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 Annual Level 2 Additional Procedures be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

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Analyst ________________  Date ________
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Comments as a result of supervisory review.

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Reviewer _______________  Date ________
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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...
When companies contract with providers on a capitated basis, they may consider it appropriate to include an amount in the IBNR reserve for the contingency that the provider group becomes insolvent and is not able to perform under its contract. For example, if a capitation has been paid to a provider group for medical services and the provider group becomes insolvent and does not have the funds to pay member doctors, then the company may have to pay doctors directly for services rendered to members.

Claim reserves are estimated with some level of conservatism based on the health entity’s and the actuary’s determination of the amount of margin needed for potential adverse experience. Factors affecting the need for conservatism in reserve estimates include (1) statistical fluctuation in incurred claims, (2) data problems due to system changes or inadequate data reporting, (3) new or growing product lines and (4) changes in plan design or provider arrangements that may affect claims payment patterns. Conservatism can be achieved by using a tabular method based on a conservative table, by using conservative assumptions and/or by adding explicit margins to reserve estimates. The conservatism of past claim reserve estimates can be observed by comparing Claims Incurred in Prior Years with the Estimated Claim Reserve and Claim Liability December 31 of the Prior Year in the Annual Financial Statement from the Underwriting and Investment Exhibit Part 2B - Analysis of Claims Unpaid - Prior Year - Net of Reinsurance.

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 contract may have been earned, but not paid. This payment must be set up as a liability to the company.

If a contract period has ended and there has not been a final settlement, any potential settlement with respect to provider liability should be included. If the valuation date occurs during a contract period, then an appropriate liability should be determined that represents the time period from the beginning of the contract period through the valuation date. When provider risks are minimized using stop-loss arrangements that take large claims out of the calculation, the effect of the stop-loss coverage should be estimated and included in the claim reserve calculation. In some situations, the provider contracts may allow for an additional provider payment to the company. These payments, which may be determined in a similar manner should be separated (not netted against the company’s liability) and may be admitted if recorded in accordance with SSAP 84.

Some conservatism for adverse fluctuations should be included when estimating provider liabilities. The level of conservatism depends on the variability of the liability, time period being estimated, and the quality of the data being used. Please note, conservatism that increases the claim reserve estimate and anticipates higher incurred claims can lower the estimate for provider payments under a risk-sharing contract. The health entity’s actuary should consider the total liability when doing his or her estimate.

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 than 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 not 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 - Analysis of Claims Unpaid - Prior Year-Net of Reinsurance 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 - Development of Paid and Incurred Health Claims of the Underwriting and Investment Exhibit shows a history of reserve development. If the health entity’s ratio results consistently show additional development, this could be an indication that the health entity is understating its health reserves. 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 premiums 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 reviewing: 1) 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) 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. Request information concerning the specific contract provisions of the primary bonuses and withhold arrangements that the health entity is using.
   f. Request withheld and bonus liability amounts (included in “Accrued medical incentive pool and bonus payments” from Page 3, Column 3, Line 2) for the top five provider groups.
   g. Review the actuarial opinion to determine if potential provider insolvencies were considered when determining the reserves and liabilities.
   h. Review the actuarial opinion to determine if the provider’s financial strength was or was not reviewed or excluded by the opining actuary.
   i. Contact 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 Annual Level 2 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 withhold payments 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 - Claims Liability End of Current Year 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 - Claims Incurred During the Year 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 estimated 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.
III. Annual 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? 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 the Annual Financial Statement, Notes to Financial Statements, 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 Annual Financial Statement, 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.
III. Annual Procedures – D.5. Level 2 Income Statement and Surplus (Health)

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.

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 Annual Financial Statement, 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 Annual Financial Statement, 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?
III. Annual Procedures – D.5. Level 2 Income Statement and Surplus (Health)

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 the Annual Financial Statement, 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.
III. Annual Procedures – D.5. Level 2 Income Statement and Surplus (Health)

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.

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 than 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 the Annual Financial Statement, 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.
III. Annual Procedures – D.5. Level 2 Income Statement and Surplus (Health)

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?
   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 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
III. Annual Procedures – D.5. Level 2 Income Statement and Surplus (Health)

vii. Name of holder (and indication of whether holder is an affiliated entity)
viii. Description of assets received
ix. Repayment conditions or restrictions

i. 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
   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?
III. Quarterly Procedures – D.5. Level 2 Income Statement and Surplus (Health)

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 Annual Level 2 Additional Procedures 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
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 understatement. 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 to some extent, HMOs are able to transfer some of their risk to other entities, thereby reducing their overall risk in comparison to their premium volume. Because of the above, a 10 to 1 threshold is generally used for HMOs (8 to 1 for most other health entities). However, 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) non-admitted 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 the effect on the ratio results. If the health entity has issued capital notes which are significant, the analyst should consider reviewing the information in the Annual Financial Statement, Notes to Financial Statements, Note #11 - Debt 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. Did the reporting entity write accident and health insurance premium that is subject to the federal Affordable Care Act (ACA)? If “yes”, disclose the following financial impact of an assessment to the reporting entity.
   a. The ACA fee assessment payable for the upcoming year.
   b. The premium amount that is subject to the ACA assessment.
   c. Total Adjusted Capital after surplus adjustment
   d. Adjusted control level.
   e. Would reporting the ACA assessment as of December 31, 2015, have triggered an RBC Action Level?

2. 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?

3. 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)
III. Annual Procedures – D.6. Level 2 Health Care Pursuant to Public Health Service Act (Health)

- 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.

4. 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.

5. Review the liability for rebate as reported in the Annual Financial Statement, 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.

6. Did the health entity write accident and health insurance premium that is subject to the ACA risk-sharing provisions?

a. What is the net receivable/payable effect of the Risk Adjustment, Reinsurance and Risk Corridors (3R’s) programs and what was the impact on capital and surplus?
III. Annual Procedures – D.6. Level 2 Health Care Pursuant to Public Health Service Act (Health)

b. Determine the impact of the risk-sharing provision on RBC?

7. 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.

8. 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, 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. The analyst should review the 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 Annual Level 2 Additional Procedures 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 October 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 *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 Model #190, which contains its recommendations regarding the uniform definitions and standard methodologies to HHS on October 27, 2010. On December 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 *SSAP No. 66 – Retrospectively Rate Contracts*. Beginning in 2011, MLR rebate disclosures are included as an inset to various liability lines of the Annual Financial 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 January 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 Premium Stabilization Programs

Due to uncertainties created by the ACA, state insurance departments may perform Level 2 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 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 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. 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 billion in 2014 to cover the required $10 billion in reinsurance payments, the $2 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 billion in 2014, $6 billion in 2015 and $4 billion in 2016, plus disbursements to the U.S. Treasury of $2 billion, $2 billion and $1 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 December 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 2015, 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 2015 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.** Because the regulations do not require interim settlements, an issuer will be recording an accrual at December 31 for the full year’s reinsurance recovery.

- **Potential valuation allowance on reinsurance recoverable.** Because 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.

**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 whether the reporting entity wrote accident and health insurance premium that is subject to Section 9010 of the federal Affordable Care Act. If so, the procedure asks the analyst to review the Annual Financial Statement, Notes to Financial Statements, Note #22 for a reporting entity subject to the assessment of the disclosure of the assessment payable in the upcoming year consistent with the guidance provided under *SSAP No. 9, Subsequent Events* for a Type II subsequent event. The disclosure should 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. The analyst should review the estimated amount of the assessment payable for the upcoming year (current and
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 Section 9010 fee assessment to be paid in the subsequent year (net assessable premium). The analyst should also review the Total Adjusted Capital before and after adjustment and Authorized Control Level to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The analyst should also determine whether the reporting entity provided a response as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

Procedure #2 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 Percent 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 #3 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 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 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 1,000 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 #3a. 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 #3 and #4. 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 December 31 of the Statement Year and March 31 of the following year. The second and far more important reason is that the ACA MLR includes a credibility adjustment that is based on the number of covered lives and certain benefit
provisions of the coverages provided. The adjustment takes the form of an addition of percentage points to the calculated MLR. The ACA MLR is then used to determine if a rebate is due and to calculate the amount of the rebate. If the ACA MLR is greater than the relevant MLR standard no rebate is due. If the ACA MLR is less than the relevant MLR standard the rebate is calculated by multiplying the difference between the ACA MLR and the standard MLR by earned premium. Except for very large blocks of business (75,000 lives or more), the ACA MLR will always be larger than the Preliminary MLR. Conversely, for very small blocks of business (under 1,000 lives) the ACA MLR is not calculated since no rebate is due.

Despite the differences, the validity and reasonableness of the ACA MLR calculation, and therefore of the rebate calculation can be assessed using the data from the 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 #4 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 #5 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 #6 asks whether the reporting entity wrote accident and health insurance premiums that is subject to the federal Affordable Care Act risk-sharing provision. If so, the procedure asks the analyst to review the Annual Financial Statement, Notes to Financial Statements, Note #24E for an insurer subject to the disclosure. The disclosure should provide information regarding the admitted assets, liabilities, and revenue by program regarding the risk-sharing provisions of the ACA for the reporting periods that are impacted by the programs.

The analyst should review the net receivable/payable effect of the Risk Adjustment, Reinsurance and Risk Corridors programs and determine what the impact they would have on capital and surplus. Also determine what the impact would be on the company’s RBC.

Procedure #7 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

It is recommended to consider the following procedures in reviewing insurers who write health insurance as they pertain to the ACA.

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 the Annual Financial Statement, Notes to Financial Statements, Note #22–Events Subsequent - 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 the Annual Financial Statement, Notes to Financial Statements, Note #24 – Retrospectively Rated Contracts & Contracts Subject to Redetermination item D. disclosures of the amounts for MLR rebates required pursuant to the PHS Act 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 December 31, 2013, and thereafter, an insurer subject to the ACA assessment will provide a disclosure in the Annual Financial Statement, Notes to Financial Statements, Note #22 – Subsequent Events, 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 December 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 the Annual Financial Statement, Notes to Financial Statements, 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. Is the RBC ratio less than or equal to 300 percent?
   b. 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?
   c. Has there been a downward trend in the RBC ratio over the past two years? If “yes,” document the cause(s) of the decline. If a broader trend (e.g. five or more years decline) has been noted, document how the health entity plans to mitigate this continued decline.

2. Determine if the change in the health entity’s RBC ratio was due to the Total Adjusted Capital.
   a. Has Total Adjusted Capital declined by 10 percent or greater from the prior year? If “yes,” explain the cause(s) of the decline.
   b. If the health entity reported an increase in Total Adjusted Capital due to special surplus or capital infusion, etc. document the source and plan for continued support.

3. Determine if the change in the health entity’s RBC ratio was due to the Authorized Control Level.
   a. Has Authorized Control level increased by 10 percent or greater from the prior year?
   b. Review the RBC risk and document the underlying causes of the changes.

4. Did the health entity trigger the RBC Trend Test? If yes, review and document the reason(s).

5. If the health entity has triggered an RBC Action Level event and if authorized by state statute, obtain and review a copy of the health entity’s RBC plan and monitor the overall progress.

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 for 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
- Implement state mandated action
- Other (explain)

Analyst ________________ Date ________

Comments as a result of supervisory review.

Reviewer _______________ Date ________
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. Model #315 supplements the system of absolute minimums and considers the risk profile of each individual health entity.

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:

- ≥ 300%        No Action Level
- > 200% to < 300%    Trend Test Level
- ≥ 150% to < 200%    Company Action Level
- ≥ 100% to < 150%    Regulatory Action Level
- ≥ 70% to < 100%    Authorized Control Level
- < 70%        Mandatory Control Level

Every health entity that does business in a state that has adopted Model #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 1. 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.
III. Analyst Reference Guide – D.7. Level 2 Risk-Based Capital (Health)

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 and a broader trend (e.g., five or more years decline) and the insurer’s plans to mitigate. If a downward trend is identified, the analyst should review the insurer’s projections and document its plan to improve the capital position.

Procedure #2 determines if the change in the insurer’s RBC ratio was due to Total Adjusted Capital Total Adjusted Capital is computed by subtracting the value of any reserving discounts from policyholders surplus and adjusting for AVR and half of any dividend liability of the insurer’s life insurance affiliates, in addition to applying credit for capital notes.
Procedure #3 determines if the change in the insurer’s RBC ratio was due to the Authorized Control Level. The components of the Authorized Control level are factored to apply the level of risk. There are five major categories as detailed below.

**Asset Risk-Affiliates**

This is the risk of default for certain affiliated investments. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the subsidiary’s statutory surplus, multiplied in either case by the percentage of the subsidiary owned by the health entity. There are 10 categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items (e.g., non-controlled assets, guarantees for affiliates, and contingent liabilities, etc.) are included in this risk component. 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 a higher affiliated asset risk of between 14 percent and 20 percent of RBC (before covariance).

**Asset Risk-Other**

Asset risk attempts to measure the risk that a health entity’s assets will default or will decline in fair value. Each category of assets is assigned a factor that increases with the perceived riskiness of the asset. For example, high quality bond investments are assigned a low factor and non-investment grade bonds are assigned a high factor. Similar factors are assigned to other asset categories. An asset concentration factor adds RBC for holdings of a single issuer that represent a substantial proportion of the health entity’s assets. Refer to Analyst Reference Guide—Investments for more discussion on concentration of investments.

The Asset Risk – Other 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 and equipment can account for up to 4 percent of RBC for HMOs and HMDIs.

**Underwriting Risk**

Underwriting risk represents the risk associated with the unexpected fluctuation of incurred claims, typically resulting from variations in such factors as mortality, morbidity, and persistency. The risk factors are applied to the previous year’s incurred claims or earned premiums for different categories of health insurance.

The factors are smaller for large volumes of business, because less fluctuation is expected than for small volumes. Similarly, the factors are reduced by a credit for managed care arrangements, which generally reduces the fluctuation of incurred claims relative to fee-for-service arrangements. Note: The factors are larger for coverage that can fluctuate more in claim experience, such as comprehensive medical, which can have individual claims of $1 million or more, compared to the smaller factors for less volatile coverage, such as dental.

The underwriting risk calculation does not directly reflect the risk of underpricing or other poor management decisions by the health entity, although these risks were implicitly reflected in the
studies of needed capital on which the formula is based, to the extent they existed in the general population of health entities.

A minimum RBC requirement is applied for each category for small companies, equal to the dollar amount of two unusually large claims, which are assumed to be no less than $750,000 each. For companies that have purchased stop-loss reinsurance and are liable for less than $750,000 per claim, the minimum requirement is reduced to reflect their lower liability.

Refer to the Income Statement and Surplus section and the Health Reserves and Liabilities section 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.

Credit Risk

Health credit risk is the risk that health benefits (or other receivables) that are due from health care providers or other creditors will become an obligation of the health entity as a result of a default by the providers or other creditors. Refer to the following sections for more discussion: Other Assets; TPAs, IPAs and MGAs; and Reinsurance.

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.

Business Risk

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. Business risk for HMDIs 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.

Procedure #4 determines whether the health entity triggered the RBC Trend Test. The RBC Trend test is triggered when a health entity has an RBC ratio that falls below 300 percent (the Trend Test level) and has a combined ratio greater than 105 percent. A state could place the health entity in RBC Company Action level if it has adopted the RBC trend test.

Procedure #5 directs the analyst to obtain and review a copy of the health entity’s RBC plan. If applicable, 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 Model #315, and:
III. Analyst Reference Guide – D.7. Level 2 Risk-Based Capital (Health)

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 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.

The analyst should 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.
III. Annual 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 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 the Annual Financial Statement, 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.

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 the Annual Financial Statement, Schedule E - Part 3 - Special Deposits 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
- 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 Quarterly Financial Statement 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 Annual Level 2 Additional Procedures 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 duration 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 assessments, 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 incurred 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 the Annual Financial Statement, Notes to Financial Statements, 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 the Annual Financial Statement, Underwriting and Investment Exhibit - Part 3 - Analysis of Expenses 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?
III. Annual Procedures – D.9. Level 2 Risk Transfer Other Than Reinsurance (Health)

o. Have disclosures been made in the Notes to Financial Statements regarding the possible uncollectability of amounts receivable under uninsured plans?

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 - Aggregate Reserve for Accident and Health Contracts Only, 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 - Aggregate Reserve for Accident and Health Contracts Only 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 the Annual Financial Statement, Exhibit 7 - Part 1 - Summary of Transactions with Providers 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.
III. Annual Procedures – D.9. Level 2 Risk Transfer Other Than Reinsurance (Health)

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.

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
- 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 ________
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 Annual Level 2 Additional Procedures 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 mis-estimating health care costs. Arrangements that control costs of services may not be as effective in reducing risk, if providers increase utilization to make up for lower costs. For example, controlling the cost of a day in the hospital by contracting for fixed per diems is not effective if lengths of stay increase. Contracting for reduced inpatient care cost or changing benefit designs to reduce the use of inpatient care is not effective if providers shift to outpatient facilities and increase the cost of outpatient care.

Health entities use many types of risk transfer arrangements with outside entities to help control costs. Risk can be transferred to:

- Reinsurers
- Groups
- Insured members
- 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 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 uncollectible, 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 - Aggregate Reserve For Accident and Health Contracts Only line 4, with a corresponding entry to premiums. Accounting guidance for retrospectively rated contracts with return of premium provisions can be found in SSAP No. 66, *Retrospectively Rated Contracts*.

Risk transfer to insured members is accomplished through the use of deductibles, coinsurance, and copayments (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 capititating 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 the Annual Financial Statement, 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.
   c. Briefly scan the individual reinsurers in the Annual Financial Statement, listed on Schedule S - Part 3 - Section 2.
   d. 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 the Annual Financial Statement, 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?
III. Annual Procedures – D.10. Level 2 Reinsurance (Health)

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.

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 the Annual Financial Statement, 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 the Annual Financial Statement, Notes to Financial Statements, Note #23 - Reinsurance. 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.
III. Annual Procedures – D.10. Level 2 Reinsurance (Health)

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 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 the Annual Financial Statement, Schedule S – Part 2 - Reinsurance Recoverable on Paid and Unpaid Losses Listed By Reinsuring Company as of December 31, Current Year and Schedule S – Part 3 – Section 2 - Reinsurance Ceded Accident and Health Insurance Listed By Reinsuring Company as of December 31, Current Year. 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 Financial Statements, Note #23 - Reinsurance; 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 Financial Statements, 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.
III. Annual Procedures – D.10. Level 2 Reinsurance (Health)

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.

6. Review the Annual Financial Statement, Schedule S, Note to Financial Statements, Note #23 - Reinsurance, 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
III. Annual Procedures – D.10. Level 2 Reinsurance (Health)

- 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 ________
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 the Quarterly Financial Statement, Schedule S – Ceded Reinsurance. Were any new reinsurers added since the prior quarter?
   b. Review the Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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, \textit{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 reinsurance of that individual. Facultative reinsurance is rarely encountered in the health market.

The basic objective of reinsurance is to spread the risk of loss. Through reinsurance, a health entity can limit its claims under policies issued, as the reinsurer assumes the obligation to indemnify the health entity. There are four primary reasons why a health entity enters into reinsurance transactions.

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 inpatient 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 underpriced 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 a 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.\(^1\)

   a. Review the Annual Financial Statement, 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 the Annual Financial Statement, Schedule Y - Part 1 – Organizational Chart and Part 2 – Summary of Insurer’s Transactions With Any Affiliates, 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 the Annual Financial Statement, 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 the Annual Financial Statement, Schedule Y - Parts 1 – Organizational Chart 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.

\(^1\) Health entities have not been incorporated into the *Insurance Holding Company System Regulatory Act* in all states.
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

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 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 - Analysis of Expenses, greater than 15 percent of the total incurred general expenses?

b. Review the Annual Financial Statement, 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?
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

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?

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 the Annual Financial Statement, Notes to Financial Statements, Note #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.

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 1?

   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 the Annual Financial Statement on Schedules A, B, and D, and compare with prior years.
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

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 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 Annual Financial Statement, 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 the Annual Financial Statement, 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 – Amounts Due to Parent, Subsidiaries, and Affiliates, 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?

III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

v. Are there any affiliated receivable balances from medical providers or intermediaries included on Exhibit 5 – Amounts Due from Parent, Subsidiaries, and Affiliates?

c. Review the Annual Financial Statement, 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 the Annual Financial Statement, Exhibit 7 - Summary of Transactions with Providers.
   i. Is the ratio of payments made to affiliated providers to total payments greater than 50 percent?
   ii. Has there been any indication that the amount charged by the affiliated provider is non-economic or non-arms-length?

e. Review the Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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?
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

i. Review the Annual Financial Statement, 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.
   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
III. Annual Procedures – D.11. Level 2 Affiliated Transactions (Health)

- 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?
   c. Review the Quarterly Financial Statement, Schedule Y - Part 1A – Detail of Insurance Holding Company System for the current year.
      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 the Quarterly Financial Statement, 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 the Quarterly Financial Statement, Notes to Financials. Did the health entity report a change in the health entity’s capital structure?

g. Review the Quarterly Financial Statement, General Interrogatory #3. Have there been substantial changes in the organization chart?

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 the Quarterly Financial Statement, 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 Quarterly Financial Statement, 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 the Quarterly Financial Statement, 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 the Quarterly Financial Statement, 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?

3. Review the Quarterly Financial Statement, General Interrogatory #14. Determine whether investments in affiliates are significant.
   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?
III. Quarterly Procedures – D.11. Level 2 Affiliated Transactions (Health)

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 greater than +/- 25 percent from the prior year-end?

f. Review the Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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* (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 - Summary of Insurer’s Transactions With Any Affiliates. 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 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, Note #10 – Information Concerning Parent, Subsidiaries, and Affiliates 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 guaranty 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 – Amounts Due from Parent, Subsidiaries, and Affiliates and 6 – Amounts Due to Parent, Subsidiaries, Affiliates, 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 the Annual Financial Statement, 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. The Annual Financial Statement, 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 the Annual Financial Statement, 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 the Annual Financial Statement, 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 (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 the Annual Financial Statement, Notes to Financial Statements, Note #19 - Direct Premiums Written 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...
III. Annual Procedures – D.12. Level 2 TPAs, IPAs, and MGAs (Health)

Sections 2, 4, 6, 7 and 8 of the NAIC Registration and Regulation of Third-Party Administrator (#1090) and/or the applicable sections of the Insurance Code.

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.
III. Annual Procedures – D.12. Level 2 TPAs, IPAs, and MGAs (Health)

ii. The most recent independent CPA audit of the TPA or IPA. If not available, request the most recent annual report.

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 the Quarterly Financial Statement, 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 Annual Level 2 Additional Procedures 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 Registration and Regulation of Third-Party Administrators (#1090) (TPA Statute) defines a TPA as any person who directly or indirectly solicits or effects coverage of, underwrites, collects charges 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 the Annual Financial Statement, Notes to Financial Statements, Note #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. 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.