EXAMINATION OVERSIGHT (E) TASK FORCE

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Draft Pending Adoption

Draft: 11/8/24

Examination Oversight (E) Task Force
Virtual meeting (*in lieu of meeting at the 2024 Fall National Meeting*)
November 12, 2024

The Examination Oversight (E) Task Force met Nov. 12, 2024. The following Task Force members participated: Judith L. French, Chair, represented by Dwight Radel (OH); Karima M. Woods, Vice Chair, represented by N. Kevin Brown (DC); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Blase Abreo (AL); Barbara D. Richardson represented by David Lee (AZ); Ricardo Lara represented by Laura Clements and Ber Vang (CA); Michael Conway represented by Carol Matthews (CO); Andrew N. Mais represented by Jack Broccoli (CT); Michael Yaworsky represented by Chad Mason (FL); Doug Ommen represented by Daniel Mathis (IA); Dean L. Cameron represented by Eric Fletcher (ID); Holly W. Lambert represented by Roy Eft (IN); Vicki Schmidt represented by Levi Nwasoria (KS); Sharon P. Clark represented by Jeff Gaither (KY); Timothy J. Temple represented by Melissa Gibson (LA); Michael T. Caljouw represented by John Turchi (MA); Anita G. Fox represented by Judy Weaver (MI); Grace Arnold represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by Shannon Schmoeger (MO); Mike Chaney represented by Mark Cooley (MS); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Doug Bartlett (NE); D.J. Bettencourt represented by Andrea Johnson (NH); Justin Zimmerman represented by David Wolf (NJ); Scott Kipper represented by Moli Abejar (NV); Glen Mulready represented by Eli Snowbarger (OK); Larry D. Deiter represented by Johanna Nickelson (SD); Cassie Brown represented by Shawn Frederick (TX); Scott A. White represented by Jennifer Blizzard and Greg Chew (VA); Mike Kreidler represented by Tarik Subbagh (WA); and Nathan Houdek represented by Amy Malm (WI).

1. Adopted its Sept. 25 and Summer National Meeting Minutes

Radel said the Task Force conducted an e-vote that concluded Sept. 25 to adopt its 2025 proposed charges, which remained unchanged from the Task Force's 2024 charges.

The Task Force also met Nov. 12 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss open exams that are past the 22-month deadline.

Eft made a motion, seconded by Matthews, to adopt the Task Force's Sept. 25 (Attachment One) and July 25 (*see NAIC Proceedings – Summer 2024, Examination Oversight (E) Task Force*) minutes. The motion passed unanimously.

2. Adopted the Reports of its Working Groups

   A. Electronic Workpaper (E) Working Group

Clements provided the report of the Electronic Workpaper (E) Working Group. She stated that the Working Group has not met in open session this year. She said the Working Group has held informal monthly meetings to discuss the progress of TeamMate+ transition.

   B. Financial Analysis Solvency Tools (E) Working Group

Chew provided the report of the Financial Analysis Solvency Tools (E) Working Group. He stated that the Working Group met Nov. 7 and Sept. 26 to adopt revisions to the *Financial Analysis Handbook* on the following topics:

- Revisions to the property/casualty (P/C) catastrophe reinsurance program.
- Revisions to the credit risk assessment guidance.
- Revisions to the pricing and underwriting risks of health insurers.
- Revisions to Form A and disclaimer of control/affiliation guidance.
- Revisions to guidance pertaining to the Own Risk and Solvency Assessment (ORSA) and Form F exemptions.
- Revisions regarding recovery and resolution planning to align the guidance with the current Insurance Core Principles (ICPs).
- Revisions that include new procedures for analysts to consider:
    - When reviewing applications for capital or surplus notes.
    - Parental guarantees and capital maintenance agreements as part of the Form A review.
- Revisions to merge the analyst reference guide and the risk repositories for market, pricing/underwriting, reputational, and strategic risks as part of the long-term plan to enhance automated analysis tools.
- Revisions to incorporate best practices to existing guidance on the monitoring of run-off insurers.

C. <u>Financial Examiners Coordination (E) Working Group</u>

Radel provided the report of the Financial Examiners Coordination (E) Working Group. He stated that the Working Group met Aug. 12 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss reports on group coordination.

D. <u>Financial Examiners Handbook (E) Technical Group</u>

Snowbarger provided the report of the Financial Examiners Handbook (E) Technical Group. He stated that the Technical Group met Oct. 31 and Sept. 23 to adopt revisions to the *Financial Condition Examiners Handbook* (Handbook) on the following topics:

- Revisions to Section 1-1 and the investments repository in response to a referral from the Risk-Focused Surveillance (E) Working Group to provide more guidance to regulators on reviewing affiliated investment management services and agreements.
- Revisions to Section 1-3 in response to a referral from the Risk-Focused Surveillance (E) Working Group to incorporate best practices to existing guidance on monitoring run-off insurers.
- Revisions to Exhibit V to provide an example prospective risk and Exhibit Y to provide sample interview questions related to a company's executive compensation structure and related risks.
- Revisions to the capital and surplus repository to encourage an examiner to review the manual adjustments made to risk-based capital (RBC), including those for modified coinsurance (modco) reinsurance and separate account assets.

E. <u>Information Technology (IT) Examination (E) Working Group</u>

Vang provided the report for the Information Technology (IT) Examination (E) Working Group. He stated that the Working Group met Oct. 31 and Oct. 10 to adopt revisions to the *Financial Condition Examiners Handbook* on the following topics:

- Revisions to Exhibit C, Part 2 to update IT review guidance to further align it with the Cybersecurity Framework (CSF) 2.0 of the National Institute of Standards and Technology (NIST), in response to a referral from the Cybersecurity (H) Working Group.

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Vang noted that the Working Group will continue this work in 2025 to determine how to separate work needed to conclude on IT general controls (ITGCs) from cybersecurity work. As a part of this effort, current procedures in Exhibit C may be further modified or removed.

Malm made a motion, seconded by Blizzard, to adopt reports of the Electronic Workpaper (E) Working Group; the Financial Analysis Solvency Tools (E) Working Group (Attachment Two); the Financial Examiners Coordination (E) Working Group; the Financial Examiners Handbook (E) Technical Group (Attachment Three); and the Information Technology (IT) Examination (E) Working Group (Attachment Four). The motion passed unanimously.

Having no further business, the Examination Oversight (E) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E Committee/2024-3-Fall/EOTF Minutes 11.12.24 - FINAL

Draft: 10/2/24

Examination Oversight (E) Task Force
E-Vote
September 25, 2024

The Examination Oversight (E) Task Force conducted an e-vote that concluded Sept. 25, 2024. The following Task Force members participated: Judith L. French, Chair, represented by Dwight Radel (OH); Karima M. Woods, Vice Chair, represented by N. Kevin Brown (DC); Mark Fowler represented by Sheila Travis (AL); Ricardo Lara represented by Laura Clements (CA); Michael Conway represented by Carol Matthews (CO); Andrew N. Mais represented by William Arfanis (CT); Trinidad Navarro represented by Rylynn Brown (DE); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); Kevin P. Beagan represented by John Turchi (MA); Anita G. Fox represented by Robert Lamberjack (MI); Chlora Lindley-Myers represented by Shannon Schmoeger (MO); Mike Chaney represented by Mark Cooley (MS); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Andrea Johnson (NE); D.J. Bettencourt represented by Doug Bartlett (NH); Scott Kipper (NV); Larry D. Deiter represented by Johanna Nickelson (SD); Cassie Brown represented by Shawn Frederick (TX); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by John Haworth (WA); and Nathan Houdek represented by Amy Malm (WI).

1. Adopted its 2025 Proposed Charges

The Task Force conducted an e-vote to consider adoption of its 2025 proposed charges (*see NAIC Proceedings – Fall 2024, Financial Condition (E) Committee*), which remained unchanged from the Task Force's 2024 charges. The motion passed.

Having no further business, the Examination Oversight (E) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E Cmte/EOTF/1 – EOTF E-Vote Minutes 2024_Final

Draft: 11/11/24

Financial Analysis Solvency Tools (E) Working Group
Virtual Meeting
November 7, 2024

The Financial Analysis Solvency Tools (E) Working Group of the Examination Oversight (E) Task Force met Nov. 7, 2024. The following Working Group members participated: Greg Chew, Chair (VA); Amy Garcia, Vice Chair (TX); Richard Russell (AL); Dave Lathrop and Kurt Regner (AZ); Kim Hudson (CA); N. Kevin Brown (DC); Shalice Rivers (FL); Amanda Denton (IN); Greg Ricci (MD); Judy Weaver and Kristin Hynes (MI); Shannon Schmoeger (MO); Olga Dixon (NJ); Victor Agbu (NY); Dwight Radel and Tim Biler (OH); Liz Ammerman (RI); and Kristin Forsberg (WI).

1. Adopted its Sept. 26 Minutes

The Working Group met Sept. 26. During this meeting, the Working Group took the following action: 1) adopted revisions to the *Financial Analysis Handbook* (Handbook) related to the property/casualty (P/C) catastrophe reinsurance program, credit risk assessment, Affordable Care Act (ACA) market risks, disclaimer of control/affiliation, and Own Risk and Solvency Assessment (ORSA) guidance; and 2) exposed draft Handbook guidance on recovery and resolution planning, surplus notes, capital maintenance agreements, and merged branded risk guidance and repositories for a 30-day public comment period ending Oct. 28.

Hudson made a motion, seconded by Garcia, to adopt the Working Group's Sept. 26 minutes (Attachment Two-A). The motion passed unanimously.

2. Discussed Exposure Draft Comments and Adopted Revisions to the Handbook

Chew said the next item of business was to discuss the comments received from the American Council of Life Insurers (ACLI) (Attachment Two-B) on the exposed revisions to the Handbook regarding surplus notes and recovery and resolution planning.

A. Surplus Notes

Ralph Villegas (NAIC) explained that the ACLI provided feedback on proposed guidance regarding time frame restrictions, surplus floor requirements, multiple notes and sequencing, analysis review procedures, certain vague language, and potential misalignment with specific state statutes.

Villegas stated that the proposed guidance was revised to address the ACLI's concerns. This included replacing vague language with direct language from *Statement of Statutory Accounting Principles (SSAP) No. 41—Surplus Notes*, such as guidance on the review of surplus notes and the specific provisions necessary for classification as surplus. Additionally, the time frame guidance for affiliated and unaffiliated notes was updated to 30 days and 90 days, respectively. The proposal includes additional language for references to surplus floors to indicate whether they are required by insurance department regulations, along with other revisions to clarify language regarding the terms of the notes.

The ACLI expressed agreement with the proposed additional revisions.

Without further comments from Working Group members, interested state insurance regulators, or other parties, Chew requested a motion to adopt the proposed guidance.

Weaver made a motion, seconded by Dixon, to adopt the revisions to the Handbook related to surplus notes (Attachment Two-C). The motion passed unanimously.

B. Recovery and Resolution Planning

Jane Koenigsman (NAIC) explained that the ACLI's letter included comments on the revisions to the internationally active insurance group (IAIG) guidance on recovery and resolution plans within the supervisory college chapter. Staff aimed to clarify the draft without compromising the intent of the revisions. Koenigsman noted that under IAIS Common Framework for the Supervision of IAIGs (ComFrame) Insurance Core Principle (ICP) 16.16, developing recovery plans is mandatory for all IAIGs. While U.S. supervisors could have simply required a recovery plan from every IAIG, they opted to first assess the ORSA and other enterprise risk management (ERM)-related reporting to determine if it adequately addresses severe stresses and recovery options. If the U.S. group-wide supervisor deems the ORSA insufficient, they may request additional information, including a stand-alone recovery plan for the IAIG.

Koenigsman also addressed the ACLI's comment on management information systems, emphasizing that information technology (IT) systems should generate necessary information regardless of IAIS requirements. The Handbook edits aim to differentiate between recovery and resolution, which have distinct requirements under ComFrame. The revised language reflects the expectations outlined in ComFrame.

The ACLI confirmed its agreement with the proposed additional revisions.

With no further comments from Working Group members, interested state insurance regulators, or other parties, Chew requested a motion to adopt the proposed guidance.

Hudson made a motion, seconded by Weaver, to adopt the revisions to the Handbook related to recovery and resolution planning (Attachment Two-D). The motion passed unanimously.

3. Adopted Revisions to the Handbook

Chew said the last item of business was to consider the adoption of Handbook guidance related to three items: 1) capital maintenance agreements; 2) insurers in run-off; and 3) the combined analyst reference guide and repositories for the remaining eight branded risk categories. Chew said that the proposed revisions on capital maintenance agreements and the branded risk categories were recently exposed by the Working Group, and no comments were received. The proposed guidance related to insurers in run-off was previously exposed by the Risk-Focused Surveillance (E) Working Group and referred to the Financial Analysis Solvency Tools (E) Working Group.

Russell made a motion, seconded by Weaver, to adopt the revisions to the Handbook related to capital maintenance agreements (Attachment Two-E), insurers in run-off (Attachment Two-F), and the combined analyst reference guide and repositories for the remaining eight branded risk categories (Attachment Two-G). The motion passed unanimously.

Having no further business, the Financial Analysis Solvency Tools (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E CMTE/2024_Fall/EOTF

Draft: 10/2/24

Financial Analysis Solvency Tools (E) Working Group
Virtual Meeting
September 26, 2024

The Financial Analysis Solvency Tools (E) Working Group of the Examination Oversight (E) Task Force met Sept. 26, 2024. The following Working Group members participated: Greg Chew, Chair (VA); Amy Garcia, Vice Chair (TX); Richard Russell and Todrick Burks (AL); Dave Lathrop (AZ); Kim Hudson (CA); Jack Broccoli (CT); N. Kevin Brown (DC); Amanda Denton (IN); Lynn Beckner (MD); Judy Weaver (MI); Debbie Doggett (MO); Olga Dixon (NJ); Victor Agbu (NY); Dwight Radel and Tim Biler (OH); Liz Ammerman (RI); and Kristin Forsberg (WI).

1. Adopted Revisions to the Handbook

Chew said the first item of business was to consider adopting revisions to the *Financial Analysis Handbook* (Handbook) related to three topics: 1) the property/casualty (P/C) catastrophe reinsurance program; 2) credit risk assessment; and 3) pricing and underwriting risks of health insurers. These revisions were initially discussed and exposed for comment during the Working Group's July 16 call. Chew said the Working Group did not receive any comments related to these three topics. However, during the review of the guidance on pricing and underwriting risk of health insurers and examining information from related health discussions, NAIC staff determined that it would be beneficial to include a procedure for evaluating business plans, specifically focusing on membership projections. Chew said that while business plans and projections are already standard review practices for all insurers, NAIC staff believe adding a more targeted review of enrollment expectations would be particularly valuable for new insurers entering the Affordable Care Act (ACA) market.

Hudson made a motion, seconded by Garcia, to adopt the revisions to the Handbook related to the P/C catastrophe reinsurance program (Attachment Two-A1); credit risk assessment (Attachment Two-A2); and pricing and underwriting risks of health insurers (Attachment Two-A3). The motion passed unanimously.

2. Discussed Exposure Draft Comments and Adopted Revisions to the Handbook

Chew said the next item of business was to discuss the comments received on the exposed revisions to the Handbook related to: 1) Form A and disclaimer of control/affiliation; and 2) Own Risk and Solvency Assessment (ORSA) guidance and Form F exemptions.

A. Form A and Disclaimer of Control/Affiliation

Chew stated that the Working Group received five comment letters regarding the Form A and disclaimer of control/affiliation guidance. NAIC staff reviewed these letters and proposed edits to address the comments.

Jane Koenigsman (NAIC) explained that the majority of comments focused on the disclaimer of control/affiliation guidance. To address these concerns, NAIC staff added a note at the beginning of the Handbook chapter clarifying that the Handbook guidance does not supersede state law and regulation but is intended as additional guidance and best practices for analysts.

Next, Koenigsman addressed concerns about the Handbook's definition of control, which commenters believed conflicted with the definition in the *Insurance Holding Company System Regulatory Act* (#440). Koenigsman noted that the Handbook guidance was edited to include the definition of control from Section 1C of Model #440 and

the disclaimer of affiliation from Section 4k of Model #440. Additionally, references to control/affiliation in the Handbook guidance were revised to align directly with these definitions.

Koenigsman then discussed the added guidance on passive investors, which was included to address concerns about the applicability of the disclaimer guidance to such investors. The 30-day notice requirement for passive investors was recommended for deletion, as it was another area of concern raised by commenters. Koenigsman highlighted other, less substantive edits made to the guidance to address the comments.

Matthew Thornton (Investment Company Institute—ICI), one of the five parties who submitted comments (Attachment Two-A4), recommended revised wording for part of the added passive investors guidance. This included replacing "passingly monitoring their investment" with "their ordinary course of business" in the first paragraph. The Working Group agreed with this edit.

Thornton also recommended revising the last sentence in the second paragraph from "if the investment includes prohibitions on board representation and prohibitions on proxy solicitations" to "any special rights beyond those that typically attached to the relevant securities." Thornton stated that generally shareholders may have rights to do things like put forward board members, and passive investors generally don't do that. Chew clarified that the intent of the statement was to provide further evidence of no control, while the suggested edit seemed to imply control. Bruce Jenson (NAIC) explained that the guidance aims to clarify situations where a passive investor owns more than 10% of the voting rights, determining what might still allow them to receive a disclaimer of control. In such cases, regulators would generally expect passive investors to potentially relinquish some of their ordinary investor rights to demonstrate that they will not exercise any control, such as board seats or proxy voting. Given these comments, Thornton supported the guidance as is and agreed with all other edits.

The other four parties that submitted comments, the American Council of Life Insurers (ACLI) (Attachment Two-A5), the National Alliance of Life Companies (NALC) (Attachment Two-A6), the Securities Industry and Financial Markets Association (SIFMA) (Attachment Two-A7), and Capital Group (Attachment Two-A8), had no further comments.

With no additional comments from Working Group members, interested state insurance regulators, or interested parties on the edits made to the guidance, including the additional edits recommended by Thornton, Chew asked if Working Group members were comfortable adopting the edits or preferred to re-expose them for another 30-day comment period.

Garcia made a motion, seconded by Hudson, to adopt the revisions to the Handbook related to Form A and disclaimer of control/affiliation (Attachment Two-A9). The motion passed unanimously.

B. <u>ORSA Guidance</u>

Chew said the next set of exposed revisions pertained to the ORSA guidance within Section VI.I.—Group-Wide Supervision of the Handbook. The Working Group received comments from UnitedHealthcare (UHC).

Jeff Martin (UHC) indicated that he understood the revisions were intended to align with the *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual) and therefore supported the proposed changes to the Handbook.

Since no additional revisions were deemed necessary based on UHC's comment letter (Attachment Two-A10), Chew requested a motion to adopt the changes.

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Russell made a motion, seconded by Broccoli, to adopt the revisions to the Handbook related to the ORSA guidance (Attachment Two-A11). The motion passed unanimously.

3. Exposed Draft Revisions to the Handbook

Chew announced that the next item on the agenda was to consider exposing revisions to three specific areas of the Handbook: 1) recovery and resolution planning; 2) surplus notes and capital maintenance agreements; and 3) merged guidance and repositories for market, pricing/underwriting, reputational, and strategic risk categories.

A. Recovery and Resolution Planning

Chew said the first set of revisions stemmed from a referral by the Group Solvency Issues (E) Working Group (Attachment Two-A12). The Group Solvency Issues (E) Working Group identified that the supervisory plan guidance in the Handbook contained limited information on recovery and resolution planning. The International Association of Insurance Supervisors (IAIS) was nearing completion of its revisions to Insurance Core Principles (ICP) 12 (Exit from the Market and Resolution) and 16 (Enterprise Risk Management for Solvency Purposes), which address recovery and resolution planning for internationally active insurance groups. The IAIS is expected to adopt these ICP revisions in December. Chew noted that the proposed Handbook revisions from the Group Solvency Issues (E) Working Group aimed to align with the current ICP revisions and the U.S. practice on recovery plan expectations, whereby US group-wide supervisors would consider the ORSA and other available information when determining a recovery plan requirement. Given the anticipated adoption of the ICPs in December, NAIC staff will continue to monitor the IAIS's work. While no substantive changes are expected, any minor editorial edits will be incorporated before publishing the Handbook.

B. Surplus Notes and Capital Maintenance Agreements

Chew said the proposed guidance on surplus notes and capital maintenance agreements was recommended by the drafting group formed at the Working Group’s July 16 meeting to address the referral from the Risk-Focused Surveillance (E) Working Group.

Ralph Villegas (NAIC) summarized the proposed revisions, including recommended new procedures for analysts to consider when reviewing applications for capital or surplus notes. These procedures involved assessing the purpose and impact of the transaction on the insurer, verifying compliance with statutory accounting principles (SAPs), and other guidance recommended by the drafting group. Villegas also outlined new procedures recommended by the drafting group regarding analysts' consideration of parental guarantees and capital maintenance agreements as part of their Form A review. This included specific information such agreements should contain and their potential impact on the insurer, especially in cases where the insurer may heavily rely on capital support.

C. Merged Guidance and Repositories for Market, Pricing/Underwriting, Reputational, and Strategic Risk

Chew said NAIC staff completed merging the analyst reference guide and the risk repositories for market, pricing/underwriting, reputational, and strategic risk. This was part of the long-term plan to enhance automated analysis tools. While the automated repositories will be phased out, the procedures they contain have been integrated into the reference guide. The existing guidance remains unchanged; it has simply been reorganized.

The Working Group agreed to expose the proposed revisions to the Handbook for a 30-day public comment period ending Oct. 28, covering: 1) recovery and resolution planning; 2) surplus notes and capital maintenance

agreements; and 3) merged guidance and repositories for market, pricing/underwriting, reputational, and strategic risk.

Having no further business, the Financial Analysis Solvency Tools (E) Working Group adjourned.

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Pricing/Underwriting Risk: Pricing and underwriting practices are inadequate to provide for risks assumed.

Note: The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk. Also, note that key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with pricing and underwriting. For example, many of the procedures also may be related to operational risks or strategic risks.

Analysis Documentation: Results of pricing and underwriting risk analysis should be documented in Section III: Risk Assessment of the insurer.

Underwriting Performance

1. Determine whether concerns exist regarding the insurer's underwriting performance.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Change in net premiums earned	OP*	>25% or <-25%	[Data]	[Data]
b. Change in net incurred losses and loss adjustment expense (LAE)	OP*	>20% or <-35%	[Data]	[Data]
c. Other underwriting expense ratio		>25%	[Data]	[Data]
d. Net loss ratio	OP*		[Data]	
e. Change in net loss ratio	OP*	>20 pts or <-20 pts	[Data]	[Data]
f. Direct commissions to direct premiums ratio		>30%	[Data]	[Data]

	Other Risks
g. Review the five-year trend with the Financial Profile Report and/or the Management Discussion and Analysis (MD&A), for the following measures of operating performance, and note any unusual fluctuations, events (e.g., catastrophes) or trends between years for each ratio: • Loss ratios for direct, assumed and ceded business • Incurred loss and LAE by line of business	OP*
h. Compare, by line of business, the pure net loss ratio to the industry averages in the Financial Profile Report to determine any significant deviations.	
i. Review each line of business included in the Annual Financial Statement, Schedule P, for trends in accident year loss ratios, on both a gross and net basis, that may indicate a deterioration in underwriting results.	
j. If concerns exist regarding underwriting results, consider the following procedures: i. Request and review additional information from the insurer on the causes of poor underwriting performance. ii. Request, review, and evaluate information from the insurer regarding its plans to address poor underwriting performance (e.g., tightening underwriting standards, rate	OP

changes, etc.). iii. Inquire of the rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.	
k. Review the write-ins for underwriting deductions in the Annual Financial Statement, Statement of Income and the Financial Profile Report and note any unusual fluctuations or trends.	

Premium Production, Concentration and Writings Leverage

2. Determine whether concerns exist regarding changes in the volume of premiums written, changes in the insurer's mix of business (lines of business and/or geographic location) and changes in writing leverage.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Change in gross premiums written		>25% or <-25%	[Data]	[Data]
b. Change in net premiums written		>25% or <-25%	[Data]	[Data]
c. Change in direct premiums written (DPW) for any line of business		>33% or <-33%	[Data]	[Data]
d. Ratio of DPW for any new lines to total DPW		>5%	[Data]	[Data]
e. Change in DPW in any one state when DPW is greater than 10% of total DPW in either the current or prior year-end		>50% or <-50%	[Data]	[Data]
f. Ratio of DPW in a new state to total DPW		>5%	[Data]	[Data]
g. Gross premiums written to surplus [IRIS #1]	ST*	>900%	[Data]	[Data]
h. Net premiums written to surplus [IRIS #2]	ST*	>300%	[Data]	[Data]

	Other Risks
i. If significant changes in premium volume are identified, consider the following procedures: i. Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume. ii. Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.	ST
j. Review, by line of business, premiums written by year in the Financial Profile Report for shifts in the mix of business between years and to gain an understanding of lines of business written.	ST
k. Determine whether the insurer has material exposure to losses resulting from acts of terrorism. If concerns are identified, consider the following procedures: i. Request additional data/information from the insurer to gain an understanding of its exposure to terrorism risk. ii. If the insurer is subject to ORSA reporting, review information provided on terrorism exposure and risk assessment in the ORSA Summary Report or obtain the lead state's	ST

review (if applicable). iii. Gain an understanding of the insurer's mitigation of terrorism risk through TRIA coverage. iv. Assess the reasonableness of the ultimate exposure based on the insurer's business strategy and capital position. v. Consider the reasonableness of the insurer's plan to limit exposures, such as policy limits, policy exclusions, location of risks, pricing modifications, non-renewal of certain policies, plans for diversification, or other risk mitigation strategies	
l. 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 so, evaluate the underwriting/marketing strategy of the insurer and its expertise in writing liability lines of business.	
m. Review Annual Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.	LG
n. Review Annual Financial Statement, Schedule T and the writings section in the Financial Profile Report to evaluate the top states in terms of direct premiums and the percentage of total DPW in those states. Based on the lines of business written, determine whether large concentrations of premiums are written in areas prone to catastrophic events.	ST
o. Is the company diversified in terms of product lines and geographical exposure? If not, request and review information from the insurer regarding mitigation strategies to limit exposure concentrations.	ST
p. Review the insurer's underwriting/marketing strategy included in its business plan. i. If 2.e is "yes," evaluate the insurer's marketing and expansion plans in that state. ii. Is the insurer planning expansion into new states or premium growth in the future? iii. Has the insurer applied for or received new licenses in other states? iv. Has the insurer reported that it has ceased writing new business, a line of business or writing in a certain geographical location? v. Does the insurer have closed block operations? vi. Does the insurer's marketing strategy and projected premium growth match actual results reported in the current period? If materially different, evaluate the reasons why, or ask the insurer for an explanation.	ST
q. Determine whether the insurer has expertise (e.g., distribution network, underwriting, claims, and reserving) in the lines of business written. Consider reviewing the insurer's MD&A, business plan and/or additional information from the insurer to determine the expertise in the lines of business written.	
r. Review the insurer's gross and net writings leverage positions to assist in evaluating risk exposure. Consider the following specific procedures in this area: i. Compare the gross writings leverage and net writings leverage ratios to the industry averages and determine any significant variances. ii. If the insurer is a member of a group, compute the gross premiums written to surplus ratio and the net premiums written to surplus ratio on a consolidated basis to	ST

determine if the group appears to be excessively leveraged. iii. Obtain an explanation from the insurer for unusual results for P/C IRIS ratios #1 and #2.	

Exposure to Catastrophic Events

3. Determine whether concerns exist regarding the insurer's exposure to catastrophic events, including the potential for increased physical losses, prospectively, due to climate change.

	Other Risks
a. Review Annual Financial Statement, Schedule T and the writings section in the Financial Profile Report (or the Mix of Business Dashboard) to evaluate the top states in terms of direct premiums and the percentage of total DPW in those states. Based on the lines of business written, determine whether there is a material concentration of premiums written in areas prone to catastrophic events.	ST
b. Review information provided by the insurer in the RCAT (PR027) section of its Risk Based Capital filing to identify and assess the insurer's current exposure to catastrophic events at modeled worst year in 50, 100, 250, and 500 levels on both a gross (direct and assumed) and net basis (after reinsurance). Evaluate the potential impact of the company's modeled loss results on its capital and surplus and RBC position.	ST
c. Review the Interrogatory on Catastrophe Risk Reinsurance Program RCAT (PR027) section of the insurer's Risk Based Capital filing. If necessary, request additional information or clarification from the insurer to gain a comprehensive understanding of its catastrophe reinsurance program and any recent changes in coverage due to market conditions. i. Evaluate the adequacy of reinsurance protection; for example, evaluate the impact that multiple, smaller events could have on the insurer's financial position if they fall below retention levels. ii. Identify any exclusions in the reinsurance treaties that could leave the insurer exposed to unexpected losses. iii. Assess the financial strength and creditworthiness of the reinsurers involved. Assess any potential concentration risk where the insurer relies heavily on one reinsurer. iv. Review the insurer's claims handling practices for catastrophe events, including factors such as reserving adequacy, loss adjustment expenses, and reinsurance recoveries.	ST
~~c.~~ d. Review information provided in the insurer's response to the NAIC's Climate Risk and Disclosure Survey (if available) on its exposure to physical losses impacted by climate change, as well as its related mitigation activity. i. Determine whether any of the company's responses require further investigation and inquiry.	ST
~~d.~~ e. Review information provided in the ORSA Summary Report and/or SEC 10K or 10Q filings (if available) regarding the insurer's exposure to physical losses impacted by climate	ST

change, as well as its related mitigation activity.	
~~e.~~f. Utilize the information gathered and/or request additional information as necessary to assess the insurer's exposure to climate/catastrophic risks, as well as processes and strategies in place to limit exposures. i. Gain an understanding of how the company incorporates catastrophe modeling results into its underwriting processes (e.g., assessment of risk appetite or determination of net retained risk). ii. Gain an understanding of and evaluate the potential impact of climate change on the company's business and underwriting strategy over medium and longer-term time horizons. iii. Determine whether there are any concerns regarding the company's risk management processes in regard to climate change, both currently and prospectively.	ST

Additional Analysis and Follow-Up Procedures

Examination Findings:

Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding pricing and underwriting risks. If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

Inquire of the Insurer:

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

Marketing Strategy and Projections

- Marketing strategy, including distribution channels/networks, planned growth or cessation of business, expansion into new states or regions, management of closed block operations, etc.
- Financial projections for expected premium/sales.

Underwriting Performance

- Descriptions of underwriting practices and policies, including any exposure limits established by the insurer.
- Descriptions of pricing practices (e.g., frequency of review) and policies.
- Status of recent and pending rate increase requests.

Premium Production and Writings Leverage

- The insurer's expertise in the lines of business written.
- Explanations for significant shifts in geographic concentrations, lines of business, amounts of premiums written, high leverage positions, etc.

Use of CAT Modeling and Exposure Limits in Underwriting

- CAT modeling processes and oversight.
- Use of modeled results to set underwriting exposure limits and refine underwriting guidelines.

Own Risk and Solvency Assessment (ORSA) Summary Report:

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

- Did the ORSA Summary Report analysis conducted by the lead state indicate any pricing and underwriting risks that require further monitoring or follow-up?
- Did the ORSA Summary Report analysis conducted by the lead state indicate any mitigating strategies for existing or prospective risks?
- Did the ORSA Summary Report present the results of the modeled CAT exposure analysis at various levels, on both a gross and net basis?

Holding Company Analysis:

- Did the Holding Company analysis conducted by the lead state indicate any pricing and underwriting risks impacting the insurer that require further monitoring or follow-up?
- Did the Holding Company analysis conducted by the lead state indicate any mitigating strategies for existing or prospective risks impacting the insurer?

Example Prospective Risk Considerations		
Risk Components for IPS		***Explanation of Risk Components***
1	Trend of poor underwriting results	A continued trend in loss and combined ratio results may be an indicator of other underlying risks, such as inadequate pricing.
2	Risk concentration (geographic, line of business, etc.)	Risk concentrations may expose the insurer to significant variances or threaten solvency if not effectively mitigated (e.g., homeowner's insurance concentrated in coastal states).
3	Lack of underwriting expertise in [name of line of business]	A lack of underwriting expertise may result in underpricing or faulty risk acceptance if the insurer is not experienced in underwriting a new line of business.
4	Lack of sufficient underwriting standards	A lack of sufficient underwriting policies and procedures may results in underpricing, acceptance of unknown/excessive risks, etc.
5	High writings leverage trend	A high writings leverage trend may indicate concentrations, overexposure to certain insurance risks and/or a lack of support from ownership/parent.
6	Negative variance on projected premium/sales to actual	Actual premium volume or new sales results vary materially from projections, leading to an inability to fulfill the strategic plan.
7	Rapid expansion/growth	Rapid growth or expansion into new geographic areas or new states may result in a higher-than-expected strain on surplus.
8	Declining premium volume	Declines in premium volume may result in insufficient revenue to sustain current operations.
9	Lack of a clear underwriting/marketing strategy	Failure to define and update the underwriting/marketing strategy of the insurer may lead to inconsistent results, inappropriate risk acceptance, etc.

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Pricing and Underwriting Risk Assessment

Pricing and Underwriting Risk: Pricing and underwriting practices are inadequate to provide for risks assumed.

The objective of Pricing and Underwriting Risk Assessment analysis is to focus on risks inherent in writing business and premium production. Although pricing and underwriting risk is a component of overall profitability and operations, it is reviewed separately from other operational risks. Analysts may require additional investigation and information requests to understand and assess the potential impact of these risks. For example, analysts may need additional information to assess the insurer's capacity for growth and plans for expansion.

The following discussion of procedures provides suggested data, benchmarks and procedures analysts can consider in his/her review. An analyst's risk-focused assessment of pricing and underwriting risk should take into consideration, the following areas (but not be limited to):

- Underwriting performance
- Premium production
- Premium concentration
- Writings leverage
- Financial impact of the federal Affordable Care Act (ACA) (Life/A&H, Health)

Discussion of Annual Procedures

Using the Repository

The pricing and underwriting risk repository is a list of possible quantitative and qualitative procedures, including specific data elements, benchmarks and procedures from which analysts may select to use in his/her review of pricing and underwriting risk. Analysts are not expected to respond to procedures, data or benchmark results listed in the repository. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document completion of the analysis. The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

In using procedures in the repository, analysts should review the results in conjunction with the Supervisory Plan and Insurer Profile Summary and the prior period analysis. Communication and/or coordination with other internal departments are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures in the repository.

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

The placement of the following data and procedures in the pricing and underwriting risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with pricing and underwriting risk.

ANALYSIS DOCUMENTATION: Results of pricing and underwriting risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to

explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.

Quantitative and Qualitative Data and Procedures – Property & Casualty

Underwriting Performance

PROCEDURE #1 assists analysts in determining the impacts of the various components of underwriting performance, including premium revenue, incurred losses, loss adjustment expenses and commissions expenses.

Key ratios included in assessing underwriting performance are the underwriting expense ratio, net loss ratio and the commissions to direct premium ratio. The procedure includes recommendations to look at Annual Financial Statement, Schedule P and trending on the Financial Profile Report. 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.

Premium Production, Concentration and Writings Leverage

PROCEDURE #2 assists analysts 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.

Analysts should consider reviewing premiums written by line of business to determine which lines increased or decreased significantly and whether any new lines of business are being written. Analysts should also consider verifying that the insurer is authorized to write all lines of business being written. If new lines of business are being written, or if premiums are being written in new states, analysts should consider determining whether the insurer has expertise in the new lines of business or new sales territories. This would include expertise in distribution, underwriting, claims, and reserving. There is no information in the Annual Financial Statement to assist analysts in making this determination. However, there may be helpful information in the insurer's Management's Discussion and Analysis (MD&A). Otherwise, information may be requested from the insurer.

Within several lines of business and policy types (most notably commercial property), property/casualty insurers may be exposed to losses resulting from acts of terrorism. Following the September 11, 2001, attacks on the New York World Trade Center and the U.S. Pentagon, terrorism coverage became prohibitively expensive, if offered at all. In response, the U.S. Congress passed the Terrorsim Risk Insurance Act (TRIA) of 2002. TRIA was initially created as a temporary three-year federal program that required insurers to offer commercial policyholders with terrorism coverage, while allowing the Federal Government to share monetary losses with insurers on commercial property/casualty losses from a terrorist attack. Since then, it has been renewed four times and is due to expire on December 31, 2027. Before this backstop can be accessed, several stipulations and limits are applied, many of which have been adjusted under subsequent extensions of the Act to limit the support available to insurers. Analysts should assess the insurer's exposure to losses related to acts of terrorism and consider any mitigation by

TRIA. Procedure #2 also assists analysts in determining whether the insurer is excessively leveraged due to the volume of premiums written. Surplus can be considered as underwriting capacity, and the ratios of gross and net writings leverage measure the extent to which that capacity is being utilized and the adequacy of the insurer's surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross writings leverage ratio result greater than 900% may indicate that the insurer is excessively leveraged, and special attention should be given to the adequacy of the insurer's reinsurance protection and the quality of the reinsurers. A net writings leverage ratio greater than 300% may also indicate that the insurer is excessively leveraged and lacks sufficient surplus to finance the business currently being written. In evaluating these ratios, analysts should also consider the nature of the insurer's business. For example, an insurer that has historically written primarily short-tail property lines of business might not be considered excessively leveraged even though it has higher ratio results, because the risk of significant underpricing or adverse underwriting results is less than that of an insurer that writes primarily volatile long-tail liability lines of business such as medical professional liability.

Analysts should consider reviewing the net premiums written by line to determine which lines of business are being written. An insurer that writes primarily short-tail property lines may be able to write at higher levels of premiums to surplus than an insurer that writes primarily long-tail liability lines, because the risk of underpricing and significant adverse underwriting results is less with the short-tail property lines of business. Analysts should also consider comparing the ratios of gross and net writings leverage to industry averages to help evaluate the insurer's leverage. If the insurer is a member of an affiliated group of insurers, analysts might want to compute the net and gross writings leverage ratios on a consolidated basis to help evaluate whether the affiliated group of insurers is excessively leveraged. If the net and gross writings leverage ratios results are high, analysts should consider determining whether the insurer has adequate reinsurance protection against large losses and catastrophes and that the reinsurers are of high quality.

Exposure to Catastrophic Events

PROCEDURE #3 assists analysts in identifying and assessing the insurer's current and prospective exposure to catastrophic events as well as the risk management practices of insurers writing a significant percentage of their business in products and geographic areas that are exposed to severe loss events. ~~These types of c~~Catastrophic ~~risk exposures~~events have ~~frequently been the cause or~~historically contribut~~ing factor in~~edto insurer insolvencies. Various steps included in this procedure assist in identifying the potential concentrations of exposure through a review of information provided in the annual statement as well as additional information provided within the RBC filing regarding modeled catastrophic risk exposures.

The Catastrophe Risk Charge in RBC (RCAT or PR027) is required to be completed by all insurers filing on the Property/Casualty blank unless they are exempted from filing due to limited exposure to property lines or coverage in catastrophe-prone areas. Insurers that are not exempted from this charge are required to provide modeled loss outputs from an approved catastrophe model for the worst year in 50, 100, 250, and 500, using the insurance company's own insured property exposure information as inputs to the model. Insurers are not required to utilize any prescribed set of modeling assumptions but are expected to use the same exposure data, modeling, and assumptions used in its own internal catastrophe risk management process.

If the analyst identifies potentially significant concentrations or exposures in writings or modeled losses, ~~the analyst should gain an understanding of the~~further investigation into the insurer's risk mitigation practices ~~in place to identify, monitor and mitigate significant exposures~~is crucial. An understanding could be gained through a review of existing information available to the analyst through company responses to the NAIC Climate Risk Disclosure Survey, RBC Interrogatory on the insurer's Catastrophe Risk Reinsurance Program RCAT (PR027), ORSA Summary Report filings, or public information sources such as SEC 10K or 10Q filings. If these existing information sources are not available or do not provide adequate details of exposures and risk management practices, the analyst is encouraged to reach out to the company to request and review additional information.

In reviewing the insurer's exposure to catastrophic losses, it is important to consider both the current and prospective nature of the exposures. Increases in weather-related catastrophic losses may result from noticeable changes in climate that have been recorded over an extended period, including rising sea levels, changes in temperatures, precipitation, and/or wind patterns. The concern is that climate change or change in weather patterns may increase the severity and frequency of future weather events including, but not limited to: thunderstorms, including severe hail and strong winds; tornadoes; hurricanes; windstorms; floods; heat waves; drought; and wildfires. If the insurer is exposed to significant catastrophic losses that could be the result of climate change, the analyst should ~~take steps to gain an understanding of and~~ evaluate the potential impact on the company's business and underwriting strategy over medium and longer-term time horizons.

Quantitative and Qualitative Data and Procedures – Life, Accident & Health (A&H), Fraternal

Underwriting Performance

PROCEDURE #1 assists analysts in determining the impacts of the various components of underwriting performance, including net gain from operations before realized capital gains to total revenue, operating loss trends, loss ratio and commissions expenses.

PROCEDURE #2 assists analysts 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, analysts should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated when the contract was made. If the insurer is reporting unusual results, analysts should consider if any delays in payments from the federal Centers for Medicare & Medicaid Services (CMS) are affecting results.

Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for a period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If policyholders utilize more benefits than were projected in the contract, the insurer may experience losses because the income from CMS is set for a full year. Analysts should consider obtaining and reviewing information on the contracted benefits, premium, and cost-sharing with CMS. Analysts should also evaluate a comparison of premiums, reserves, expected utilization, and benefit costs to actual experience on each plan.

PROCEDURE #3 assists analysts in evaluating the underwriting performance of the individual A&H lines of business through a review of the Annual Financial Statement, A&H Policy Experience Exhibit, including a review of the loss ratio by line and consideration of multiyear trend analysis by line.

PROCEDURE #4 assists analysts in evaluating the underwriting performance of long-term care insurance (LTC) line of business through a review of the Annual Financial Statement, Long-Term Care Experience Reporting Forms, the Actuarial Guideline-51 reporting, actuarial memorandum or any other related actuarial information filed to the department including trends in premiums, claims and loss ratios. Analysts should consider requesting the assistance of the department actuary to review trends in reserving that may affect underwriting results. (See additional guidance in the Reserving Risk Repository Analyst Reference Guide of this Handbook).

Premium Production, Concentration and Writings Leverage

PROCEDURE #5 assists analysts 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.

Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums may be an indication of an insurer's entrance into new lines of business or sales territories which might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses, particularly if the insurer primarily writes A&H insurance.

Analysts may also perform qualitative procedures if concerns exist regarding changes in the volume of premiums and deposit-type funds or changes in the insurer's mix of business (lines of business written and/or geographic location of the premiums written) include reviewing the insurer's mix of business to determine: 1) which lines of business are being written; 2) which lines of business have increased or decreased significantly; and 3) whether any new lines of business are being written. Analysts should also consider verifying that the insurer is authorized to write all lines of business being written. If new lines of business are being written or if premiums are being written in new states, analysts should consider determining whether the insurer has expertise in the new lines of business or new sales territories. This would include expertise in distribution, underwriting, claims, and reserving. There is no information in the Annual Financial Statement to assist analysts in making this determination. However, there may be helpful information in the insurer's Management's Discussion and Analysis. Otherwise, information may be requested from the insurer. Analysts should also consider determining if, as a result of changes in the mix of business, the insurer's business is concentrated in specific geographic areas that could result in the insurer being potentially exposed to catastrophic losses.

PROCEDURE #6 assists analysts in determining whether the insurer is excessively leveraged due to its volume of business written.

A&H: Capital and surplus can be considered as underwriting capacity, and the ratios of gross (direct plus assumed reinsurance) A&H premiums to capital and surplus and net (gross less reinsurance ceded) A&H premiums to capital and surplus measure the extent to which that capacity is being utilized and the adequacy of the insurer's capital and surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross A&H premium to capital and surplus ratio greater than 500% may indicate that the insurer is excessively leveraged, and special attention should be given to the adequacy of the insurer's reinsurance protection and the quality of the reinsurers. A net A&H premium to capital and surplus ratio greater than 300% may also indicate that the insurer is excessively leveraged and lacks sufficient capital and surplus to finance the A&H business currently being written. In evaluating these leverage ratios, analysts should also consider the nature of the insurer's business. For example, an insurer that has written primarily A&H business for many years and has proven that it can manage the business profitably is probably not as risky as an insurer which has just begun writing A&H business, even if both insurers have the same leverage ratio results.

Analysts may also consider performing qualitative procedures if there are concerns regarding whether the insurer may be excessively leveraged due to its volume of A&H business including comparing the ratios of gross A&H premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to help evaluate the insurer's leverage. Analysts might also want to review Annual Financial Statement, Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written, determine whether the A&H lines of business have historically been profitable for the insurer, and determine whether A&H loss reserve adequacy has been maintained. As noted previously, an insurer that has historically written primarily A&H business might not be considered excessively leveraged, even though it has higher leverage ratio results, because the risk of significant underpricing or adverse underwriting results is less than for an insurer that has just begun writing A&H business.

HEALTH: 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, analysts should still assess the level of business written by the health entity by comparing premium and risk revenue to capital and surplus. This comparison should include premium and risk revenue recorded by the health entity in its income statement since both sources of revenue represent exposure to the health entity. This type of comparison is generally considered a measure of a health entity's operating leverage and is important in determining the potential losses to the health entity. The higher the writings ratio, the more likely the health entity will record a material loss when morbidity spikes. For example, if a health entity is writing at a 5 to 1 ratio and reports a combined ratio of 105% (assuming no investment income and no federal income taxes) the health entity would report a 25% decrease in capital and surplus based upon the net loss alone. Therefore, for every $5 in writings at a loss of 5%, surplus would be impacted 5 times greater and incur a 25% loss. If a health entity is writing at a 10 to 1 ratio and reports a combined ratio of 105% (assuming no investment income and no federal income taxes) the health entity would report a 50% decrease in capital and surplus. Therefore, for every $10 in writings at a loss of 5%, surplus would be impacted 10 times greater and incur a 50% loss.

Financial Impact of the Federal Affordable Care Act

PROCEDURE #7A–F assists analysts 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. Note that the preliminary medical loss ratio (MLR) included in this supplemental health care exhibit (for any given state) is not the MLR that is used in calculating the federal mandated rebates.

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

Despite the differences, the validity and reasonableness of the ACA MLR calculation, and therefore of the rebate calculation can be assessed using the data from the Annual Financial Statement, Supplemental Health Care Exhibit (SHCE). The following elements from the SHCE and the rebate calculation can be used for such an assessment.

For the following items, there should be little or no difference between the amounts in the SHCE and the rebate calculation:

- Earned premium.
- Federal and state taxes and licensing or regulatory fees.
- Expenses to improve health care quality.

For other items, there are expected to be differences between the SHCE and the rebate calculation due to the difference in the time of reporting between the two:

- Paid claims, unpaid claim reserve, and incurred claims.
- Experience rating refunds and reserves for experience rating refunds.
- Change in contract reserves.
- Incurred medical pool incentives and bonuses.
- Net healthcare receivables.

For the Contingent Benefit Reserve, the expected relationship between the SHCE and the rebate calculation is unknown as yet.

PROCEDURE #7G assists analysts in identifying any risks or concerns with recent rate reviews. The rate review process may be performed by the U.S. Department of Health and Human Services (HHS) or by the state department of insurance (DOI), depending on the states' authority. Analysts should review any recent rate reviews performed (or if a different department, communicate with the rate review staff) and assess if any concerns exist. An analyst should also consider how the increase in the per member per month (PMPM) premiums compares with approved rate increases. Consider that there may have been different rate increases for different plans. Also consider the overall increase in premium PMPM for reasonableness compared to the approved rate increase.

In 2010, the NAIC adopted a form used to meet the requirements of Section 2794 of the federal Patient Protection and Affordable Care Act (PPACA) that specifies insurers must provide justifications for any rate filing request that meets an "unreasonable" threshold. The form is not an endorsement of any definition of "unreasonable" that HHS may develop. The form does not apply to large group business.

Analysts should have a general understanding of the states' rate regulation laws and practices. Currently, states have a number of ways to regulate rates. In the individual market, the majority of states rely on actuarially justified ratings, while some states rely on community ratings, adjusted community ratings and rating bands. In the small group market, rating bands are more prevalent, while a small number of states utilize community ratings and adjusted community ratings. Rating bands limit the variation in premiums attributable to health status and other characteristics. Community ratings prohibit the use of any case characteristics besides geography to vary premium. Adjusted community ratings prohibit the use of health status or claims experience in setting premiums. Actuarial justification requires the insurer to demonstrate a correlation between the case characteristics and the increased medical claims costs. The NAIC has adopted safe harbors for case characteristics commonly used for setting premiums without providing justification. For further guidance, refer to the applicable state law or regulation.

Quantitative and Qualitative Data and Procedures – Health

Underwriting Performance

PROCEDURE #1 assists analysts in determining whether concerns exist regarding the pricing of the health entity's products. To the extent the health entity's premium PMPM has not increased by an amount that approximates the expected increase in health care costs PMPM, this may be an indication that the health entity's premium rates may not be able to keep pace with the health entity's medical inflation. Although this ratio is a measure of what has occurred since the prior year, it can be used as a gauge in evaluating whether a health entity may be exposed. The ratio is also limited since it can't be applied at the product level using Annual Financial Statement information. However, the purpose of the ratio is to provide analysts some sense of how the entity's premium rate changes compare with medical inflation in general. Analysts should also use the ratio of change in claims PMPM to change in premium PMPM. A result greater than zero indicates that claims increased from the prior year at a faster rate than premiums have increased from the prior year. A result less than zero would indicate that premiums have increased from the prior year at a faster rate than claims have increased from the prior year. The use of PMPM allows the ratio to be broken down to a more meaningful comparison. One other item that analysts should consider is the health entity's use of multiple year provider contracts. Multiple-year provider contracts allow a health entity and a provider to lock in agreed upon rates for an extended period of time. Although not necessarily an indication of underpricing, clearly it is much more difficult to predict the cost of health care three years out than it is one year out. As a result, multiple year contracts by their nature lend themselves to greater pricing risk. Analysts should be aware of the use of these contracts and the extent to which they are used.

If there are concerns, analysts may also consider procedures to assess if one or more of the health entity's products may be underpriced. Although it may be difficult to determine if any specific products are underpriced, one procedure analysts may want to consider is the level of losses on the individual statutory lines of business. To the extent the health entity had a combined ratio of greater than 105% on any line of business; it may be an indication that the product is underpriced. To the extent a health entity has underpriced a product; the financial impact could be significant depending upon the health entity's leverage and the type of product. Analysts should also consider the need to determine if the health entity has established a premium deficiency reserve on a line of business. As discussed in the Health Reserves and Liabilities section, this reserve is established when future premiums and current reserves are not sufficient to pay future claims and expenses. This type of reserve is established because it meets the definition of a loss contingency and should therefore be considered in evaluating the current financial position of the health entity. Analysts should use the information, along with any information from the health entity, to better assess the current financial position of the health entity. Other information could include a monthly assessment from the health entity on the adequacy of the current deficiency reserve based upon updated information. Since the reserve is essentially an estimate of the expected 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 #2 assists analysts 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, analysts should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated in the contract. If the insurer is reporting unusual results, analysts should consider if any delays in payments from the CMS are affecting results.

Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for a period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If the policyholder's use more benefits than were projected in the contract, the insurer may experience losses since the income from CMS is set for a full year. Analysts should consider obtaining and reviewing information on the contracted benefits, premium and cost sharing with CMS. Analysts should also evaluate a comparison of premiums, reserves, expected utilization and benefit costs to actual experience on each plan.

PROCEDURE #3 assists analysts in evaluating the underwriting performance of the individual A&H lines of business through a review of the Annual Financial Statement, A&H Policy Experience Exhibit, including a review of the loss ratio by line and consideration of multiyear trend analysis by line.

PROCEDURE #4 assists analysts in evaluating the underwriting performance of the LTC line of business through a review of the Annual Financial Statement, Long-Term Care Experience Reporting Forms, the Actuarial Guideline-51 reporting, actuarial memorandum or any other related actuarial information filed to the department including trends in premiums, claims and loss ratios. Analysts should consider requesting the assistance of the department actuary to review trends in reserving that may affect underwriting results. (See additional guidance in the Reserving Risk Repository Analyst Reference Guide of this Handbook)

Premium Production, Concentration and Writings Leverage

PROCEDURE #5 assists analysts 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.

If there are concerns analysts may also consider procedures to assess the financial impact of fluctuations in premiums or changes in business mix (line of business written and/or geographic location of premiums written) may have on the insurer's financial position. Analysts should consider comparing any significant changes in premiums to the health entity's most recent projections and business plan. Variances could suggest that consumers have responded to the health entity differently than anticipated. As previously discussed, growth can have a material impact on the operations of a health entity, and analysts should gain more information from the health entity when this has occurred, including how current and future growth is expected to be supported. However, decreases in premium can also place some pressure on the health entity through forced expense reductions. Analysts should attempt to understand how decreases in premiums are expected to impact this issue. If new lines of business are being written or if premiums are being written in new regions, analysts should review the health entity's MD&A for related information. Otherwise, information may be requested from the health entity showing operating results vs. projections for the new lines of business or territories and describing any changes in implementation strategy or revisions in financial projections for future periods. Analysts should also consider determining if, as a result of increases in sales regions, how the health entity prices its products, the contracts used with providers and any future expected changes in the health entity's business. The business of health insurance is very localized and the health entity must have a reasonable understanding of that market to be successful.

PROCEDURE #6 assists analysts 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-health maintenance organizations (HMOs)) may indicate that the health entity is excessively leveraged. Special attention should be given to the type of coverage provided and the extent to which the health entity is able to transfer some of the risk from the business to another entity. Two health entities both with a 10 to 1 ratio may have different leverage depending on the type of coverage that they write. For example, to the extent the health entity has written primarily comprehensive business for many years in the same region, and is able to capitate some of its business, it may not be as risky as a health entity which has just begun writing Medicare business in a new region and is unable to transfer any of its risk. Even if both of these health entities have the same leverage ratio results, the one starting Medicare Risk coverage will have a riskier financial position. Analysts should also specifically consider if a significant portion of the premium is written on longer tail lines. On these lines, the ultimate experience may not be known for some time, thereby increasing the risk of reserve understatement. Analysts

should also determine whether there has been an increase in the writing's ratio or an increase in the amount of long-tail business that is being written, to assist in identifying future trends.

If there are concerns analysts may also consider procedures to assess whether the health entity may be excessively leveraged due to its volume of business. Generally, the threshold for health business on leverage ratios is set at a much higher level than for property/casualty business. This is because property/casualty business tends to carry more catastrophic risk (risk of large loss) than health business, due in part to the long-tailed nature of property/casualty major lines of business. The threshold for HMOs tends to be set at a higher level than other health entities. This is because to some extent, HMOs are able to transfer some of their risk to other entities, thereby reducing their overall risk in comparison to their premium volume. Because of the above, a 10 to 1 threshold is generally used for HMOs (8 to 1 for most other health entities). However, analysts should consider the type of business written by the health entity and the health entity's use of risk transfer in considering the extent to which a health entity may be leveraged. These procedures assist by directing analysts to consider how these items may impact the health entity's overall leverage. Once analysts have a better understanding of these issues for a health entity, analysts may want to consider requesting additional information from the health entity on how it intends to address this issue.

Financial Impact of the Federal Affordable Care Act

PROCEDURE #7A-F assists analysts 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.

Note that the preliminary MLR included in this supplemental health care exhibit (for any given state) is not the MLR that is used in calculating the federal mandated rebates.

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

Despite the differences, the validity and reasonableness of the ACA MLR calculation, and therefore of the rebate calculation can be assessed using the data from the Annual Financial Statement, Supplemental Health Care Exhibit (SHCE). The following elements from the SHCE and the rebate calculation can be used for such an assessment.

For the following items there should be little or no difference between the amounts in the SHCE and the rebate calculation:

- Earned premium.
- Federal and state taxes and licensing or regulatory fees.
- Expenses to improve health care quality.

For other items, there are expected to be differences between the SHCE and the rebate calculation due to the difference in the time of reporting between the two:

- Paid claims, unpaid claim reserve, and incurred claims.
- Experience rating refunds and reserves for experience rating refunds.

- Change in contract reserves.
- Incurred medical pool incentives and bonuses.
- Net healthcare receivables.

For the Contingent Benefit Reserve, the expected relationship between the SHCE and the rebate calculation is unknown as yet.

PROCEDURE #7G assists analysts in identifying any risks or concerns with recent rate reviews. As stated above, the rate review process may be performed by the U.S. Department of Health and Human Services (HHS) or by the state department of insurance (DOI), depending on the states' authority. Analysts should review any recent rate reviews performed (or if a different department, communicate with the rate review staff) and assess if any concerns exist. An analyst should also consider how the increase in the PMPM premiums compares with approved rate increases. Consider that there may have been different rate increases for different plans. Also consider the overall increase in premium PMPM for reasonableness compared to the approved rate increase.

In 2010, the NAIC adopted a form used to meet the requirements of Section 2794 of the federal Patient Protection and Affordable Care Act (PPACA) that specifies 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.

Analysts should have a general understanding of the states' rate regulation laws and practices. Currently, states have a number of ways to regulate rates. In the individual market, the majority of states rely on actuarially justified ratings, while some states rely on community ratings, adjusted community ratings and rating bands. In the small group market, rating bands are more prevalent, while a small number of states utilize community ratings and adjusted community ratings. Rating bands limit the variation in premiums attributable to health status and other characteristics. Community ratings prohibit the use of any case characteristics besides geography to vary premium. Adjusted community ratings prohibit the use of health status or claims experience in setting premiums. Actuarial justification requires the 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.

Additional Analysis and Follow-Up Procedures

EXAMINATION FINDINGS direct the analsyt to consider a review of the recent examination report, summary review memorandum and communication with the examination staff to identify if any pricing and underwriting risk issues were discovered during the examination.

INQUIRE OF THE INSURER directs analysts to consider requesting additional information from the insurer if pricing and underwriting risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of pricing and underwriting risk for specific topics where concerns have been identified.

OWN RISK AND SOLVENCY ASSESSMENT **(ORSA)** directs analysts to obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing risks faced by the insurer.

HOLDING COMPANY ANALYSIS directs analysts to obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

Example Prospective Risk Considerations

The table provides analysts with example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general discription of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the pricing and underwriting risk category.

Discussion of Quarterly Procedures

The Quarterly Pricing and Underwriting Risk Repository procedures are designed to identify the following:

1) Concerns with the insurer’s underwriting performance
2) Concerns with the changes in volume of premiums written, changes in the insurer’s mix of business and changes in writing leverage
3) Determine whether the insurer is excessively leveraged due to the volume of premiums written
4) Concerns with the pricing of the insurer's products
5) Concerns with the impact of the federal Affordable Care Act (ACA) (Life/A&H, and Health)

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

~~Credit Risk Assessment~~

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

The ~~objective of~~ Credit Risk Assessment ~~analysis~~ is focused primarily on exposure to credit risk of investments and reinsurance receivables. ~~The following discussion of procedures provides suggested data, benchmarks and procedures analysts can consider in their review.~~ In analyzing credit risk, analysts may analyze specific types of investments and receivables held by insurers. Analysts' risk-focused assessment of credit risk should take into consideration the following areas (but not be limited to):

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

~~Overview of Investments~~Derivatives:
Refer to IV.A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations for general information and a primer on derivatives.

~~Discussion of Annual Procedures~~GENERAL GUIDANCE

~~Using the Repository~~

To assess ~~The~~ credit risk, ~~repository is a~~ consider the ~~list of possible quantitative and qualitative~~ procedures, including specific data elements, metrics and benchmarks in this chapter. ~~and procedures from which analysts may select to use in their review of credit risk.~~ The following is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

The placement of procedures, metrics and data within credit risk is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting financial determinations of the analysis. For example, key insurance operations or lines of business may have related risks addressed in different risk categories. Therefore, analysts may need to review other risks in conjunction with credit risk.

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

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

the risks and reflect the strengths and weaknesses of the insurer.

~~The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.~~
~~In using procedures in the repository, a~~Analysts should ~~review the results in~~complete their credit risk assessment in conjunction with:

- ~~-~~A review of the Supervisory Plan and Insurer Profile Summary and the prior period analysis~~-~~.
- C~~C~~ommunication and/or coordination with other internal departments. ~~are a critical step in the overall Risk Assessment process and are a crucial consideration in the review of certain procedures in the repository.~~
- ~~Analysts should also consider~~ T~~t~~he 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 placement of the following data and procedures in the credit risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with credit risk.~~
~~**Analysis Documentation:** Results of credit risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.~~

ANNUAL CREDIT RISK ASSESSMENT~~Quantitative and Qualitative Data and Procedures~~

~~example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general discription of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the credit risk category.~~

~~**Investment Portfolio Diversification**~~

~~*Property/Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*1*~~	~~*1*~~	~~*1*~~

Significant Investment Concentration by Asset Class

~~The procedure assists analysts in d~~Determine~~ing~~ whether the insurer's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by asset type, duration or issuer.

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

Procedures / Data

- Consider evaluating the following assets classes that may have credit default risk in comparison to total admitted assets to determine the level of concentration:
  - Industrial and miscellaneous bonds (unaffiliated)
  - Residential mortgaged-backed securities (RMBS), commercial mortgage-backed securities (CMBS) or other loan-backed and structured securities (LBaSS)

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

Additional ~~r~~Review ~~c~~Considerations

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

Default and Volatility of Bond Exposures

~~**Exposure to Non-Investment Grade Bonds**~~

~~***Property/Casualty #***~~	~~***Life/A&H/Fratrnal #***~~	~~***Health #***~~
~~2~~	~~2~~	~~2~~

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

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

Procedures / Data

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

Additional Review Considerations

~~Additional review considerations~~

- ~~Review Annual Financial Statement, Schedule D – Part 1A – Section 1 and compare the insurer's holdings of non-investment grade bonds to the limitations included in Model #340 by NAIC designation.~~
- If the level of non-investment grade bonds is material, review Annual Financial Statement, Schedule D Part 1A and Part 1, Jumpstart Reports (e.g., Bond Investment Designation Exception Report) and the Financial Profile Report and Dashboards to assess and understand the composition of non-investment grade bonds:
  - Amount and/or percentage of bonds in each class 3, 4, 5 or 6.
  - Fluctuations and shifts in concentrations by class; new purchases; downgrades or upgrades.
  - Concentration by sector or issuer, including affiliates.
  - Whether or not bonds have been rated by a credit rating provider (CRP) (e.g., Moody's Investors Service, Standard & Poor's, A.M. Best, or Fitch Ratings).
  - Issuers that the rating agencies have on negative watch.
- Inquire of the insurer:
  - Explanation of significant exposures.
  - Policies and strategy for investing in non-investment grade bonds. Determine if the insurer is adhering to those investment policies.
  - For the more significant non-investment grade bonds, consider requesting from the insurer audited financial statements and a rating agency report from a CRP for the issuer of the bonds to assess the issuer's current financial position and ability to repay its debt.

~~**Exposure to Mortgage - and/or Asset-Backed Securities**~~

~~*Property/Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*3*~~	~~*3*~~	~~*3*~~

Borrower Default for RMBS, CMBS and LBaSS Securities, Volatility of RMBS, CMBS, and LBaSS Securities, and Prepayment Variability for RMBS

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The procedure assists analysts in dDetermininge whether concerns exist over borrower default risk due to the level of investments in residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS) and loan-backed and structured securities (LBaSS) or prepayment variability risk in RMBS. Lower credit quality of the borrowers (i.e., prime versus subprime) may result in higher risk of default, leading to credit losses in the event of a housing and/or commercial real estate market downturn.

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

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

Procedures / Data

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

Additional Review Considerations

ADDITIONAL REVIEW CONSIDERATIONS

- Review the RMBS, CMBS and LBaSS securities categories in Annual Financial Statement, Schedule D – Part 1 for bonds with a book/adjusted carrying value (BACV) significantly in excess of par value,. whichThis could result in a loss being realized if bond prepayments occur faster than anticipated.
- Review the RMBS, CMBS and LBaSS categories in Annual Financial Statement, Schedule D – Part 1 for bonds with an unusually high effective yield.
- Analysts 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.
- Review Annual Financial Statement, Schedule D, Part 1, and the Snapshot Investment Summary Report on iSite+ to assess exposure to agency versus non-agency RMBS, CMBS and LBaSS.
- 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. Historically, the constant prepayment rate (CPR) and the standard prepayment model of the Bond Market

Association (PSA curve) are simple methods used to measure prepayments. Numerous other methods have evolved. Analysts should consider further analysis in those instances that prepayment risk appears high.

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

FOR LIFE INSURERS: For Life/A&H Insurers:

- Consider a review of the insurer's life risk-based capital (RBC) formula or its Statement of Actuarial Opinion. The life RBC formula includes a C-3 Interest Rate Risk Component that charges insurer's for securities that have not been cash flow tested. The insurer is charged 0.5 times the excess of the statement value over the value of the security if all of the collateral was immediately repaid.
- Alternatively, or in addition 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 by the insurer.

- The rationale behind requesting information on these types of investments outlined in the repository is to provide analysts with some insight regarding the level of prepayment risk the insurer holds in its RMBS portfolio and the measurement and monitoring tools the insurer uses to manage this risk. Parts f and gRBC C-3 Interest Rate Risk Component and the Actuarial Opinion cash flow testing ask the insurer to break down its RMBS portfolio by general definitional classes, each of which has its own relative level of prepayment and cash flow volatility risk. Individual insurers may use different measures and monitoring techniques. If an insurance company cannot supply this data with reasonable ease, analysts may want to look more closely at the management and monitoring systems in place for the RMBS portfolio.

Default, Volatility and Collateral Concentration of Structured Notes

Determine whether concerns exist due to the level of structured notes held by the insurer. If the amount is material compared to the the insurer's capital and surplus plus asset valuation reserve (AVR) (L/H), to policyholder surplus (P/C), or to capital and surplus (Health), 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.

Structured notes are issuer bonds where the cash flows are based on a referenced asset and not the issuer credit. These notes differ from structured securities in that they do not have a related trust. Structured notes that are classified as mortgage-referenced securities are valued in accordance with *Statement of Statutory Accounting Principles (SSAP) 43R—Loan-Backed and Structured Securities* while all other structured notes are valued in accordance with *SSAP 86—Derivatives*. Some examples of mortgage-referenced securities include, secutiries 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 FE, and the Structured Securities Group (SSG) assigns their NAIC designation based upon modeling assumptions.

Risks related to structured notes include:

- Structured notes collateral concentration risk
  - Material investment in structured notes that may have collateral type concentration may result in concentration risk (lack of diversity) to the insurer's portfolio.
- Structured notes default
  - Structured notes may be subordinated in the overall transaction representing exposure to non-payment in event of default.
- Structured notes cash flow volatility risk (Refer to Market Risk)
  - Impact of the volatility of structured notes and the underlying asset on which its cash flows are based.

Procedures / Data

- Ratio of investments in structured notes to capital and surplus plus AVR (L/H), to policyholder surplus (P/C), or to capital and surplus (Health).

Additional Review Considerations

- Review the Annual Financial Statement, Schedule D – Part 1, to identify and understand the types of structured notes.
- Refer to any recent examination findings.
- Inquire of the insurer on such items as the structured note's use and investment strategy, the insurer's level of expertise with this type of security and controls the insurer has implemented to mitigate this risk.

Default Risk of Foreign Securities

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

Procedures / Data

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

Additional Review Considerations

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

Exposure to Mortgage Loans

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
4	*4*	*4*

Default or Volatility of Mortgage Loans

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

Procedures / Data

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

Additional Review Considerations

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

Default of Second Lien Mortgage Loan

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

For mortgage loans with interest overdue or in process of foreclosure, analysts 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, analysts should utilize postal code and property type information along with the city and state location information in Schedules A and B to identify geographic concentrations and to identify differences in volatility based on the property type and geographic location.

Procedures / Data

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

Inadequate Collateral for Mortgage Loan Risk

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

Procedures / Data

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

Additional Review Considerations

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

ADDITIONAL REVIEW CONSIDERATIONS FOR LIFE INSURERS

- Review Annual Financial Statement, Schedule B – Part 1 to determine the amount of each type of mortgage loan owned. Commercial mortgages have historically been riskier investments than farm mortgages and residential mortgages.

  Compare the BACV of each loan to the value of the land and buildings mortgaged. Analysts 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. Important considerations in this analysis are the adjusted loan-to-value and debt service coverage ratio for each property, which are used in the determination of the mortgage's CM category and are detailed in the RBC worksheet.

  - **For mortgage loans with interest overdue or in process of foreclosure, analysts should consider reviewing the year of last appraisal of the underlying land and buildings to determine whether updated appraisals should be required.**

Exposure to Other Invested Assets (Schedule BA)

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
5	*5*	*5*

Default or Volatility of Other Invested Assets (Schedule BA)

The procedure assists analysts in dDetermininge 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. BA assets often have complex investment strategies and unpredictable cash flows. The volatility of underlying assets (e.g., certain hedge funds and private equity funds) may result in underlying assets not being adequate. Credit risks for Schedule BA assets include:

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

Procedures / Data

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

Additional Review Considerations*ADDITIONAL REVIEW CONSIDERATIONS*

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

- Review Annual Financial Statement, Schedule BA – Other Invested Assets Owned, to determine the amount and types of other invested assets owned and identify if the insurer's exposure to certain classes of BA assets are significant (e.g., hedge funds, private equity funds, etc.).

- Determine whether concerns exist regarding the insurer's exposure to non-traditional investments, (i.e., hedge funds and private equity funds) as compared to capital and surplus and impact on liquidity.
- Review the experience of the insurer with respect to investing in alternative investments such as hedge funds and private equity funds.
- Obtain and review cash flow projections to ensure that the insurer understands the cash flow characteristics of such investments.
- Perform procedures to test the accuracy of reporting for non-traditional investments.
- Ensure that senior management and the Board of the insurer have signed off on non-traditional investments.

- Review Schedule BA to determine if a significant amount of BA assets have NAIC ratings of 3, 4, 5 or 6 or have a "Z" designation.
- Inquire of the insurer:
  - Investment strategy regarding investment in Schedule BA assets.
  - Request information necessary to determine the fair value of collateral to the amount loaned to ensure the loan is adequately collateralized.
  - See Market Risk and Liquidity Risk for other related inquiries.

Exposure to Other Invested Assets (Schedule BA) – Value of Collateral Loans

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
N/A	*7*	*N/A*

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

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

Procedures / Data

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

Additional Review Considerations ***ADDITIONAL REVIEW CONSIDERATIONS***

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

Invested Asset Exposure to Climate Change Risk

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
6	*6*	*6*

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

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

Procedures / Data

~~In assessing an insurer's exposure to these risks, the analyst is encouraged to review information disclosed by the insurer in its responses to the NAIC's Climate Risk Disclosure Survey, U.S. Securities and Exchange Commission (SEC) filings, and/or the Own Risk and Solvency Assessment (ORSA) Summary Report filings. In addition, the analyst is encouraged to review the results of basic scenario analysis conducted by the NAIC using insurers' Annual Statement filings (U.S. Insurance Industry Climate Affected Investment Analysis) to identify potential concentrations in exposure.~~

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

Additional Review Considerations ~~***ADDITIONAL REVIEW CONSIDERATIONS***~~

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

~~**Reinsurance Recoverable and Reinsurer Credit Quality**~~

~~***Property/Casualty #***~~	~~***Life/A&H/Fraternal #***~~	~~***Health #***~~
~~***7, 8, 9, 10***~~	~~***8, 9, 10***~~	~~***6, 7***~~

Collectability of Reinsurance Recoverables and Reinsurer Credit Quality

~~The procedure assists analysts in d~~Determin~~ing~~e whether reinsurance recoverables and receivables are significant and if so, whether the amounts involved are collectable. Reinsurance payments may be delayed or not be paid when due, resulting in cash flow mismatch.

Under a reinsurance contract, the primary insurer transfers or ~~"~~cedes~~"~~ to another insurer (~~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~~ direct insurer to pay policyholder claims. Only after ~~loss~~ claims have been paid can the ~~primary company~~direct insurer seek reimbursement from a reinsurer for its share

of paid losses. As a result, evaluating the collectability of the recoverables and receivables, as well as the overall ~~credit-worthiness~~creditworthiness of the reinsurers~~,~~ is ~~a key concern~~important. 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:

- Professional Reinsurers – The main business of professional reinsurers is assuming ~~reinsurance~~ premiums 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, 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.
- Alien Insurers – Reinsurers domiciled in another country may pose a ~~significant~~ collectability concern, if the reinsurer is domiciled in a jurisdiction with a solvency framework that may not be as strong as the U.S.

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

A~~The~~ ceding insurer may not take credit for reinsurance recoverables in dispute with an affiliate~~e~~, which may result in ~~.~~a~~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.~~

Collectability of Reinsurance Recoverables For Life/A&H Insurers

Procedures / Data

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

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

Additional Review Considerations

- Review L/H Annual Financial Statement, Schedule S – Part 3 – Section 1 and Schedule S – Part 3 – Section 2 and determine if any unusual items were noted regarding the types of reinsurance or the concerns with specific reinsurers.
- If concerns exist, review the reinsurer's history of payments of recoverables and determine compliance with the NAIC *Life and Health Reinsurance Agreements Model Regulation* (#791) regarding quarterly settlements of payments due from reinsurers.

- Review the Annual Financial Statement, Notes to Financial Statements, Note #23 and determine if the insurer reported any items of concern regarding reinsurance balances.
- Determine if and assess any significant write-offs of reinsurance collectables that have occurred during the period.
- Verify by direct contact or confirmation that funds withheld for payment are valid and adequately segregated for payment of losses.
- Inquire of the Insurer the aging of reinsurance amounts payable (e.g., concerns with reinsurance related transactions that may require inquiry to the insurer)/receivable.

~~FOR PROPERTY/CASUALTY (P/C) INSURERS:~~**Collectability of Reinsurance Recoverables For P/C Insurers**

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

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

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

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

Additional Review Considerations

- Review, by individual reinsurer, the amounts shown as collateral. Identify any unusual trends and determine the need to examine the underlying collateral in more detail to ensure its validity.
- Credit quality and poor financial strength of a reinsurer may result in future collectability risk, which may result in ongoing credit risk and future liquidity issues.
- If the insurer holds a material letter of credit (LOC) securing unauthorized and/or certified reinsurance recoverables, identify the amount of the LOC and the issuing bank. Identify any concerns and assess whether the collateral is at an adequate level.
- Review the Annual Financial Statement, Notes to Financial Statements, Note #23 and determine if there any relevant concerns regarding reinsurance balances.
- Review the reinsurer's history of recoverables and note on findings or concerns.

- Verify by direct contact or confirmation that funds withheld for payment are valid and adequately segregated for payment of losses.
- Inquire of the Insurer the aging of reinsurance amounts payables(e.g., concerns with reinsurance related transactions that may require inquiry to the insurer)/receivable.

Collectability of Reinsurance Recoverables For Health Insurers

Procedures / Data

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

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

Additional Review Considerations

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

Collectability of Reinsurance Recoverables due to Credit Quality of Retrocessionaires

Additional Review Considerations

- Determine whether retrocession may be occurring that could cause significant collectability risk to the insurer if the retrocessionaire is of poor credit quality and unable to pay its obligations to the reinsurer.
    - For the five largest individual unauthorized reinsurers and the five largest individual certified reinsurers listed in the Annual Financial Statement, [P/C Schedule F – Part 3; L/H and Health Schedule S–Part 3] consider the need to obtain the reinsurer's Annual Financial Statement and determine the extent to which the reinsurer has engaged in retrocession agreements.
    - Determine if any unauthorized and/or certified reinsurers have ceded reserves greater than 50% of total gross reserves.
        - If so, consider reviewing the Annual Financial Statement of the more significant reinsurers or inquiring of the insurer, to evaluate the extent to which the reinsurers cede business to other reinsurers.
        - If significant collectability concerns surface as a result of these procedures, perform the appropriate procedures to evaluate collectability.
    - Consider discussing with the insurer and/or the reinsurer or retrocessionaire's domiciliary regulator any identified risks or concerns with credit quality of the reinsurer or retrocessionaire.

Credit Quality and Default of Reinsurer

Additional Review Considerations

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

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

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

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

Procedures / Data

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

Additional Review Considerations

- Review Annual Financial Statement, Schedule S – Part 4. Determine if there are any concerns about the appropriateness of reinsurance credits taken.

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

Affiliated Receivable or Payable

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
10	*11*	*11*

Collectabilty of LOCs and Credit Quality of Issuing/Confirming Banks

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

Additional Review Considerations

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

Collectability of Affiliated Receivable or Payable

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

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

Procedures / Data

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

Additional Review Considerations

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

Other Receivables

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
11, 12	*N/A*	*8, 9, 10*

The procedures assist analysts in reviewing receivable assets of an insurer that may have limited collectability.

Collectabilty/Default of Investments Involving Related Parties

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

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

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

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

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

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

5. The investment is identified as a related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.
6. The investment does not involve a related party.

Procedures / Data

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

  Consider exposure by asset class and in aggregate, and by the role of the related party in the investment as designed by the "Investments Involving Related Parties" disclosure.
- If concerns exist regarding a material related party exposure in the investment portfolio, assess the credit quality of those investments and assess any historical default experience.

Additional Review Considerations

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

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

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

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

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

Although agents are used by health entities, they are generally used more extensively with P/C insurers or even life insurers. Agents' balances are admitted to the extent that the assets conform to the requirements of *SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts due from Agents and Brokers*, which also requires that premiums owed by agents should be reported net of commissions and are non-admitted under a 90-day rule. Remaining amounts that are determined to be uncollectable must be written off. Generally, if a contract with an agent permits offsetting, amounts payable to an agent may be offset against a receivable from that agent. Agents' balances carry credit risk and can have a material impact on the net income and capital and surplus of an insurer if the balances are significant. Significant or growing balances can also lead to liquidity problems if the insurer is unable to convert the receivables into cash to be used to pay claims.

Irrespective of the type of business written, inadequate systems and controls over the collection process can lead to uncollectable premiums. Uncollected premium balances on non-government business that 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 an insurer at a given point in time.

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

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

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

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

For Health InsurersFOR HEALTH INSURERS:
The collectability of amounts reported for uncollected premiums may also be impacted as a result of retroactive additions and deletions that are made subsequent to the date the group was invoiced. There may be a delay (sometimes several months) between the time that a large group adds a new covered employee or deletes an employee that is no longer covered and notice of the change is sent to the health entity. This length of the delay increases since the invoicing of the monthly premium is frequently in advance of the effective date of the coverage. This delay can result in the health entity reporting part of a monthlythe 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 premiumpremiums may also result from amounts due from the Centers for Medicare and Medicaid Services or other government plans. Although coverage periods onfor 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.

Procedures / Data (P/C Insurers)
Review and assess uncollected premiums and agents' balances for potential collectability issues. Consider the following ratios.

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

Procedures / Data (Health Insurers)
Review and assess uncollected premiums and agents' balances for potential collectability issues. Consider the following ratios.

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

Additional Review Considerations (P/C and Health Insurers)

- Review amounts non-admitted and compare to prior years.
- With respect to agents' balances, verify the creditworthiness of the agent.
- Inquire of the insurer:
  - Explanation for the significant balance.
  - Listing of balances of subscribers, which individually account for 10% or more of the premiums uncollected and compare to a similar list from prior years.
  - Amounts of any uncollectable balances that have been written off in the current period. Compare the write-offs to those of the prior reporting period, if any.
  - Written procedures for monitoring and collecting uncollected premiums, including amounts already written off.
  - If the insurer has factored or sold its uncollected premium balances to a third party, note whether the receivables were discounted in the transaction.
  - Concerns over uncollected agents' balances warrant further investigation to ensure that adequate controls are in place and that trust accounts are properly managed. An increase or trend of material non-admitted agents' balances or write-offs may be a sign of mismanagement or misappropriation of premium trust accounts by the agency. If there are concerns in this area, consider the following:
    - Request additional data/information from the insurer to identify the source(s) of the balances and the reason(s) for the non-admitted or charged-off amounts.

        - Request the insurer to provide a summary of the controls in place over agencies and ensure proper management and oversight of trust accounts.
        - Request monthly reports from the insurer.
    - Discuss concerns with the exam team, including whether a targeted exam is necessary.

Collectability of Uninsured Plan Receivables ~~(~~for Health Insurers~~)~~

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

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

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

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

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

Procedures / Data

- Compare the ratio of ASO/ASC claim payments to total hospital and medical expenses plus ASO/ASC claim payments [Annual Financial Statement, Notes to Financial Statements, Note #18, Part A and Part B].
- Compare the ratio of reimbursements from uninsured plans to total expenses plus reimbursements from uninsured plans [Annual Financial Statement, Underwriting and Investment Exhibit – Part 3].
- Ratio of receivables relating to uninsured plans to capital and surplus.
- Change in uninsured receivable relating to uninsured accident and health plans.
- Non-admitted uninsured receivables relating to uninsured accident and health plans.

Additional Review Considerations

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

Collectability of Health Care Receivables (for Health Insurers)

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

Procedures / Data

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

Additional Review Considerations

- Review amounts non-admitted and compare to prior years.
- Review capitation and other agreements with providers and hospitals and the level of receivables from these parties.
- Inquire of the insurer:
    - Explanation for the significant balance.

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

Collectability Risk of Exposure toRecoverables for High-Deductible Policies (for P/C Insurers)

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

The procedures assist analysts in gaining some basic understanding of the materiality of any reserve credit that has been recorded and is recoverable, as well as the materiality, aging and collateral held on any deductible recoverables and unpaid balances.

Additional Review Considerations

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

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

Investments Involving Related Parties

Property/Casualty #	***Life/A&H/Fraternal #***	***Health #***
13	***12***	***12***

This procedure assists analysts in determining related party exposure in the investment portfolio and assessing any related credit risk.

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

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

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

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

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

ADDITIONAL ANALYSIS AND FOLLOW-UP PROCEDURES APPLICABLE TO CREDIT RISK

INVESTMENT STRATEGY Investment Strategy

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

Two possible credit risks associated with Investment Stategy include:

- Investment strategy contemplates higher credit risk.
    - The insurer's investment strategy may not be structured to support its ongoing business plan, which could indicate the strategy enjoys higher credit, market and liquidity risks than are appropriate for the liabilities of the insurer and may lead to financial concerns in the future.
- Variance in actual to projected investment results.

- The insurer's actual investment portfolio and/or portfolio performance may vary significantly from projections if the insurer is not adhering to the strategy in place (i.e., higher actual credit compared to the plan).

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

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

Examination Findings

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

Identify any examination findings regarding credit risks associated with:

- Investment concentration.
- Exposure to riskier asset classes.
- Climate change, transition, and asset devaluation.
- Asset liability management.
- Adherence to investment policies and strategies.
- Investment management and use of and monitoring of external investment managers.
- Proper classification (i.e., authorized, unauthorized, certified) and calculation of reinsurance collateral and provision.

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

NAIC Capital Markets Bureau Analytical Assistance

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

Consider requesting the following analytical reviews:

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

Third-Party INVESTMENTInvestment Advisors

assist analysts in dDetermineing whether concerns exist regarding the use of third-party investment advisers. As investments and investment strategies grow in complexity, insurers may consider the use of unaffiliated third-party investment advisers to manage their investment strategy. Investment advisers may operate independently or as part of an investment company. Investment advisers and companies are subject to regulation by the U.S. Securities and Exchange Commission (SEC) and/or by the states in which they operate, generally based on the size

of their business. In certain situations, insurers may use a broker-dealer for investment advice. Broker-dealers are subject to regulation by the Financial Industry Regulatory Authority (FINRA). Regardless, most broker dealers and investment advisers will register with the SEC and annually update a Form ADV–Uniform Application for Investment Adviser Registration and Report Form by Exempt Reporting Advisers, which provides extensive information about the nature of the organization's operations. To locate these forms, analysts can go to *https://adviserinfo.sec.gov* and perform a search based on the company name.

Key information provided on a Form ADV includes:

a. Regulatory agencies and states in which the adviser/broker is registered.
b. Information about the advisory business including size of operations and types of customers (Item 5).
c. Information about whether the company provides custodial services (Item 9).
d. Information about disciplinary action and/or criminal records (Item 11).
e. A report of the independent public accountant verifying compliance if the investment advisor also acts as a custodian.

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

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

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

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

If the insurer uses an external asset manager and if investments on Schedule BA assets are invested in funds that are affiliated with the asset manager or are managed by that asset manager, analysts should consider several possible issues that may result from this scenario. A possible concern may exist when the asset manager is also managing other funds in addition to managing assets for the insurer and then invests the insurer's assets in those

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

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

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

If "yes," consider the following procedures:

- Verify that all affiliated and unaffiliated investment advisors the analyst is aware of are disclosed in the interrogatory, whether primary or sub-advisors.
  - Verify that Investment Management Agreements required to be filed with the department have been filed and consider requesting copies of agreements that have not been filed with the department for review.
  - Gain an understanding of the types of investments that are being managed by each of the advisors/sub-advisors disclosed in the interrogatory.
- Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners and determine if the examination identified any issues with regard to investment advisers and associated contractual arrangements that require follow-up analysis or communication with the insurer. If "yes," document the follow-up work performed.
- Compare Annual Financial Statement, General Interrogatories, Part 1, #29.05 for the current year to the prior year to determine if there have been any changes in advisors.
  - If there has been changes in advisors, consider obtaining an explanation for the change from the insurer.
  - If there has been changes in advisors, consider obtaining a copy of the new investment advisor agreement and review it for appropriate provisions.
- Using the information reported in Annual Financial Statement, General Interrogatories, Part 1, #29.05, obtain and review SEC Form ADV (if available), to determine if the investment advisor is in good standing with the SEC. If not in good standing, contact the insurer to request an explanation.
- Determine if agreements with third party investment advisers are affiliated, have the appropriate Form D – Prior Notice of Transactions been filed and approved by the department. And note any concerns or follow-up recommended.
  - See additional guidance in V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for reviewing affiliated investment manager agreements.
- Request information from the insurer regarding the background and expertise in any complex or non-traditional assets (such as structured securities, mortgage loans, investment funds) of its investment advisors (in-house and/or contractual) and its analytical system capabilities. Determine whether the advisors and systems are adequate to allow the insurer to continuously monitor its investments.
- If the insurer uses an external asset manager, consider if there are any investments that may represent a potential conflict. Examples of this are: (1) if there are investments reported on Schedule BA that are funds that are affiliated/related with the asset manager or are managed by that asset manager, (2) structured securities in which the asset manager or an affiliate/related party had a role in originating, or (3) direct

investments in the asset manager or any of its affiliates/related parties. If the external asset manager qualifies as a related party, utilize guidance provided in the "Related Party Exposure in the Investment Portfolio" section above to assist in this review. Consider the following issues:
- If any potential conflicts of interest have been reviewed and formally approved by the Board or Investment Committee..
- If the investment is appropriate for the insurer's portfolio and is arm's-length.
- If the insurer is paying overlapping fees.

Inquire of the Insurer

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

If concerns exist, consider requesting information from the insurer regarding:
- If management has adequately reviewed the investment portfolio and understands the yields, underlying collateral, cash flows and investment volatility.
- Any additional concentration by collateral type.
- Management's process for valuing securities so as to assist the analyst in assessing if the securities are valued appropriately.
- Management's intended use of certain riskier investments and purpose within the insurer's portfolio.
- Credit risk associated with sector concentration.
- If management has an appropriate level of knowledge and expertise with the type of securities being purchased/held.
- If the insurer has controls implemented to mitigate the risks associated with this investment type.
- Sources of liquidity, such as LOCs.

OWN RISK AND SOLVENCY ASSESSMENT (ORSA) Own Risk and Solvency Assessment (ORSA)

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

If the insurer is required to file ORSA or part of a group that is required to file ORSA,
- Determine whether the ORSA Summary Report analysis conducted by the lead state indicates any credit risks that require further monitoring or follow-up.
- Determine whether the ORSA Summary Report Analysis conducted by the lead state indicates any mitigating strategies for existing or prospective credit risks.

HOLDING COMPANY ANALYSIS Holding Company Analysis

directs analysts to oObtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.
- Determine whether the Holding Company Analysis conducted by the lead state indicates any credit risks affecting the insurer that require further monitoring or follow-up.
- Determine whether the Holding Company Analysis conducted by the lead state indicates any mitigating strategies for existing or prospective credit risks affecting the insurer.

Asset Liability Management (ALM)

Consider a review of assets in conjunction with a review of sufficiency of reserves.
- Determine whether the review of the Statement of Actuarial Opinion or other actuarial filings indicate any concerns regarding the adequacy of ALM and the sufficiency of assets to meet the business obligations of the insurer.

- If concerns are identified regarding overall liquidity of the asset portfolio, request a copy of the insurer's asset/liability matching policy and/or liquidity stress testing/scenario analysis.

~~Example Prospective Risk Considerations~~

~~The table provides analysts with example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general discription of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the credit risk category.~~

~~DISCUSSION OF~~ QUARTERLY CREDIT RISK ASSESSMENT~~PROCEDURES~~

The ~~Q~~quarterly ~~C~~credit ~~R~~risk ~~Repository~~ procedures are designed to identify the following.

~~:~~Significant Investment Concentration by Asset Class

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

Procedures/Data

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

Additional Procedures

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

Increased Exposure to Possible Default or Volatility Risk by Asset Class

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

Procedures/Data

- Review and determine whether there are concerns due to the change in certain asset classes from the prior year-end.
  - Increase in non-investment grade bonds and non-investment grade short-term investments from the prior year-end, where such investments are material compared to cash and invested assets (L/H) or policyholder surplus (P/C), or capital and surplus (Health).
  - Increase in mortgage loans from prior year-end, where the ratio of total mortgage loans are material compared to cash and invested assets (L/H) or policyholder surplus (P/C), or capital and surplus (Health).
  - Increase in BA assets from prior year-end, where the ratio of BA assets is material compared to cash and invested assets (L/H) or policyholder surplus (P/C) or capital and surplus (Health).
  - Increase in aggregate write-ins from prior year-end, where the ratio of aggregate write-ins are material compared to cash and invested assets (L/H) or policyholder surplus (P/C) or capital and surplus (Health).

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

Additional Procedures

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

Exposure to and/or changes in risk related toCollectabilty of rReinsurance rRecoverables and Reinsurer Credit Quality

Procedures/Data

- Determine whether amounts recoverable (both paid and unpaid losses on claims and reserve credits) or amounts receivable from reinsurers are significant and collectable.
  - Reinsurance amounts recoverable on paid and unpaid losses on claims to capital and surplus [L/H, Health] or policyholder surplus (P/C).
  - Change in reinsurance recoverables/receivables from prior year-end where recoverables/receivables are material.
  - Provision for reinsurance to policyholder surplus (P/C).
  - Change in the provision for Reinsurance, where the provision is material (P/C).
  - Review Quarterly Financial Statement, [L/H or Health Schedule S; P/C Schedule F] and notate any new reinsurers added since the prior quarter.
  - Determine if there any agreements to release reinsurers from liability during the quarter. [P/C Quarterly Financial Statement, General Interrogatories, Part 2, #2].
  - Determine if there any cancellations of primary reinsurance contracts during the quarter. [P/C Quarterly Financial Statement, General Interrogatories, Part 2, #3.1 and #3.2].
  - Determine whether the liability for reinsurance in unauthorized and certified companies is significant.
    - Liability for reinsurance in unauthorized and certified companies.
    - Change in liability, reinsurance in unauthorized and certified companies.
    - Change in liability for reinsurance in unauthorized and certified companies
  - Determine whether the insurer experienced any material transactions requiring the filing of Disclosure of Material transactions with the state of domicile as required by the Model Act. [Quarterly Financial Statement, General Interrogatories, Part, #1.1].
    - If "yes," determine whether the insurer failed to make the appropriate filing of Disclosure of Materiality Transactions with the state of domicile. [Quarterly Financial Statement, General Interrogatories, Part 1, #1.2].

Additional Procedures

- If amounts recoverable or amounts receivable from reinsurers are significant, and concerns exist, consider the following procedures:

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

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

Exposure to and/or changes in risks related to aCollectability of Affiliated rReceivables; Significant Payable to Affiliates

Procedures/Data

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

Additional Procedures

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

Exposure to and/or changes in risks related toCollectability of uUncollected pPremium and aAgents' bBalances for P/C and Health Insurers and r

Procedures/Data

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

Additional Procedures

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

Collectability of Receivables rRelating to uUninsured pPlans and health carefor Health Insurers

Procedures/Data

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

Collectability of Health Care Receivables for Health Insurers

Procedures/Data

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

Additional Procedures

For additional guidance on inidividual procedure steps, please see the corresponding annual procedures dicusseddiscussed above.

III.B.6. Pricing/Underwriting Risk RepositoryAssessment –

Health - Annual Additional Review ConsiderationsProcedures

1. For health insurers who offer ACA plans, particularly smaller and/or newer health insurers in the ACA Exchange, consider the following additional procedures:
   a. Request and review projections from the insurer, including the volume and the type of membership being attracted during open enrollment periods to compare against future actual membership.
   a.b. Review and compare rates against their peers to identify any indications that they may be underpricing one or more of their products which could assist in determining the impact of the risk adjustment calculation.
   b.c. Gain an understanding and assess the insurer's expertise and resources for pricing ACA business and managing the impact of pricing and health care coding on the risk adjustment process.
   c.d. Inquire of the insurer and assess its prospective strategic plan for preparing for and managing the operational and capital support that would be necessary should the insurer experience potentially large shifts in enrollment.

Analyst Reference Guide – Pricing/Underwriting
Risk Related to Enrollment Fluctuations – New Entrants into the ACA Market

Health insurers are exposed to a variety of pricing and underwriting risks that have the potential to impact their insolvency position. This is particularly true for those insurers that participate in the ACA Health Insurance Market Exchange where guaranteed issuance is required, and pricing differential of products between the participating insurers have the potential to result in significant variances in enrollments. In addition, health insurers are sometimes exposed to significant increases or decreases in enrollment which can greatly impact solvency if the insurer is not adequately capitalized or has access to additional capital resources to be prepared to adjust operational support either up or down to accommodate the swings in membership. These considerations increase the importance of closely reviewing pricing adequacy in ongoing solvency monitoring efforts.

The intent of the ACA risk adjustment program is to transfer funds from insurers with a relatively low-risk enrollee population to insurers with a relatively high-risk membership population. Operational and coding issues have the potential to impact the risk adjustment calculation and could result in an insurer owing a material risk adjustment payment even though it experienced higher than expected medical loss ratios. This can be most detrimental to some smaller or new insurers on the ACA Exchange where their projected marketing and growth strategy resulted in higher than projected claims experience. Insurers and regulators should be aware of the need to balance gaining membership growth, e.g., by creating more competitive pricing, with the insurer's sustainability and future solvency, especially for smaller or newer health insurers. It is possible at times, that increased membership at lower prices could result in better overall risk than the market average which results in the insurer paying into the risk assessment program,

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which in turn puts upward pressure on future premium as the insurer should account for future risk assessment payments.

It is important for regulators to evaluate and assess the insurer's operational and coding expertise in this area, particularly for those insurers that may be thinly capitalized or growing quickly, where the risk adjustment calculation could potentially negatively impact insurer solvency. Further the risk assessment process is complicated and requires expertise and significant resources that may result in unpredictable results and initially disadvantage a smaller or new health insurance carrier.

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ICI The Asset Management Industry
SERVING INDIVIDUAL INVESTORS
INVESTMENT COMPANY INSTITUTE
Washington, DC // Brussels // London // www.ici.org

August 30, 2024

Submitted Electronically

National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197
Attn: Rodney Good and Ralph Villegas

Re: Comments on the Financial Analysis Handbook Exposure Draft

Dear Messrs. Good and Villegas:

The Investment Company Institute (ICI)[1] is writing to express concern with the National Association of Insurance Commissioners' (NAIC) decision to include references to certain investment companies in the recent Financial Analysis Handbook Exposure Draft (the "Exposure Draft") of the Financial Analysis Solvency Tools (E) Working Group.[2] ICI's members include mutual funds, ETFs, and closed-end funds registered and regulated under the Investment Company Act of 1940 ("regulated funds") that invest in equity securities, including those issued by publicly-traded insurance holding companies.

In a section labeled "complex ownership structures," the Exposure Draft proposes additional guidance relating to regulatory reviews of certain transactions involving a domestic insurer. The proposed changes are part of a broader initiative focused primarily on private equity firms' investments in insurance companies and intended to address concerns that "[r]egulators may not be obtaining clear pictures of risk due to holding companies structuring contractual agreements

[1] The Investment Company Institute (ICI) is the leading association representing the asset management industry in service of individual investors. ICI's members include mutual funds, exchange-traded funds (ETFs), closed-end funds, and unit investment trusts (UITs) in the United States, and UCITS and similar funds offered to investors in other jurisdictions. Its members manage $35.7 trillion invested in funds registered under the US Investment Company Act of 1940, serving more than 100 million investors. Members manage an additional $9.3 trillion in regulated fund assets managed outside the United States. ICI also represents its members in their capacity as investment advisers to certain collective investment trusts (CITs) and retail separately managed accounts (SMAs). ICI has offices in Washington DC, Brussels, and London and carries out its international work through ICI Global.

[2] Available at: https://content.naic.org/sites/default/files/inline-files/FASTWG%20Exposure%20Draft%20%281%29.pdf.

in a manner to avoid regulatory disclosures and requirements."[3] We take no position on this initiative generally or on whether the Exposure Draft is necessary or appropriate as applied to private equity firms. We strongly object, however, to the suggestion that regulated fund investment in an insurer (or parent of an insurer) constitutes a "complex ownership structure."[4]

In this letter, we explain how substantive requirements and regulatory protections distinguish regulated funds from other investors in insurance companies. We highlight how investment intent can be discerned from current reporting to the Securities and Exchange Commission (SEC). Finally, we comment on the "best practices" envisioned by the Exposure Draft and why they would be ill-suited to regulated funds and fund advisers.

Substantive Requirements and Regulatory Protections Distinguish Regulated Funds from Other Investors

Each regulated fund is a separate legal entity, organized under state law usually as a corporation or a business trust. Regulated funds have officers and directors (or trustees, if the fund is a trust), including a minimum percentage of independent directors. The regulated fund's board oversees the management and operations of the fund, and the independent directors serve as "watchdogs" for the interests of fund shareholders.[5]

Regulated funds are subject to a comprehensive regulatory scheme under federal securities and other laws. These laws impose substantive requirements on the management and operations of regulated funds and the oversight function of fund directors, as well as extensive disclosure and reporting requirements.

A number of regulated funds may each engage a single investment adviser, an arrangement commonly referred to as a fund "complex." It is important to recognize, however, that each fund must have its own agreement with the investment adviser, and that the adviser is required to manage each fund's portfolio in accordance with the fund's own stated investment objectives and strategies. The adviser, which itself is registered with the SEC, acts as a fiduciary to each regulated fund and, in this capacity, owes *each fund* a duty of care and a duty of loyalty.

Regulated funds and their advisers are also subject to certain proxy voting requirements. In their capacity as shareholders in portfolio companies, regulated funds must disclose their proxy voting policies and procedures and publicly report their proxy votes. Specifically, a regulated fund must (i) describe in its registration statement the policies and procedures that it uses to determine how

[3] *See* NAIC's "Regulatory Considerations Applicable (But Not Exclusive) to Private Equity (PE) Owned Insurers," available at https://content.naic.org/sites/default/files/inline-files/List%20of%20MWG%20Considerations%20-%20PE%20Related%20and%20Other.pdf.

[4] The proposed "Disclaimer of Control/Affiliation" subsection indicates that when reviewing a disclaimer of affiliation filing, "Consideration should be given to situations where a disclaiming party may exert influence or control over the insurer, such as:… passive investment companies with more than 10% ownership of voting shares within funds they manage, where the actions and activities do not support that the investment company's assertion that it does not exert control."

[5] *Burks v. Lasker*, 441 U.S. 471, 484 (1979).

to vote proxies relating to its portfolio securities, and (ii) publicly report to the SEC how the fund voted proxies relating to its portfolio securities, requirements that the SEC further enhanced in 2022.[6] Regulated funds are unique in this regard—no other type of institutional investor must file with the SEC and publicly disclose how it voted each of its proxies.

Accordingly, SEC regulation of regulated funds and their advisers distinguishes them from private equity firms and other types of investors in insurance companies.

Investment Intent Can Be Discerned from Current Reporting to the SEC

Regulated funds typically invest in companies' equity securities (including those issued by insurance companies) solely for investment exposure to those companies, not in order to control the companies. This investment-only intent can be discerned from the beneficial ownership filings that regulated funds—actively managed funds and index funds alike—make with the SEC. Under SEC rules, any person who beneficially owns more than five percent of any registered class of equity securities must file a publicly available report containing certain information. Regulated funds typically file on Schedule 13G under the Securities Exchange Act of 1934 ("Exchange Act"), which is reserved for investors that acquire securities "in the ordinary course of ... business and not with the purpose nor with the effect of changing or influencing the control of the issuer, nor in connection with or as a participant in any transaction having such purpose or effect...."[7] Often the filers of Schedule 13G are referred to as "passive" investors.

In contrast, if an investor acquires the securities of a company with an intent to influence the management or control of the company, the investor must file on Schedule 13D under the Exchange Act, which requires additional and more timely reporting.

This SEC framework is well developed and broadly recognized, and investors (including regulated funds) must adhere to the framework or face legal liability. If NAIC seeks an efficient and reasonable way to help insurance regulators distinguish between investors that seek to control insurance companies and those that do not, we strongly recommend that it rely on the SEC framework in its new guidance.

The "Best Practices" Envisioned by the Exposure Draft Would be Ill-Suited to Regulated Funds and Their Advisers

Several of the proposed provisions would not be consistent with the activities and legal requirements of regulated funds and their advisers. To highlight just one, the Exposure Draft suggests including as a stipulation or condition in a disclaimer approval "[r]equir[ing] 30-day notice to the Department if a 'passive owner' is acting counter to management recommendations for proxy voting." This provision is problematic for several reasons. First, a regulated fund may

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[6] *See Enhanced Reporting of Proxy Votes by Registered Management Investment Companies; Reporting of Executive Compensation Votes by Institutional Investment Managers*, SEC Release Nos. 33-11131; 34-96206; IC-34745 (Nov. 2, 2022).

[7] Section 13(d)(5) of the Exchange Act.

cast hundreds or even thousands of votes each year, most of which involve recurring and non-controversial items (*e.g.*, ratification of auditors); more controversial items (*e.g.*, contested director elections) represent a tiny percentage of funds' overall votes. Simply comparing large volumes of fund votes cast "for" or "against" proposals to any other entity's voting recommendations (including those of company boards) would generate information of little value.

Second, a discrete vote against a portfolio company board's recommendation on a proxy matter is not indicative of an intent to control the company. A share of stock typically provides the shareholder (in this case, a regulated fund) the right to vote on certain corporate matters. Consistent with proxy voting obligations imposed by the SEC, a regulated fund or its adviser makes voting determinations in the regulated fund's best interest. Sometimes, this binary choice results in a vote against the portfolio company board's recommendation, but it does not follow that such a vote indicates a desire to "control" the company. Rather, this is simply an aspect of the fiduciary relationship described above.

While we do not believe examining fund votes against recommendations of a portfolio company board—either individually or in the aggregate—conveys useful information about control, we nevertheless would point out that in most cases, regulated funds vote consistently with recommendations by portfolio company boards. Based on our analysis of proxy votes cast on management proposals by regulated funds in 2023, the percentage of funds voting "for" management proposals was about 87% (on elections of directors, the percentage was about 92%.).[8] These figures demonstrate that regulated funds and their advisers understand and appreciate that shareholders, directors, and officers each have distinct rights and responsibilities with respect to a corporation.

Finally, satisfaction of the proposed 30-day notice requirement often would be impracticable or inconsistent with advisers' fiduciary duty. The period between receipt of initial proxy materials and when a regulated fund must vote in many cases is not much more than 30 days. Moreover, funds and their advisers subsequently may receive additional relevant information about a proposal within this 30-day window. In such cases, it would be impracticable and potentially infringe on an adviser's duty as a fiduciary to reach a firm voting decision and provide notice of it so quickly. As fiduciaries, advisers must vote proxies on behalf of their clients with care, and often they do not decide how to vote 30 days before the shareholder meeting. Funds and advisers should not be forced to choose between thoughtful and diligent proxy voting and meeting an arbitrary advance notice requirement of this kind.

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[8] These figures (i) are measured as the number of regulated funds recording a "for" vote for management proposals, divided by the total number of funds that cast votes, including funds that abstained from voting; (ii) represent votes cast by regulated funds on proxy proposals for companies in the Russell 3000 Index during proxy year 2023, starting on July 1, 2022, through June 30, 2023, (iii) exclude votes on securities listed on foreign stock exchanges and proxy votes related to say-on-pay "frequency" proposals; and (iv) are based on ICI's tabulations of Form N-PX data and ISS Corporate Services data.

For all of these reasons, the proposed proxy voting notice provision is misguided policy and would be immensely burdensome if applied to regulated funds and their advisers.

ICI and Its Members Would Welcome the Opportunity to Engage Further with NAIC on These Matters

Significant variety exists among the advisers, investment vehicles, and investor types in the asset management universe, along with the investment objectives and strategies they pursue and the laws and regulations under which they operate. This universe includes private equity firms, which may acquire all or significant portions of companies, sit on their boards, and control their day-to-day operations; "activist" hedge funds that may invest in and engage with a company to effect specific corporate change, including by soliciting proxies or seeking representation on a company's board; and regulated funds that buy and hold (often for multi-year periods) minority positions in company stock in pursuit of their stated investment objectives (*e.g.*, to track an index or to seek capital appreciation) and strategies, typically without the purpose or effect of changing or influencing the company's control. Overly broad regulations or standards that fail to fully appreciate these distinctions are likely to create unintended costs and burdens on investors, insurance companies, and regulators.

We appreciate NAIC's extension of the comment period and consideration of our comments. ICI and its members would welcome the opportunity to engage further with NAIC staff and members of the Financial Analysis Solvency Tools (E) Working Group to better understand the purpose of the Exposure Draft and provide more fulsome feedback.[9]

If you have any questions, please do not hesitate to contact me at paul.cellupica@ici.org or 202-326-5991.

Sincerely,

/s/ Paul G. Cellupica

Paul G. Cellupica
General Counsel

[9] We would like to understand better, for example, the Exposure Draft's reference to potential review and pre-approval of investment management agreements and, if needed, the opportunity to explain why such an approach is wholly unwarranted in the case of regulated fund investment in the equity securities of publicly-traded insurance holding companies.

August 30, 2024

National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Attn: Rodney Good & Ralph Villegas

Re: Financial Analysis Solvency Tools Working Group (E) – Complex Ownership Structures

Submitted Electronically

Dear Mr. Good and Mr. Villegas:

The American Council of Life Insurers (ACLI) is writing is response to the Financial Analysis Solvency Tools Working Group's ("FASTWG") proposed revisions to the Financial Analysis Handbook ("Handbook") applicable to Form A Procedures. ACLI's members appreciate the opportunity to comment on the proposal.

The ACLI is committed to a fair and transparent insurance industry, emphasizing the importance of uniform standards to maintain integrity and consumer protection. A strong solvency framework helps ensure that insurance companies remain financially stable, which is crucial for safeguarding policyholders' interests and maintaining trust in the industry. This approach promotes consistency and reliability across the board, ultimately benefiting both insurers and their customers.

The NAIC's Insurance Holding Company System Regulatory Act (#440) (Model Act) has been central to the regulatory framework for insurance groups in the United States. It sets out clear, measurable standards for insurers, helping them understand what regulators expect and how they should manage their operations. This consistency across states is crucial and is enforced through the NAIC Accreditation Program, which mandates adoption of the Model Act by all states.

To assist both regulators and insurers in interpreting and applying the Model Act, the Handbook provides useful guidance but is not permitted to supersede the standards set by the Model Act itself.

While the goal of the proposal is to look at insurance acquisitions and mergers, we have concerns that the proposed changes may conflict with existing definitions and practices of ownership and control, specifically those of the Model Act. There are additional concerns on the downstream impacts and regulatory guidance conflicts.

The American Council of Life Insurers is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 275 member companies represent 93 percent of industry assets in the United States.
acli.com

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The updated definitions in the Model Act related to Disclaimers of Control/Affiliation section grants regulators considerable discretion in assessing control and influence, which could create complexities or even direct conflicts when interacting with existing Model Act definitions.

Potential Conflicts and Considerations

1. Consistency with Existing Definitions: The new disclaimers of control appear to conflict with existing ownership-based definitions. For instance, if ownership of 10% or more was previously a clear indicator of control, the proposed changes blur these lines, making it harder to apply the standard definitions consistently.
2. Introduces Regulator Subjectivity: The proposed changes remove certainty around the ownership and control regulatory considerations for stakeholders. While other components of the state regulatory system for insurers more appropriately utilize regulator discretion, any ownership or control assessments should be consistent with the overall intent of the Model Act to maintain clear and fair regulation.
3. Potential for Discrepancies: There could be variations in how different states apply these new definitions and discretion, potentially leading to inconsistencies across jurisdictions. These discrepancies might affect insurers operating in multiple states, requiring them to navigate varying regulatory expectations and create unlevel playing fields for companies with different control and ownership structure.

The ACLI advocates for a strong regulatory framework characterized by the consistent application of rules to all insurers. We recommend that the FASTWG consider potential conflicts and relevant factors when integrating objective standards of examination. Doing so would improve predictability and ensure a clear understanding of regulatory requirements across the industry, irrespective of the insurer's geographic location.

Thank you for the opportunity to provide feedback on the proposed revisions to the Handbook. The ACLI is dedicated to collaborating with the NAIC and state regulators to further enhance the strong regulatory framework currently in place and welcome further detailed discussion given the timeframe for this exposure.

Sincerely,

Shannon Jones
Senior Director - Financial Reporting Policy
Shannonjones@acli.com
202-624-2029

August 8, 2024

National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Attn: Rodney Good & Ralph Villegas

Re: Financial Analysis Solvency Tools Working Group (E) – Complex Ownership Structures – Comment Letter -

Dear Mr. Good and Mr. Villegas:

Thank you for the opportunity to provide feedback on the Financial Analysis Solvency Tools Working Group's ("FASTWG") proposed revisions to the Financial Analysis Handbook ("Handbook") applicable to Form A Procedures.

I serve as Executive Director of the National Alliance of Life Companies (the "NALC"), a trade group of more than fifty (50) life and health insurers and associates. We represent our members on issues of interest to small and mid-sized life and health insurers across the United States.

The NALC fully supports a well-regulated insurance industry. This includes quantifiable and measurable standards that ensure a level playing field for all insurance companies while adhering to our primary goal of protecting policyholders and insurance consumers. A rigorous solvency framework that is consistently applied across all states and all companies benefits both the regulated industry and its policyholders.

Since the 1970's, the NAIC's Insurance Holding Company System Regulatory Act (#440) (Model Act) has been the foundation of insurance group supervision in the U.S. The Model Act establishes objective, measurable and quantitative standards that enable insurers to understand regulator expectations, and to plan and operate their business accordingly. The consistent application of those standards across every state was considered so vital to the state system of insurance regulation that adoption by every state is mandatory under the NAIC Accreditation Program.

The Handbook is a valuable tool that provides regulators and carriers with interpretive guidance regarding the Model Act. The Handbook, however, cannot amend or otherwise change the Model Act (as adopted by the states). This limitation on the use of the Handbook is clearly stated in the Special Note to section V.B. Domestic and/or Non-Lead State Analysis – Form A Procedures: "[t}he following procedures do not supersede state regulation but are merely additional guidance analysts may consider useful."

NALC is supportive of the majority of the proposed revisions to the Handbook, though we respectfully express significant concerns regarding new language that would replace the objective standards of review established by the Model Act with a subjective standard. As an example of this new language is as follows:

> "Consideration should be given to situations where a disclaiming party *may exert influence or control over the insurer* such as: over management decisions, or the operations of the insurer; where there is a minority owner; where lending agreements may result in ownership of the insurer in the event of default; where non-voting shareholders have protective rights affording them the opportunity to acquire control in certain circumstances; any non-voting arrangement or contract that may convey an element of control (e.g., investment management, reinsurance, administrative service, employment); or passive investment companies with more than 10% ownership of voting shares within funds they manage, where the actions and activities do not support the investment company's assertion that it does not exert control.
>
> These are only a few examples of situations that may require additional inquiry and a deeper review of the disclaimer application to determine if control exists, if the disclaimer should be approved or denied, or if any conditions or stipulations should be placed on the approval. The burden of proof is on the applicant to demonstrate they do not have control or affiliation." *Emphasis added.*

Our concerns with this approach are as follows:

1. Permitting consideration of whether a disclaiming party "may exert influence or control over the insurer …" conflicts with the definition of Control stated in the Model Act. The handbook is an interpretive tool, efforts to use the Handbook to amend this or any other Model Act are inappropriate. This limitation is acknowledged in the Special Notes to V.B. Domestic and/or Non-Lead State Analysis – Form A Procedures: "The following procedures do not supersede state regulation but are merely additional guidance analysts may consider useful."
2. This new standard eliminates one of the most valuable elements of the Model Act definition of Control: predictability. The standard is vague and entirely subjective, providing no guidance with respect to how the standard for Control should be applied to a particular set of circumstances. Uniformity and consistency in analysis is essential to our regulatory system; both to prevent regulatory disparities and to ensure that all insurers operate under the same standards.
3. Injecting amorphous standards into the analysis will ensure uneven application of the standard, from company to company and state to state. The Model Act was carefully specifically designed to ensure uniform treatment from company to company and from state to state.
4. This standard will also result in unlevel playing fields, the pursuit of competitive advantages, or conversely, disadvantages for insurers in different states. It is also easy to foresee companies engaging in forum shopping seeking the most favorable jurisdiction for interpretation of the Handbook.

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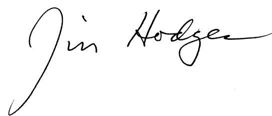
5. A vague standard could potentially harm policyholders due to differing interpretations; increasing costs for carriers as well as hindering their ability to attract new capital into the industry. Further, the industry may face a potential stall in new entrants into the market or product innovation due to the uncertainty created by the proposed regulations. Increasing costs, especially upon smaller carriers, will likely have a larger impact on the policyholders of those smaller companies due to lesser ability to absorb the costs, necessitating they be passed on to consumers. Competition in the market drives companies to create better products for consumers.

As stated earlier, the NALC is supportive of a measurable and quantitative standard application that allows insurers to evaluate and prepare accordingly for the rules under which they operate. The NALC believes a strong regulatory system is built upon consistency in the application of rules to insurers. We also believe the proposed changes to the Handbook, in general, are effective and beneficial to policyholders, however, we would urge the FASTWG to consider objective standards of examination to provide predictability and a clear understanding of the rules across the industry regardless of where an insurer may be engaging in business.

Thank you for the opportunity to comment on the proposed revisions to the Handbook. The NALC is committed to working in conjunction with NAIC and state regulators to continue strengthening the robust system of regulation currently in place. Please feel free to contact me if you have any questions.

Regards,



Jim Hodges
Executive Director
NALC

asset management group

August 29, 2024

National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197
Attn: Rodney Good & Ralph Villegas

Re: Financial Analysis Solvency Tools Working Group (E) – Complex Ownership Structures

Submitted Via Email

Dear Mr. Good and Mr. Villegas:

The Asset Management Group of the Securities Industry and Financial Markets Association ("SIFMA AMG")[1] appreciates the opportunity to provide comments to the National Association of Insurance Commissioners ("NAIC") on the Financial Analysis Handbook Exposure Draft.

The NAIC recently published an exposure draft of potential changes to the NAIC Financial Analysis Handbook ("Handbook") and requested public comment. The proposed changes are part of a broader initiative to address "Regulatory Considerations Applicable (But Not Exclusive) to Private Equity (PE) Owned Insurers."

SIFMA AMG members span a wide range of asset management firms. The proposed changes to the Handbook could have indirect implications for asset managers to the extent they have made investments in, or manage money for, state-regulated insurance companies. We recognize the policy objective of being able to identify situations where a party with partial ownership exercises control over an insurance company. We also recognize the challenge of writing guidance that will be useful across a wide range of circumstances.

Asset managers are a source of long-term stable capital for insurers and continued insurer access to affordable capital should remain a priority. We are particularly concerned, however, that the proposed section titled "Disclaimer of Control/Affiliation"

[1] SIFMA's Asset Management Group brings the asset management community together to provide views on U.S. and global policy and to create industry best practices. SIFMA AMG's members represent U.S. and global asset management firms that manage more than 50% of global AUM. The clients of SIFMA AMG member firms include, among others, tens of millions of individual investors, registered investment companies, endowments, public and private pension funds, UCITS and private funds such as hedge funds and private equity funds. For more information, visit http://www.sifma.org/amg.

could create ambiguities, conflict with other regulatory structures, or have practical aspects that make them infeasible. Guidance with specific fact patterns in mind might have unintended consequences by applying unsuitable conditions or criteria to disclaimer applicants with different facts and without associated control risks.

Asset managers invest on behalf of their clients directly and indirectly in the equity of insurance companies and may also be retained to manage money for insurance companies. The heading for the changes reference Private Equity but also suggests the considerations are not limited to private equity. The vast majority of asset managers invest for the purpose of pursuing economic returns for their clients and investors and not for the purpose of becoming involved in the management or day-to-day control of the companies in which they invest.

Given that background, we offer the following observations and suggestions:

1) The proposed guidance states that some contracts may convey an element of control:

> Consideration should be given to situations where a disclaiming party may exert influence or control over the insurer such as: …any non-voting arrangement or contract that may convey an element of control (e.g., ***investment management***, reinsurance, administrative service, employment); (emphasis added)

The presence of an investment management agreement is not a per se indicia of control. Investment management agreements that are negotiated at arm's length and include customary terms do not implicate control. Language should be amended to clarify that only contracts that include non-customary terms that implicate control or the intent to control are relevant to disclaimer assessments, such as onerous termination provisions, excessive control given over the insurance company's strategy and implementation, or risks associated with non-arm's length affiliated arrangements. This is consistent with prior work of the Risk-Focused Surveillance (E) Working Group.

We suggest the following revised text:

> Consideration should be given to situations where a disclaiming party may exert influence or control over the insurer such as: …any non-voting arrangement or contract that may convey an element of control (e.g., investment management ***agreements with non-customary terms that extend beyond advisory services and into broader influence over the insurer's business such as termination provisions that would be onerous and implausible in practice, authority over the insurer's strategy and implementation for managing its assets, or an affiliated adviser becoming intertwined in the insurer's business operations***, reinsurance, administrative service, employment);

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2) Accumulating a position of an insurance company's outstanding equity is typically an investment decision rather than a mechanism to obtain and exercise control. Applicable Securities and Exchange Commission regulations under Section 13 of the Securities Exchange Act of 1934 require public disclosure of positions held by institutional investment managers, as well as public disclosure by beneficial owners that own more than 5% of a public company. These regulations require distinct disclosure for those that own more than 5% of a public company if they purchase or hold shares with the purpose or effect to change or influence control of a company. Handbook guidance should look to these filings as a reliable source of authority if appliable.

3) The proposed guidance states that "actions and activities" of investment companies may be relevant:

> Consideration should be given to situations where a disclaiming party may exert influence or control over the insurer such as:... passive investment companies with more than 10% ownership of voting shares within funds they manage, where the ***actions and activities*** do not support the investment company's assertion that it does not exert control. (emphasis added)

This text is ambiguous and risks creating confusion regarding what "actions and activities" are viewed as indicia of control. This language should be clarified or augmented to avoid any implication that ordinary course stewardship, engagement and proxy voting by an asset manager or investment company constitutes exerting control.

We suggest the following text to be added at the end of the paragraph:

> Actions asset managers take in the ordinary course of their advisory services, such as engagement with management and proxy voting, should not be viewed as actions and activities that indicate exerting influence or control for these purposes.

4) The proposed guidance lists a variety of measures and considerations as "best practices." The "Best practices" heading may inadvertently endorse measures that may not be appropriate in all fact patterns. The heading should be amended to better show the subsequent bullet points as "alternatives depending on the circumstances" rather than a checklist of "best practices" that may be viewed as recommended and applicable across all scenarios.

5) Asset managers buy, sell and hold investments on behalf of their clients. They make ongoing investment determinations and vote proxies in the same manner for insurance company holdings as holdings of other issuers and in the same

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manner as any other shareholder. They and the funds and accounts they manage are subject to their own regulatory frameworks and requirements. Several of the suggested required conditions run afoul of these constructs. Handbook guidance should ensure flexibility to recognize these business models and avoid imposing conditions that will be inapplicable or infeasible and otherwise frustrate the investment process. Examples:

a. "Consider state laws that require limitations on investments (e.g., three-year waiting period)"

   The objective and implications of this language are not clear. Imposing minimum waiting periods to invest, minimum holding periods, and other limits on investment timing will hamper potential investments into insurers, interrupting the flow of capital to these companies. For example, index funds may be unable to trade shares of insurers as needed to track their respective indices, limiting or preventing index funds from investing in the insurance industry.

   Holdings may be viewed as impaired or illiquid which have implications for financial statements and investment guidelines and will deter investment. Restrictions on the ability of an asset manager to exit investments in insurance companies would have an adverse impact on the market for those instruments and increase costs for an insurance company to raise capital.

   The Handbook text should avoid any implication that passive owners whose disclaimers have been approved must re-apply for disclaimers every three years. We suggest that this text be omitted altogether.

b. "Require 30-day notice to the Department if a "passive owner" is acting counter to management recommendations for proxy voting."

   Requiring advance notice of proxy voting is infeasible and impractical for most public equity proxy votes. Decisions are often made close to the meeting date and disclosing voting intentions may disclose material non-public information or voting strategy. Asset managers have a responsibility to vote in the best interests of the funds they manage and therefore decisions must be made thoughtfully and carefully, often involving reviews of company disclosures and engagement with company management to understand the company's disclosures and corporate governance practices. The responsibility to vote can result in votes for or against management recommendations, but that should not be viewed as a per se control indicator. Insurance companies with public equity are no different than any other public issuer in this respect, and shareholders

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must be free to vote in their interests regardless of management recommendations.

If voting transparency is an issue, proxy votes for mutual funds, exchange traded funds and other funds registered under the Investment Company Act of 1940 are publicly available on Form N-PX on an annual basis.

c. "Post-Disclaimer Considerations: The disclaiming person/entity should:
   - Provide notice before taking action on any of the rights and privileges of the non-voting shares.
   - Provide notice before transferring non-voting shares.
   - Provide notice before taking any position at the insurer or its affiliates."

Requiring advance notice by an asset manager for ordinary investment decisions is infeasible and impractical. Investment management decisions are made on a daily basis and such investments could extend to non-voting instruments (depending on the terms of the instruments the insurance company has issued to the public). Requiring advance notice for ordinary course trading that has no impact on a control determination or disclaimer serves no purpose and raises the risk of administrative reporting violations.

In general, ongoing notice requirements should be avoided. Adding requirements creates impediments to investment and anything that deters the flow of capital is not in the interests of insurers. A notice requirement should only be an option if there is a is a compelling reason to believe there is an active question regarding control intentions.

6) The proposed changes replace objective standards based on ownership with more subjective standards based on ambiguous indicia of control. Introducing too many subjective standards risks reducing predictability and putting those considering disclaimer requests in awkward positions of making their own determinations. Ambiguity also puts prospective applicants including asset managers that typically buy and sell public equity on a daily basis on behalf of their clients, in the position of not knowing how a determination will be made. The changes could frustrate one of the primary objectives of the Insurance Holding Company System Regulatory Act (#440) - to promote consistency and uniform treatment among and between companies and states.

Handbook changes that impose new substantive requirements that change how asset managers invest in and do business with insurance companies warrant caution. The assessment of disclaimer applications and potential conditions for approval should be

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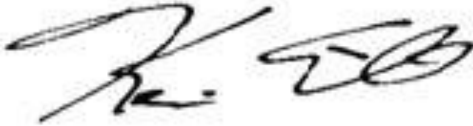
approached carefully to avoid imposing new requirements or requirements that impair access to capital for insurance companies.

SIFMA AMG appreciates NAIC's consideration of these comments and would be pleased to discuss any of these views in greater detail if that would assist deliberations on this issue. Please feel free to contact me via email at kehrlich@sifma.org.

Sincerely,



Kevin Ehrlich
Managing Director & Associate General Counsel
SIFMA AMG

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The Capital Group Companies, Inc.
333 South Hope Street
Los Angeles, California 90071-1406

capitalgroup.com

August 30, 2024

VIA E-MAIL

Mr. Greg Chew, Chair
Financial Analysis Solvency Tools (E) Working Group
National Association of Insurance Commissioners
110 Walnut Street, Suite 1500
Kansas City, MO 64106-2197
Attn: Rodney Good (RGood@naic.org); Ralph Villegas (RVillegas@naic.org)

Re: ***Revisions to the*** **Financial Analysis Handbook** ***(2024 Annual/2025 Quarterly Edition) proposed by the NAIC Financial Analysis Solvency Tools (E) Working Group regarding Complex Ownership Structures***

Dear Mr. Chew:

We appreciate the opportunity to comment on the above-referenced revisions to the *Financial Analysis Handbook* (the "Proposal") proposed by the Financial Analysis Solvency Tools (E) Working Group (the "Working Group"). While we appreciate the motivation for the Proposal, we are concerned that changing the requirements for filing disclaimers of affiliation ("Disclaimers") as recommended in the section of the Proposal entitled "Disclaimer of Control/Affiliation" would unnecessarily restrict the flow of capital to insurers and/or their respective insurance holding company systems ("Insurers"). As an asset manager that invests in Insurers on a fiduciary basis, for the long-term and subject to strict regulatory and internal restrictions on our ability to invest for control, our investments do not present the issues the Working Group is trying to address in the Proposal—namely, the potential for complex ownership structures and contractual arrangements that give an investor control over an insurer, even at relatively low ownership levels of voting securities. In addition to inhibiting capital flows, we are concerned that the Proposal would encourage regulators to apply unnecessary requirements to our Disclaimer filings and create reporting obligations that would be impossible for us to satisfy. We support the comments submitted by the Investment Company Institute and the Securities Industry and Financial Markets Association – Asset Management Group[1] and urge the Working Group to provide discretion to insurance

[1] *See* Letter to the National Association of Insurance Commissioners from Paul G. Cellupica, General Counsel of the Investment Company Institute, dated August 30, 2024; Letter to the National Association of Insurance Commissioners from Kevin Ehrlich, Managing Director & Associate General Counsel, Asset Management Group of the Securities Industry and Financial Markets Association, dated August 29, 2024.

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regulators not to apply the proposed changes to the current Disclaimer review practice for asset managers who do not invest for control.

I. Capital Group background

The Capital Group Companies is one of the oldest asset management organizations in the United States with more than 90 years of investment experience. Through our investment adviser subsidiaries, we actively manage equity and fixed income investments across all market sectors in various collective investment vehicles and institutional client separate accounts. Most of these assets consist of the American Funds family of mutual funds as well as other U.S. regulated investment companies managed by Capital Research and Management Company.

We are long-only investors, do not invest our own proprietary capital[2] and instead manage only our clients' capital. We file beneficial ownership reports with the U.S. Securities and Exchange Commission (the "SEC") on Schedule 13G, requiring us not to invest for control or management. These same restrictions are also a fundamental investment policy of the American Funds that would require the vote of millions of fund shareholders to change. Our employees do not serve as officers or directors of portfolio companies. We do not mount proxy solicitations. In brief, Capital Group funds do not engage in any activities that seek to exercise control over the day-to-day operational or management decisions of the Insurers in our various investment portfolios.

Our mutual funds provide retail investors with the opportunity to build wealth by investing in diversified portfolios at low cost. Shares in the American Funds are held by approximately 60 million investor accounts, representing individuals, retirement plans and other institutions. The average account size is approximately $25,000. Our funds are among the most used investment options in retirement plans of small- and medium-sized businesses across the U.S. Our funds and accounts invest in equity securities of over 2,000 global companies.

II. Disclaimers currently facilitate meaningful capital flows to Insurers, especially in times of market stress

Funds and accounts managed by Capital Group currently hold equity securities of approximately 65 companies that are subject to state insurance limits. As a result, any changes to the Disclaimer filing process would have meaningful impact on our investments. Other asset managers may experience a similar impact, thereby restricting the flow of capital to Insurers.

Section 4K of the Insurance Holding Company System Regulatory Act (Model #440) sets forth the requirements for submitting Disclaimers. Investors like Capital Group file Disclaimers to rebut the presumption of control that would otherwise exist when such investors acquire 10% or more of the voting securities of an insurer or insurance holding company. The Proposal aims to supplement the Disclaimer filing requirements by suggesting certain situations where an applicant could be deemed to exert influence or control over an insurer, including "where

[2] Capital Group may contribute immaterial amounts of seed capital to assist with the launch of new funds and managed accounts.

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lending agreements may result in ownership of the insurer in the event of default; where non-voting shareholders have protective rights affording them the opportunity to acquire control in certain circumstances; [and in the case of] any non-voting arrangement or contract that may convey an element of control (e.g., investment management [agreements]).”[3] To that end, the Proposal suggests best practices to regulators for review of Disclaimers and recommends specific inquiries that regulators should make of applicants when assessing whether an applicant has control “in-fact” over a particular insurer.

Increasing the number and complexity of factors to be considered by regulators in a Disclaimer application will increase the burden for disclaiming parties. This has the potential to restrict the flow of investment capital into Insurers, disadvantaging them relative to non-regulated companies. For example, if the Disclaimer filing process becomes so burdensome and unpredictable that asset managers cannot reliably obtain approval to hold more than 10% of an insurer’s voting securities, the 10% threshold may act as a de facto limit on investments. This could force Insurers to seek capital from other sources, such as activist investors, and/or require Insurers use greater leverage to meet their needs. Neither of these options is likely to be viewed as preferable to the current arrangement, whereby investment companies provide such capital subject to strict limits on the exercise of control.

Furthermore, placing additional restrictions on investment companies’ ability to invest in Insurers would constrain asset manager participation in the capital markets during times of market stress. U.S. capital markets are among the most active and deep in the world. However, during times of market stress, liquidity may contract as similar programmatic traders adapt to changing conditions. For example, transactions by index funds are solely governed by client flows and are potentially pro-cyclical. In times of downward market stress, an active asset manager’s investment professionals may act in a counter-cyclical manner and use available cash to buy securities of companies with reduced valuations that represent a buying opportunity. Timely participation by diverse market participants is important to support healthy U.S. capital markets. Such timely participation would be foreclosed by burdensome Disclaimer application procedures.

III. The Proposal is inconsistent with modern investment paradigms and would create impractical or impossible reporting obligations

We understand and appreciate the concerns the Proposal is seeking to address, including any potential consequences associated with increased acquisitions of U.S. insurers by private equity firms.[4] However, these concerns do not apply to asset managers like Capital Group, which invest in a fiduciary capacity, for investment purposes only and subject to strict prohibitions on the exercise of control.

As described above, we file beneficial ownership reports with the SEC on Schedule 13G, which require us to certify that the securities we hold “were acquired and are held in the

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[3] Proposal at 20.

[4] *See* Jennifer Johnson & Jean-Baptiste Carelus, *Number of Private-Equity Owned U.S. Insurers Remains Constant, but Total Investments Increase by Double Digits in 2023*, NAIC Capital Markets Special Report, 7 (August 7, 2024), https://content.naic.org/sites/default/files/capital-markets-pe-owned-ye2023.pdf.

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ordinary course of business and . . . [not] for the purpose of or with the effect of changing or influencing the control of the issuer."[5] In contrast, investors who cannot make such a certification must file beneficial ownership reports on Schedule 13D. Each of our U.S. mutual funds also has a fundamental investment policy not to invest for control, which cannot be changed without the vote of millions of fund shareholders. Our employees do not serve as directors or officers of our portfolio companies, nor do we propose directors or solicit proxies with respect to portfolio companies.

Moreover, unlike private equity firms, we generally acquire securities on the open market. These securities would not afford us special protective rights relative to other holders that would allow us to acquire control of an issuer in specified circumstances. With respect to debt securities specifically, we typically purchase debt securities (i) issued in public or private offerings to multiple investors, where the price and key terms are standardized across investors, or (ii) from a third party in the secondary market. Again, this should eliminate the concerns raised in the Proposal that investors can exercise control over an insurer through the unique contractual terms of such investor's debt or equity securities.

As a result of the foregoing, we respectfully request that the Proposal be revised to clarify that insurance regulators have the discretion not to apply the new requirements for Disclaimer filings to asset managers like Capital Group that do not invest for control. When determining whether to approve a Disclaimer for such asset managers, we would encourage regulators to continue their current practice of looking to customary indicia of control, such as 13G filing status and prohibitions on board representation and proxy solicitation.

We are particularly concerned with the suggestion that disclaiming parties should give regulators 30 days' prior notice before voting against management's recommendation on a proxy proposal.[6] We believe that exercising our proxy voting rights for the companies in which we invest is fundamental to fulfilling our obligations to investors. As such, although we vote "with" management on an overwhelming majority of the tens of thousands of proposals we review each year, we oppose any requirement that would curtail our ability to exercise the voting discretion delegated to us by investors. We are concerned that the Proposal would do just that.

In addition, from a practical perspective, it is unlikely that *any* investor could comply with a requirement to give regulators 30 days' advance notice of its intention to vote a particular way. We have observed that we generally only have 10-15 business days between receipt of the proxy statement and the voting deadline to complete our analysis of the various proposals, engage with company management where necessary, seek input from investment professionals, obtain approval from the relevant internal committee and make our final voting determination. In certain jurisdictions, statutory notice requirements for shareholder meetings are less than 30 days, meaning that meeting agendas do not need to be finalized 30 days in advance of a meeting. In other jurisdictions, we may be required to vote within 1-2 days of receiving a proxy statement. Before adopting any changes that would require investors to give regulators 30 days' advance notice of a particular voting decision, we would

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[5] Schedule 13G, Item 10.

[6] Proposal at 21.

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encourage the Working Group to seek feedback from Insurers on the feasibility of this change. For example, would an Insurer be able to give investors adequate notice of proxy proposals, while allowing sufficient time for the company to engage with shareholders on the proposals as desired? In addition, we respectfully encourage the Working Group to consider the burden this requirement will place on state regulators who may be unable to respond to disclaiming parties' voting notifications on this compressed timeline.

Finally, we are concerned with the suggestion that regulators should review all investment management agreements ("IMAs") between a disclaiming party and an Insurer. We believe the issues raised by NAIC with respect to IMAs—in particular, whether an IMA can give a disclaiming party "control" of an issuer through unfair pricing terms or draconian termination provisions—arise only in the context of IMAs between insurers and affiliated investment managers.[7] These concerns should not arise if an IMA has been negotiated at arms' length. As such, we would respectfully request that the Proposal be revised to clarify that an IMA would not be requested and reviewed by regulators in the context of a Disclaimer application filed by asset managers that do not invest for control.

* * * *

We appreciate the opportunity to comment on the Proposal. While we understand the motivation for the Proposal, we urge the Working Group to provide discretion to insurance regulators not to apply the proposed changes to the current Disclaimer review practice for asset managers who do not invest for control.

If you have any questions regarding our comments, please contact Donald H. Rolfe at (213) 615-0457 or Katherine Z. Solomon at (213) 615-0956.

Sincerely,

Donald H. Rolfe
Senior Vice President and Senior Counsel
Capital Research and Management Company

Katherine Z. Solomon
Vice President and Associate Counsel
Capital Research and Management Company

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[7] *See List of 13 MWG Considerations – PE Related and Other*, Macroprudential (E) Working Group of the Financial Stability (E) Task Force, https://content.naic.org/sites/default/files/inline-files/13%20MWG%20Considerations%20-%20Status%208-13-24_0.pdf (accessed August 22, 2024).

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Special Notes: The following procedures do not supersede state regulation but are merely additional guidance analysts may consider useful. The procedures may be completed in part, or in total, at the discretion of the analysts depending on the level of concern, and the area in which the risk was identified.

Form A – Statement of Acquisition of Control of or Merger with a Domestic Insurer

Model Act and Database Procedures

Form A is transaction-specific and is not part of the regular annual/quarterly analysis process. Every Form A review should be tailored to the risks associated with the proposed acquisition, including the target company, acquiring entity, and the complexity of the transaction. The review of these transactions may vary, as some states might have regulations that differ for Form A.

Initial Review

1. Determine if the filing is complete, note the missing items and promptly send a deficiency letter to the Applicant. A filing may not be considered complete and active until all relevant information has been received. Enter any changes to the status of the filing or other data elements into the NAIC Form A database within 10 days of receipt of the Form A. Data and information should be entered by the state's designated person.
   a. Identify attorneys, party contacts (all stakeholders), and other insurance regulators reviewing the Form A, including the lead regulator.
   b. Assign appropriate analyst, legal, and other professional staff to conduct regulatory review.
   c. Carefully consider whether regulatory review can be completed by Applicant's target close date, including any interim deadlines and obtain deemer extension or waiver if appropriate.
   d. Schedule and notice hearing/consolidated hearing, if applicable, within statutory timeframes.
   e. Review the NAIC Form A database to determine whether the current Form A is pending or has been approved, denied, or withdrawn in another state. Assess any reasons noted for denial and document any risks or concerns.
2. Establish contacts with other states and regulators to discuss the status and/or disposition of the current and prior filings made with those states. Where multiple jurisdictions are involved, coordination of information between the states and functional regulators should be initiated by the lead states(s). Perform the following steps:
   a. The domestic state should notify the lead state regulator of the holding company group of any merger or acquisition of a domestic insurer in the group.
   b. The lead regulator should obtain key contact information from each state reviewing the Form A and consider organizing a regulator to regulator call to discuss concerns with the filing.
   c. Create a contact list of relevant persons and representatives.
   d. Separate confidential and public documents, information, and communications and maintain as appropriate.
   e. Contact and collaborate with other reviewing regulators involved in the review process, as appropriate, including the lead state regulator regarding ORSA and ERM reviews.
   f. As applicable, contact other regulators of noninsurance entities of the acquiring party or target.
   g. Based on the nature and materiality of the transaction, the lead state and domestic state(s) should regularly communicate with all states and other functional regulators, as necessary throughout the filing

review process, to provide updates on the transaction, states' reviews, and to share feedback between regulators.

h. Where multi jurisdictions are involved and based on the size and complexity of the acquisition/merger, the lead state should take responsibility for the coordination and facilitation of communication. Regulators should work jointly on the Form A review to maximize efficiency and promote coordinated communications with the insurers involved to reduce duplication of regulatory efforts, where possible.

Compliance Assessment and Review

Transaction Details

3. Review details provided on the transaction for compliance with application filing requirements by determining whether the Form A application provides the required content, which may include the following:
   a. Provides a brief description of how control is to be acquired.
   b. Contains the following information:
      - Name and address (legal residence for an individual or street address if not an individual) of the applicant
      - States the nature of the applicant's business operations for the past five years, if the applicant is not an individual
      - Describes the business to be performed by the applicant and its subsidiaries
      - Identifies and states the relationship of every member of the insurance holding company system on the organizational chart
   c. Contains the required signature and certification, and include copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and of additional soliciting material relating thereto.
   d. Contains any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by the Form A.
   e. Contains an agreement to provide the information required by Form F – Enterprise Risk Report within the required timeframe.
   f. Includes the number of each class of shares of the insurer's voting securities that the applicant, its affiliates, and any person that plans to acquire; 2) the terms of the offer, request, invitation, agreement, or acquisition; and 3) the method by which the fairness of the proposal was determined.
   g. States the amount of each class of any voting security of the insurer that is beneficially owned or concerning that there is a right to acquire beneficial ownership by the applicant, its affiliates, or any person.
   h. Gives a full description of any contracts, arrangements, or understandings with respect to any voting security of the insurer in which the applicant, its affiliates, or any person is involved. Discussion includes, but is not limited to, the transfer of any of the securities, joint ventures, loan or option agreements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies.

4. Perform analysis review considerations, in addition to the compliance review in #3 as necessary, to analyze the details of the transaction, which may include, but is not limited to the following:

a. Document any risks or concerns by carefully reviewing transactional documents (e.g., merger, stock purchase, stock exchange).

    i. Consider disposition of all classes of target shares, including addressment of any beneficial owners.

    ii. Ascertain propriety of disposition of minority interests and concerns, if applicable.

b. Consider any affiliate or employee benefit as appropriate.

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

d. Determine how any ancillary regulatory reviews or other interim procedural steps will be completed, including Form E – Pre-Acquisition Notification Form, for other licensed states.

e. Obtain copies of shareholder communications or sole shareholder consent.

f. Consider obtaining copies of fairness and other contractually required opinions, if available.

g. Review relevant portions of board resolutions, power points and related board minutes pertinent to the Form A transaction, using care to keep documents confidential.

h. Determine if after the change of control:

    i. The insurer will be able to satisfy the requirements for the issuance of a license to write the classes of insurance for which it is presently licensed.

    ii. The insurer's surplus will be reasonable in relation to its outstanding liabilities and adequate for its financial needs.

i. Review financial projections for the applicant and the insurer to ensure that they are consistent with the description of the intended business plan of the insurer and other assertions and representations made in the Form A filing. Determine whether the projections are based on reasonable expectations.

    i. Determine the target's estimated post-acquisition financial condition and stability.

j. If not included in the Form A filing, request copies of all contracts between the applicant (or other entities for which it exhibits control) and the insurer. Review these contracts to ensure that the terms are at arm's-length, fair, and reasonable to the insurer.

k. Will the proposed merger or acquisition comply with the various provisions of the state's General Administrative Amendments or Business Corporation Law (e.g., board resolutions, plans of merger, draft articles of merger, etc.)?

l. Does the Form A describe any plans or proposals for which the applicant might have to declare an extraordinary dividend, to liquidate the insurer, to enter into material agreements (including affiliated agreements), to sell the insurer's assets, to merge the insurer with any person or persons, or to make any other material change in the insurer's business operations, corporate structure, or management?

m. Consider suitability of any new affiliated and non-affiliated material agreements, including managing general agents, third party administrators, any professional organizations and reinsurance arrangements.

n. Consider plans for technological interfacing with new affiliates and any potential adverse impact on operations including claims.

o. Require Form D filings for any affiliated material transactions, post-acquisition; consider including language in the approval order.

p. Consider with disfavor any plans to liquidate the target or sell its assets, consolidate or merge, that may be unfair, unreasonable, or hazardous to policyholders.

q. Review required statutory deposits and authorized lines of business.

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

Ultimate Controlling Person/Parent (UCP), Officers, and Directors

5. To identify the UCP, review the ownership documents/agreements and other information provided in the Form A application to understand its ownership structure, the terms of the documents/agreements, each parties' rights and responsibilities conveyed by the documents/agreements, who has responsibility for decisions and who controls the insurer.

5.6. Review the background information and financial statements provided in the application for the UCP.

a. Does the Form A summarize the fully audited financial statements regarding the earnings and financial condition of the ultimate controlling party(ies)/person(s) for the preceding five years, and are exhibits and three-year financial projections of the insurer(s) attached to the filing?

i. Identify the Audited Financial Statements (or CPA reviewed financial statements for individuals) of the ultimate controlling party(ies)/person(s).

ii. Review holding company, and the UCP, 10K and 10Qs, and other current financial information for enterprise condition, potential debt service by the UCP and its ability to service such debt.

iii. If fully audited financial information is not available, consider acceptability of unaudited financial statements regarding the earnings and financial condition, compiled personal financial or net worth statements and/or tax returns of the ultimate controlling party(ies)/person(s), as deemed acceptable to the commissioner.

iv. Financial statements accompanied by a certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations.

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

6.7. Perform additional review considerations as necessary to analyze and identify potential risks concerning the UCP, Officers, and Directors which may include but not limited to the following:

a. Perform a query of the NAIC Form A database on the name of the UCP, directors, executive officers, or owners of 10 percent or more of the voting securities of the applicant and perform the following step(s):

i. Assess the feasibility of the acquiring person's holding company structure including location and control (direct/indirect) of the target company post acquisition.

ii. Carefully scrutinize and understand complex organization and ownership structures.

1. Whether a simple corporate structure, or a unique or complex structure such as trusts, limited partnerships (LP) and limited liability corporations (LLC), review the ownership documents and agreements to understand the terms of the structure, each parties' rights and responsibilities conveyed by the agreement, who has responsibility for decisions and who controls the insurer. For LPs, also identify who has controlling interest in an LP's general partner and who has the right to unilaterally replace the general partner (if anyone). For trusts, also identify who has the ability to modify a trust.

2. For structures with complex or unique share classes and voting carefully review the voting and non-voting share classes rights and agreements to determine who has rights to control and vote to make decisions.

3. Request and review corresponding investment, management or operational agreements as necessary to determine if any delegate control or decision making to another specific person or entity.

b. Review other external sources to gain a better understanding of the acquiring persons, its affiliates, and the UCP.

c. Identify and review all relevant parties to the proposed acquisition and the nature of other filings made in other states by similar individuals.

d. Consider suitability of UCP through background review and regulatory review of the prospective new owners, using UCAA biographical affidavits and third-party background reviews by NAIC listed independent third-party reviewing companies or fingerprinting criminal checks if applicable and note any risks or concerns regarding competence, experience, and integrity of the applicant, as well as the results of any background investigation.

e. Does the Form A provide adequate background information (e.g., biographical affidavits including third-party background checks) on the applicant (if an individual) or all persons who are directors, executive officers, or owners of 10% or more of the voting securities of the applicant (if the applicant is not an individual)?

f. Review the lead state's assessment of the acquiring UCP's most recent ORSA Summary Report and information in the Group Profile Summary (GPS) regarding Form F, if applicable; to better understand the impact on risk assessment, risk appetite and tolerances, and prospective solvency (capital and liquidity).

g. Cross check the UCP with source of funds and consider debt funding sources.

g.h. Review and assess the UCPs ability to provide future capital support to the insurer, if needed.

i. Consider acceptability of SEC disclosures by board members of publicly traded UCPs in suitability review.

j. Review rating agency reports and public news sources to identify and assess comments or concerns, have been expressed regarding the acquiring entity (or group).

k. For non-U.S. acquiring parties: Carefully evaluate Form A applications and supporting documentation received from non-U.S. acquiring entities to understand its ownership structure and identify the UCP. Consider the following steps:

i. Carefully consider the impact of varying accounting and auditing standards utilized in other countries when evaluating financial data and results.

ii. Identify and investigate the nature and extent of government control over or involvement with the acquiring entity.

iii. Ask the parties involved in the transaction for the results of the Committee on Foreign Investment in the U.S. (CFIUS) review (if applicable).

iv. Communicate and coordinate with the group-wide supervisor regarding each jurisdiction's review of affiliated entity acquisitions, requesting assistance to verify biographical affidavits and understanding the roles, responsibilities, and expectations for post-acquisition solvency monitoring.

Purchase Consideration

7.8. Analyze the source, nature, and amount of consideration used (or to be used) in effecting the merger or acquisition of control and assess the ability of the entity to fund the insurance company.

a. Determine fairness (equivalency) of total amount to be paid to total value to be received, including derivation of price and value of target under standard valuation methodologies or to book value.

b. Consider quality of consideration, giving careful scrutiny to payments other than cash or cash equivalents which are disfavored particularly when any funds are being transferred to the target.

c. Consider fairness opinions and actuarial appraisals, if provided.

d. Consider source, type and valuation basis of funds to be used for consideration.

i. If funds are from a regulated entity, confirm the existence and valuation of such assets with that entity's regulator.

e. Where the applicant issues or assumes debt obligations or is required to fulfill other future obligations as a result of the purchase or through existing agreements, review the holding company's cash flow projections to ensure that cash flows appear adequate to cover such obligations without relying heavily on cash flows from the insurer.

f. Review dividend expectations and projections, including amounts expected to be paid from the insurer to the owner.

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

8.9. If amounts will be borrowed, consider the following:

a. Does the Form A describe the relationship between the borrower and lender, the amounts to be borrowed, and include copies of all agreements, promissory notes, and security arrangements relating thereto?

b. Does the Form A describe the nature, source, and the amount of funds or other consideration (e.g., pledge of stock, other contributions, etc.) used or expected to be used in effecting the merger or acquisition of control?

c. Does the Form A:

i. Describe any purchases of any voting securities of the insurer by the applicant, its affiliates, or any person during the 12 calendar months preceding the filing of the Form A.

ii. Describe any recommendations to purchase any voting securities of the insurer made by the applicant, its affiliates, or any person—or by anyone, based on interviews or the suggestion of the applicant, its affiliates or any person—during the 12 calendar months preceding the filing of the Form A.

iii. Describe the terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions, or other compensation to be paid to broker-dealers.

d. Perform additional review considerations as necessary to analyze the purchase conditions and implications of any debt financing, which may include, but is not limited to the following:

i. The mechanics of any debt financing to be used to fund the transaction, whether funds are being borrowed in the ordinary course of business or on terms that are less favorable than generally commercial loans.

ii. The percentage of debt versus non-debt funds to be used.

iii. The source of funds or stream of income to be used by parent for repayment and the ability of the acquiring party to repay the debt from sources other than the target.

iv. Identity of the creditor(s) and creditors' financial condition.

v. How will debt be secured; consider prohibiting securing of debt on shares of target or target's assets if not already prohibited by state statute.

vi. Compare time period of loan commitment with parent's income stream over the same time period, including the ability of the acquiring party to repay the debt from sources other than the target until loan is repaid/retired.

vii. Consider the long-term impact of parent's debt service on operations of the target company and group.

viii. Does the Form A explain the criteria used in determining the nature and amount of such consideration?

Market Impact

9.10. Is the acquisition of control likely to lessen competition substantially or likely to lead to a monopoly in insurance in the state? If "yes," has a Form E been filed?

10.11. Perform additional review considerations to analyze market impact, which may include, but is not limited to the following:

a. Consider anticompetitive impact of acquisition on lines or products. Disapprove transaction if completion will create a monopoly.

b. Consider Form E information and market concentration for combined lines and other appropriate information to assess market impact if warranted by nature of transaction, including coordination with other states where the target is admitted.

c. Consider imposing tailored conditions subsequent or undertakings as necessary to address competitive market concerns.

Record Maintenance and Conclusion

11.12. Respond as appropriate to questions from third parties and interested regulators and keep the acquiring party representatives informed as to status of the review.

12.13. Receive and consider any information provided by external sources, including possible financial or other incentives or motivation of those commenting on a particular transaction.

- File and maintain documents under state procedures

13.14. Has the application been publicized to all interested persons inside and outside of the insurance department, in accordance with the department's policy or applicable laws?

14.15. Perform any additional procedures, as deemed relevant, to evaluate the Form A application in accordance with the specific circumstances identified, which may include, but is not limited to, the following:

- Contact the insurer seeking explanations or additional information
- Obtain the insurer's business plan
- Meet with the insurer's management

~~15.~~16. Develop and document an overall summary and conclusion regarding the holding company Form A application.

- If application approval is deemed appropriate, consider whether any conditions precedent, specific ongoing stipulations or conditions subsequent should be included with the approval.

~~16.~~17. Add any material items from the Form A review to the Insurer Profile Summary.

Post-Approval

Post-Approval Considerations (if applicable)

~~17.~~18. Receive notification of changes to effective closing date.

~~18.~~19. Confirm compliance with conditions precedent.

~~19.~~20. Receive waivers for market conduct or financial examination.

~~20.~~21. Receive notification if transaction does not close and consider withdrawal of approval.

Post-Acquisition Considerations

~~21.~~22. Receive confirmation of the transaction following the closing, per your state's statutory requirement timeframe.

~~22.~~23. Request written details of the final purchase price after all adjustments are complete on the transaction.

~~23.~~24. Request confirmation of any capital contribution contemplated in the transaction. Request the names and titles of those individuals who will be responsible for the filing of the amended Insurance Holding Company System Annual Registration Statement.

~~24.~~25. Request an amended Insurance Holding Company System Registration statement per your state's statutory timeframe within each applicable state's statutory required timeframe after the close of the proposed transaction.

~~25.~~26. Consider requesting for a period of two years, commencing six months from closing, a semiannual report under oath of its business operations in your state, including but not limited to, integration process; any changes to the business of the Domestic Insurers; changes to employment levels; changes in offices of the Domestic Insurers; any changes in location of its operations in your state; and notice of any statutory compliance or regulatory actions taken by other state regulatory authorities against the acquiring parties or the Domestic Insurers.

~~26.~~27. Consider prior approval of all dividends for a two-year period from the close date.

~~27.~~28. If concerns are identified during the post-acquisition review, consider the following actions:

- Conduct a target financial and/or market conduct examination
- Hold a meeting, conference call or requesting additional information from the insurer or applicant

- Require additional interim reporting from the insurer
- Obtain a corrective plan from the insurer

Post-Closing Monitoring:

Consider monitoring the following after the close of the acquisition.

28.29. Confirm ongoing compliance or satisfaction with any other conditions subsequent, or undertakings or other expectation and stipulations that were set as part of the Form A approval.

29.30. Monitor target's market performance to projections two years after transaction close date.

31. Ongoing commitments and capital support to the insurer from the new owner.

32. Review of subsequent Board minutes.

33. Specific to an international acquisition:
    a. Monitor the Board and the International UCP's involvement and influence over the U.S. operations
    b. Assess the implementation of how the U.S. business is incorporated into or decentralized from the non-U.S. operations
    c. Access to the Group ORSA (as opposed to the US ORSA)
    d. Actively participating in supervisory colleges and other international coordination efforts to evaluate the solvency position of the acquiring entity/group as appropriate.

34. Monitor the ongoing financial condition of the acquiring entity/group by:
    a. Comparing actual results to pre-transaction projections to determine whether results of the acquisition/merger are meeting expectations. If not, gain an understanding of why projections have not been achieved and the company's planned actions to address issues.
    b. Requesting and reviewing information on the integration of company processes and systems (if applicable), as well as steps taken to ensure that adequate cybersecurity precautions are taken during the integration process.
    c. Reviewing the impact of the acquisition on the risk profile of the insurer and assessing whether it has been incorporated into the group's ERM, ORSA and Form F reporting, including the overall assessment of group risk capital.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the review of the Form A.

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

- Contact the insurer seeking explanations or additional information
- Require additional interim reporting from the insurer
- Meet with the insurer's management
- Other (explain)

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

Non-Lead State Holding Company System Analysis Procedures

Note: This Handbook guidance does not supersede state law and regulation but is merely additional guidance and best practices that analysts may consider useful. This guidance and accompanying procedures may be used in part, or in total, at the discretion of the analysts depending on the level of concern, and the area in which the risk was identified.

Commented [Staff1]: Added this note in response to comments for consistency with the Procedures chapter.

Refer to section VI.C. Group-wide Supervision - Insurance Holding Company System Analysis Guidance (Lead State) for additional guidance on holding company analysis procedures.

Forms A, B, D, E (or Other Required Information), and Extraordinary Dividend/ Distribution

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

Form A – Statement of Acquisition of Control of or Merger with a Domestic Insurer

The *Insurance Holding Company System Regulatory Act* (#440) outlines specific filing requirements for individuals wishing to acquire control of or merge with a domestic insurer. Form A is filed with the domestic state of each insurer in the group. Every attempt should be made to coordinate the analysis and review of holding company filings among all impacted states and other functional regulators to avoid duplicate processes. The domestic state or lead state should communicate the filing with all impacted states.

The period for review and action on proposed affiliations for transactions falling under the Gramm-Leach-Bliley Act (GLBA) is limited to 60 days prior to the effective date of the transaction. Under GLBA Section 104(c)(2), the states have a 60-day period preceding the effective date of the acquisition, change, or continuation of control in which to collect information and take action. Individual state statutes and regulations may or may not impose other time limitations on the review period.

Form B – Insurance Holding Company System Annual Registration Statement

Model #440 defines insurance holding companies and the related registration, disclosure, and approval requirements. Form B is the insurance holding company system annual registration statement. Model #440 requires every insurer, which is a member of an insurance holding company system, to register by filing a Form B within 15 days after it becomes subject to registration, and annually thereafter. Any non-domiciliary state may require any insurer that is authorized to do business in the state, which is a member of a holding company system, and which is not subject to registration in its state of domicile, to furnish a copy of the registration statement.

An insurance holding company system consists of two or more affiliated individuals, one or more of which is an insurer. An affiliate is an entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, another entity. Control is presumed to exist when an entity or person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies, representing 10% or more of the voting securities. The review of Form B should be completed by Oct. 31st for analysis conducted by a lead state and by Dec. 31st for analysis conducted by a non-lead state.

Form D – Prior Notice of a Transaction

Model #440 requires each insurer to give notice of certain proposed transactions. Form D must be filed with the domestic state. Material transactions include but are not limited to sales, purchases, exchanges, loans, extensions of credit, guarantees, investments, reinsurance, management agreements, service agreements and cost-sharing agreements. The transaction is considered material if for non-life insurers, it is the lesser of 3% of the insurer's

admitted assets or 25% of surplus, and for life insurers, 3% of the insurer's admitted assets, each as of the most recent prior Dec. 31. Some states have stricter definitions of materiality in their holding company regulations.

Holding company regulations require that affiliated transactions be fair and reasonable to the interests of the insurer. Generally, affiliated management or service agreements should be based on actual cost in order to meet the fair and reasonable standard.

The appropriate Statement of Statutory Accounting Principle should be reviewed within the NAIC *Accounting Practices and Procedures Manual* to ensure proper accounting.

Form E (or Other Required Information) – Pre-Acquisition Notification Form Regarding the Potential Competitive Impact of a Proposed Merger or Acquisition by a Non-Domiciliary Insurer Doing Business in This State or by a Domestic Insurer

Model #440 mandates that any domestic insurer, together with any person controlling a domestic insurer, proposing a merger or acquisition to file a Form E (or Other Required Information), pre-acquisition notification form. Any differences between Model #440 and the applicable state regulations should be considered. As state requirements for Form E vary, in many states the Form E or other required information is filed to the non-domestic regulator. The insurer may also be required to file documents with the Federal Trade Commission under the Hart-Scott-Rodino Act.

The period for review and action on proposed affiliations for transactions falling under the GLBA is limited to 60 days prior to the effective date of the transaction. Under GLBA Section 104(c)(2), the states have a 60-day period preceding the effective date of the acquisition, change, or continuation of control in which to collect information and take action. It may not be mandatory for some states to approve or disapprove the Form E (or Other Required Information). These states may only have a certain period of time that an insurer's license to do business in the state is denied or a cease and desist order is put into effect.

Extraordinary Dividend/Distribution

Model #440 indicates that any domestic insurer planning to pay any extraordinary dividend or make any other extraordinary distribution to its shareholders receive proper prior regulatory approval. The insurer is required to wait 30 days after the commissioner has received notice of the declaration and has not, within that period, disapproved the payment or until the commissioner has approved the payment within the 30-day period.

Each state has its own definition of "extraordinary"; however, Model #440 defines an extraordinary dividend or distribution as any dividend or distribution of cash or other property, whose fair value, together with that of other dividends or distributions made within the preceding 12 months, exceeds the lesser of:

- 10% of the insurer's surplus as regards to policyholders as of Dec. 31 of the prior year; or
- For life insurers, net gain from operations and for non-life insurers, net income, excluding realized capital gains for the twelve months ending Dec. 31 of the prior year. This should not include pro-rata distributions of any class of the insurer's own securities.

Form A – Statement of Acquisition of Control of or Merger with a Domestic Insurer

Determination of the Ultimate Controlling Person (UCP)

For all ownership structures, when reviewing Form A applications, it is most important for the analyst to understand the terms of the ownership documents, whether traditional stock ownership or other unique or complex ownerships structures such as trusts, limited partnerships, limited liability corporations, international owners, or structures with unique share classes and voting rights. Certain agreements within the structure may convey control through unique share classes and voting rights, or through certain management or operational agreements that delegate decision making and control to a specific person or entity. For all of these structures

and unique situations, it is important to identify an individual ultimate controlling person (UCP) at the top of the organizational structure, i.e., to trace the ownership/control to the top person/entity. It is at the UCP level that financial statements and other insurance holding company filings will be submitted to the department.required to be submitted to the department, although other controlling entities (e.g., minority owners) may also be asked to provide such information when appropriate.

The state insurance department should engage the state's legal staff and other necessary internal or external expertise early in the Form A review process to assist in the review of organizational documents and agreements and in the determination of the UCP.

Review Procedures

PROCEDURES #1-2 provide instructions for the initial review of the Form A including determining if the filing is complete, establishing communication and coordination with other states and functional regulators, and updating the NAIC Form A database. States should enter the high-level information about Form A filings into the NAIC Form A Database as well as update the Form A Database with changes in status. The Form A Database allows regulators to communicate high-level information of a filing, as well as share contact information and comments on a filing. States are encouraged to use Personalized Information Capture System (PICS) alerts to notify them of Form A Database entries and updates. Such alerts would highlight any potential addition or deletion of any insurer to a Group. Contact information for the lead analyst/supervisor/chief, as applicable, responsible for the Form A review at each insurance department, as well as contact information for other functional regulators involved should be distributed to all regulators involved.

PROCEDURES #3-4 provide steps for reviewing the details of the transactions to ensure that the Form A filing is in compliance with application requirements. The procedures also suggest additional considerations and assessment of any risks and concerns regarding items such as future financial solvency of the insurer, its ability to continue to satisfy the requirements of its license, sufficiency of surplus, financial projections, debt support, suitability of affiliated agreements, technology interfacing, and dividends.

PROCEDURES #5-67 assist analysts in reviewing the background and financial information provided in the Form A application to identify the UCP, and on the ultimate controlling person (UCP) to ensure that the Form A filing is in compliance with application requirements. Additionally, the procedures provide for review considerations of the UCP, Officers and Directors.

PROCEDURES #7-8-9 provide steps to ensure that information provided on purchase considerations in the Form A filing is in compliance with application requirements. In addition, the steps provide guidance for assessing the purchase considerations including source of funds & consideration, debt financing, and voting securities.

PROCEDURES #9-10-11 provide steps for assessing the impact of the acquisition on the insurance market, any concentrations/monopolies, anticompetitive impacts, and including consideration of the review of Form E-Pre-Acquisition Notification Form.

PROCEDURES #121-176 provides steps for completion of the approval or denial of the Form A application and developing an overall conclusion regarding the Form A.

POST-APPROVAL PROCEDURES #187-2934 provide administrative steps for the conclusion of the Form A approval process as well as analytical steps for post-acquisition financial solvency analysis and compliance review. It is important for the department to conduct follow-up analysis and/or examination to ensure that stipulations or conditions of the acquisition approval have been met, that actual results are in line with the financial projections, business operations and strategy of the insurer that were provided with the Form A, and if not, to understand the reasons for variances.

General Statutory Standards and Risk Assessment for Form A Review

When performing the procedures listed above, it is appropriate to first consider the general statutory standards that regulators must apply in consideration of a Form A, namely that:

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

Although these are the general statutory standards that apply, analysts may need to think more broadly when considering whether these standards have been met. The point of this suggestion is to consider all aspects of the financial condition of the acquiring entity including the acquiring entity's group business model, its strategy in general and its specific strategy in purchasing the insurer, as well as any assumptions used by the acquiring entity in its evaluation of the benefits of the proposed transaction. Understanding these aspects of the proposed transaction should assist analysts in reaching a recommendation related to the proposed transaction.

Analysts are already required in other areas of this handbook to consider the prospective risks of any domiciled insurer as they perform their annual analysis and ongoing financial solvency oversight of the insurer. This also includes considering the financial condition of the entire holding company structure as defined within state law and discussed separately within this Section VI. Therefore, as analysts consider the application for change in control, it may be appropriate to consider the risks of the acquiring entity and the entire group of affiliated insurers and non-insurance affiliates under its control. In so doing, analysts should consider the group's exposure to branded risk classifications.

Branded Risks: In considering exposure to branded risk classifications, the issues of legal risk and reputational risk are generally well incorporated into the Form A application and its review. Many of the other risks (pricing and underwriting and reserving) tend to be most concentrated in the area of the insurers and therefore in these cases, it is reasonable that analysts initiate conversations with regulators of existing insurers in the applicant's group (domestic states or foreign jurisdictions) to determine if there are any concerns in these areas. However, the proposed transaction may put additional pressure on the insurer and the group from the standpoint that it may increase the leverage (operating or financial) which has the potential to increase the risks in each of these areas. The Form A application already contemplates obtaining proforma results for the insurer and the group. As analysts review proposed transaction, they may want to consider requesting additional information related to such proformas, such as how such results, and perhaps key ratios (e.g., operating or leverage) may look under certain feasible stress scenarios, particularly those that can be the most problematic for the group given its existing products or those included in its proposed business plan. However, stress scenarios should be evaluated in the context of how the company, as currently configured, would perform under the same stress scenarios. This may also be helpful in further assessing credit, market or liquidity risk. The results of such stresses should not be overemphasized, but should be considered when evaluating whether the proposed transaction meets the previously mentioned criteria. Such an analysis may also be helpful in evaluating the strategic risk of the company and the group. However, strategic risk may be difficult to evaluate without additional information beyond the proforma financial statements. This is because the proforma financial statements may not reveal enough information to permit analysts to evaluate the ability of the group to execute its business plan.

Non Insurance Affiliate Risks: More often, the risks that may be most difficult to discern are those that may exist within non-insurance affiliates because such entities may be unregulated, thereby eliminating the ability to obtain information from another regulator as can be done with insurers. Generally speaking, such non-insurance affiliates will not carry pricing and underwriting and reserving risks because those risks tend to be thought of as insurance risks. Those affiliates may however have other comparable risks, (or unrelated risks) that may be evident from a

review of the proforma information. In particular, something that may not be captured in the proforma information is the other types of risks not already discussed which include or pertains to credit, market and liquidity. For some non-insurance affiliates, these risks can be more pronounced, or at least by comparison to the relative risk from the insurers within the group because state investment laws may serve as a deterrent to excessive amounts of such risks. Consequently, in addition to considering the information provided in proforma financial statements and even stressed proforma financial statements, analysts may need to obtain additional information in order to evaluate whether the proposed transaction meets the four previously identified general standards. In order to evaluate credit, market and liquidity risk, analysts should evaluate the potential enterprise risks posed to the insurer from other non-insurance affiliates, and may need to request information regarding the investment portfolio of the entire group. In all cases where information is sought relating to non-insurance affiliates, controlling individuals and other equity holders, care should be taken to ensure that confidentiality of such information can be appropriately protected.

In some cases, this may require more detailed information regarding investments such as LLCs, equity and other fund holdings and other invested assets (BA for insurer). In cases where the investment portfolio appears to be complex, analysts may need to consider engaging an investment specialist and actuary to review the entire proposed transaction to determine if the investment strategy and related affiliated agreements are appropriate or not excessively risky for the backing of the insurance contracts from a risk and asset/liability matching perspective, respectively.

Such a review would consider the reasonableness of equity firm fees and other fee structures, if any, charged or to be charged to the insurance company, as well as any similar arrangements, proposed or existing, between the insurance company and affiliated broker-dealers. Unreasonable charges to the insurance company is a particular risk that can be common in many different types of holding company structures. Because of this risk, states may need to look to authority within their holding company laws to review and deny transactions that have the potential to excessively charge the insurer for certain services and transactions if the costs are not excessive in comparison to costs for a similar transaction with a non-affiliated entity. Prior to agreeing to the proposed Form A, it may be appropriate to consider whether such contracts exist and to review them.

Analysts should also consider reviewing arrangements with parties that may not be affiliates by definition, but may be parties that appear to be engaging in a manner that is similar to an affiliate. The primary concern is whether these arrangements could be excessively charging the insurer for certain services. Another concern includes the creation of relationships that are used to prevent full disclosure of the entirety of activities within the holding company structure. Again, in many cases the primary concerns with a proposed transaction may be derived from the credit, market and liquidity risk of the non-insurance affiliates (or related strategic risks), and this type of analysis may be necessary in cases where these risks may pose enterprise risks to the insurer. Further analysis of these presumably unrelated party transactions may be necessary to determine if the risks of the non-insurance affiliates may pose enterprise risks that may affect the insurer.

In many cases, provided the application includes information on the overall investment portfolio, it may be unnecessary to seek more detailed information and to perform a more detailed review by an investment specialist. In many cases, providing a five-year plan of operation may be sufficient. This type of plan can also be helpful in mitigating the need for future detailed information on the group's investments when investments, reinsurance or other items are not a concern, or do not change materially.

Conditions and Stipulations for Form A Approval

After considering all of the risks of the proposed transaction, analysts and the states may determine that the proposed transaction either meets the general standards previously referred to, or can be met with the addition of certain stipulations agreed to by the acquiring entity. These stipulations can include such things as those listed below:

Stipulations for limited period of time:

- Requiring RBC to be maintained at a specified amount above company action level/trend test level. Because capital serves as a buffer that insurers use to absorb unexpected losses and financial shocks, this would better protect policyholders.
- Requiring quarterly RBC reports rather than annual reports as otherwise required by state law.
- Prohibiting the insurer from paying any ordinary or extraordinary dividends or other distributions to shareholders unless approved by the Commissioner.
- Requiring a capital maintenance agreement from or establishment of a prefunded trust account by the acquiring entity or appropriate holding company within the group.
- Enhancing the scrutiny of operations, dividends, investments, and reinsurance by requiring material changes in plans of operation to be filed with the commissioner (including revised projections), which, at a minimum, would include affiliated/related party investments, dividends, or reinsurance transactions to be approved prior to such change.
- Requiring a plan to be submitted by the group that allows all affiliated agreements and affiliated investments to be reviewed, despite being below any materiality thresholds otherwise required by state law. A review of agreements between the insurer and affiliated entities may be particularly helpful to verify there are no cost-sharing agreements that are abusive to policyholder funds.

Continuing stipulations:

- Requiring prior Commissioner approval of material arms-length, non-affiliated reinsurance treaties or risk-sharing agreements.
- Requiring notification within 30 days of any change in directors, executive officers or managers, or individuals in similar capacities of controlling entities, and biographical affidavits and such other information as shall reasonably be required by the commissioner.
- Requiring the filing of additional information regarding the corporate structure, controlling individuals, and other operations of the company.
- Requiring the filing of any offering memoranda, private placement memoranda, any investor disclosure statements or any other investor solicitation materials that were used related to the acquisition of control or the funding of such acquisition.
- Requiring disclosure of equity holders (both economic and voting) in all intermediate holding companies from the insurance company up to the ultimate controlling person or individual, but considering the burden on the acquiring party against the benefit to be received by the disclosure.
- Requiring the filing of audit reports/financial statements of each equity holder of all intermediate holding companies, but considering the burden on the acquiring party against the benefit to be received by the disclosure.
- Requiring the filing of personal financial statements for each controlling person or entity of the insurance company and the intermediate holding companies up to the ultimate controlling person or company. Controlling person could include for example, a person who has a management agreement with an intermediate holding company.

With respect to the above, although each has its own limitations, they may provide additional assurances. For example, a capital maintenance agreement has a number of pros and cons, but, regardless it can simply raise awareness to the ultimate controlling party of the need to be a good corporate citizen.

Post Approval Review

Even after the proposed transaction has been approved, or approved with stipulations, it may be appropriate to use existing authority to perform either an annual or otherwise targeted examination of certain risks or use of ongoing (e.g., quarterly) conference calls or meetings to ascertain whether the proposed transaction and the business plan are being executed as anticipated. These are not things that would be done all the time, but only where necessary to give regulators the appropriate comfort level.

During such an examination or meeting, analysts may want to consider (as an example) any of the following procedures, using a specialist where deemed appropriate:

- Examining the insurer and its affiliates to ensure that the investment strategy provides a prudent approach for investing policyholder funds or does not create excessive contagion risk.
- Requiring ongoing annual stress testing of the insurer and the group in accordance with existing laws and regulations. This includes stress testing not only the investments but also the policyholder liabilities to ensure that the assets and liabilities continue to be properly matched.
- Conducting periodic and possible ongoing review of the investment management and other affiliated agreements, including a review of the equity firm fees and fee structure charged or to be charged to the insurer, if any, as well as arrangements with intercompany broker to ensure that they continue to be fair and reasonable. Also examine the flow of funds related to such agreements.
- Coordinating a meeting with multiple regulators and even all states to the extent there is a need for all regulators to better understand the business plan and operations of the group.
- Coordinating an examination with another regulator of a non-affiliated insurer where the direct writer has ceded a material portion of its risk to a separately controlled insurer.

Lead State Role in Form A Reviews and Disclaimers of Control/Affiliation

The lead state(s) or designee should assume the role of the coordinator and communication facilitator in a Form A and disclaimers of control/affiliation review. The lead state(s) should serve as the facilitator and central point of contact for purposes of gathering and distributing information to all regulators involved. If the lead state(s) delegate this responsibility to another domestic state within the group, all regulators, domestics and licensed states should be informed.

In identifying the UCP, the lead state should lead a discussion among the domestic states regarding who should be identified as the UCP, and therefore the person/entity primarily responsible for making insurance holding company filings. The lead state and the domestic states should come to an agreement as to who is the UCP and who is disclaimed from control (if anyone).

Where disclaimers of control/affiliation have been filed in multiple domestic states for insurers in the group, the lead state should coordinate the communication of disclaimers received, each state's review and approval/denial of the disclaimer, as well as coordinate discussions on any conditions and stipulations being considered on disclaimer approvals. The lead state should lead a discussion among the domestic states regarding each states' decision on any disclaimers that are allowed and at what percentages of control those disclaimers were allowed.

The lead state(s) or designee should schedule regular conference calls or arrange for regular e-mail communications, as deemed necessary, to receive and share status updates from each regulator involved. As many states have strict timeframes within which to complete reviews and schedule hearings, the frequency of conference calls and other communication will depend on the timelines of the particular states involved and the

sensitivity of the transaction. Additionally, regulators can share comments regarding a filing in the Form A Database. The lead state(s) or designee should compile questions and issues identified by all domestics, licensed states and functional regulators in an unbiased manner in order to coordinate the resolution of the answers to the applicable parties and reduce duplicative requests.

Review results, either internally prepared or work performed by hired consultants, or information collected by a state should be shared between the applicable regulators, where permissible. Collaborative sharing of information during the review process will reduce duplicative efforts and costs for both regulators and insurers. If the use of consultants is deemed necessary, regulators should consider coordinating the selection of the consultant and agree to share the work product of the consultant.

The lead state(s) or designee should coordinate a consolidated public hearing, if deemed necessary by the lead state as set forth in the *Insurance Holding Company* Model *Act* (#440) §Section 3(D)(3). Refer to the state's laws regarding public hearing requirements.

Merger(s) or consolidation of two or more insurers within the same Holding Company System (Section 3(E) (1))

To the extent that the merger or consolidation transaction is subject to prior approval filing under other laws of the states in which the merger/consolidation entities are licensed, the merger or consolidation is exempted from filing under the Holding Company Act.

Merger or consolidation of entities of an insurer with one or more non-insurers or insurance entities. The domestic regulator should have a clear understanding of the merger or consolidation with the following documentation requested from the insurer:

- Nature of and the reason for merger/consolidation
- Evidence relating to why the merger/consolidation is fair and reasonable
- Operational and financial impact of the merger/consolidation transaction to the domestic insurer
- If subject to oversight by another functional regulator, seek material solvency concerns or regulatory concerns affecting the domestic insurer(s) or the holding company system
- If the non-insurer is subject to oversight by another functional regulator, evidence of communication and approval of the transaction by the functional regulator

Acquisitions of Control Exemption

The general premise of the exemption provision applicable under Section 3(E) (2) for acquisition of control of an insurer within the same Holding Company System assumes minimal impact upon the insurer on the acquisition. Such assumptions should include the considerations that:

- The ultimate controlling person of the insurer being acquired remains the same
- No debt, guarantee, or other liability incurred as related to the transaction
- No significant impact upon the financial position and operations of the insurer

However, there must be a need for the acquisition of control to take place. The emphasis may not be the insurer being acquired, but the entity that is acquiring the insurer. The holding company restructure may be related to strengthen the financial position of the acquiring entities by reallocation of the stock ownership of the insurer to

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the acquiring entity in lieu of any cash contributions. Or the holding company restructure is to realign companies in preparation for sale of the insurer.

The domestic regulator of the insurer being acquired should request the following documentation:

- Nature of the acquisition
- Consideration of the acquisition
- Organizational chart – pre and post acquisition
- Operational and financial impact of the acquisition of both entities
- 3-year financial projections for the insurer
- Most recent audited financial statements of the acquiring entity
- Discussion of any anticipated changes to affiliated agreements
- If the entity acquiring the insurer is subject to oversight by another functional regulator, evidence of communication and approval of the transaction by the functional regulator.
- Biographical affidavits of all officers and directors of the acquiring entity and any intermediary company(s), to help ascertain the competence, experience and integrity of these individuals.
- All of the actual documents to be executed related to the acquisition.

Standards of Management of an Insurer Within a Holding Company System

Form A Exemptions

The following are suggestions for additional oversight when considering an exemption under Model #440 Section 3E (2) of the Holding Company Act. Specifically, the following should be considered when reviewing an exemption pertaining to investment managers/advisors that hold proxies directly or indirectly which may have more than 10% control.

Reputational Risk – Market Disruption Regarding 10% Investor Limitation

An investor with a large percentage of Holding Company stock may be entitled to divest significant shares, therefore driving the stock price down. This may cause a drop in the confidence levels of investors and policyholders and may also lead to ratings downgrades (if in combination with other issues).

Best Practices

- Although an exemption from change in control of over 10% may be contemplated for a "fund manager," consideration should be given to limit the stock ownership by an individual or group of mutual funds or commonly-managed companies to no greater than 9.9%.
- As part of the review process, obtain written confirmation of the percent limitation in individual mutual funds.
- The domestic insurer's awareness of the exemption request.
- The request does not violate the domestic insurer's bylaws.

Operational Risk – Ability to Influence Management and Policy Decisions

An investor with a large percentage of Holding Company stock may inherently have the ability to influence management and policy.

Best Practices

- Upon reviewing the exemption from change in control, the regulator should inquire not only about the ability of the investor to obtain a board seat, but also about the ability of the investor to become a "non-voting observer" on the board. Holding Company board controls should be firmly in place to assure that "influencing policy and management decisions" cannot occur.
- Board governance should be reviewed.

Financial Risk – The Financial Condition of Holding Company and Insurer Deteriorates

Reputational and operational risk (discussed above) can lead to financial risks.

Best Practice

The approval of the exemption from change in control should include a requirement that the State receive an attestation from the investor stating when there are changes in investing philosophy.

Disclaimer of Control/Affiliation

Model #440

Section 1C of Model #440, outlines the definition of control, which broadly includes "… the power to direct or cause the direction of management and policies of a person…" as follows. By this definition, control may include other situations beyond the presumed control of 10% ownership of voting securities.

> *Model #440 Section 1. Definitions. C. "Control." The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by Section 4K that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.*

Commented [Staff2]: This addition (grey highlight) is added in response to comment letters. The definition of control in Model 440 broadly encompasses situations of control other than the presumed 10% of voting shares.

Section 4K of Model #440 outlines specific requirements for filing a disclaimer of affiliation by the insurer or any member of the insurance holding company system.

> *"Disclaimer. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved."*

Considerations

Consideration should be given to situations where a disclaiming party may directly or indirectly possess the power to direct or cause the direction of the management and policies of the insurer exert influence or control over the insurer This may include situations such as:

- over management decisions, or the operations of the insurer; where there is a minority owner;
- where lending agreements may result in ownership of the insurer in the event of default;
- where non-voting shareholders have protective rights affording them the opportunity to acquire control in certain circumstances; any non-voting arrangement or contract that may convey an element of control (e.g., investment management, reinsurance, administrative service, employment); or
- passive investment companies with more than 10% ownership of voting shares within funds they manage, where the actions and activities do not support that the investment company's assertion that it does not exert control. Actions asset managers take in the ordinary course of their advisory services, such as engagement with management and proxy voting, should not be viewed as actions and activities that indicate exerting influence or control for these purposes.

These are only a few examples of situations that may require additional inquiry and a deeper review of the disclaimer application to determine if control exists, if the disclaimer should be approved or denied, or if any conditions or stipulations should be placed on the approval. The burden of proof is on the applicant to demonstrate they do not have control or affiliation.

Passive Investors

Note that the purchase of equity securities or debt securities by passive investors, such as institutional investors, regulated funds and fund advisors, do not typically result in control of the insurer. These types of investors typically purchase equity securities on the open market or purchase debt securities through offerings where terms are standardized for all investors. It is only where evidence exists that a passive investor may be engaged in actions and activities beyond passingly monitoring their investment their ordinary course of business, when further inquiry and review by the state insurance department may be necessary.

Where these types of passive investors are regulated by the SEC, additional reporting is required to the SEC, such as proxy voting disclosures. Where the insurer's equity is registered with the SEC, the analyst should determine if the investor has filed a Schedule 13G[1] with the SEC. Institutional investors file publicly available beneficial ownership reports with the SEC on Schedule 13G when acquiring SEC registered securities exceeding 5% of a company's total stock issue in the ordinary course of business and not with the intent nor with the effect of influencing control of the issuer. However, note that SEC Schedule 13D is required to be filed where investors acquire more than 5% beneficial ownership of a class of registered equity securities and who have the purpose or effect of changing or influencing the control of the issuer, in which case additional and more timely reporting to the SEC is required. Additionally, for passive investors, analysts should consider if the investment includes prohibitions on board representation and prohibitions on proxy solicitations as further evidence the investment does not represent control.

Best Practices Other Considerations

- Consider state laws that require limitations on investments, which (e.g., three-year waiting period). These laws could vary by state. It is recommended that domestic states communicate and collaborate to reach an agreement on the approval of the disclaimer and the percentage limitation.

[1] Refer to the Securities and Exchange Commission Act of 1934, Section 13G and Section 13D, for more detail.

Commented [Staff3]: Edited to match the language in Model 440.

Commented [Staff4]: Added sentence from Sifma comment letter.

Commented [Staff5]: Added this section in response to Capital Group's, ICI, and Sifma's comment letters.

Commented [Staff6]: Edit from ICI accepted on the FASTWG call.

Commented [Staff7]: Edited in response to comment from Sifma.

- Monitor annual financial statements for minority ownership and disclaimer disclosures in Schedule Y, Part 3.
- If the disclaimer approval includes stipulations or conditions, consider the following:
  - In situations where ownership percentages may fluctuate, require a condition whereby the disclaiming party must reapply for the disclaimer if the percentage ownership exceeds a specified percentage.
  - ~~Require 30-day notice to the Department if a "passive owner" is acting counter to management recommendations for proxy voting.~~
  - Require that the domestic insurer is responsible for notifying the Department if any of the conditions/stipulations in the disclaimer approval are violated.
  - Include in the disclaimer approval letter what the consequences will be for violating the conditions/stipulations (e.g., the disclaimer would be rescinded).
  - If a disclaimer is requested for tax purposes and is relied upon by the tax authority (or similar situation where the Department has concerns that another regulatory authority may be unduly relying on the disclaimer), consider including a statement in the disclaimer approval letter that makes it clear that the approval is for state insurance law purposes only.
- In situations such as reinsurance side car or other similar arrangements where a third party appears to have influence through operational management, investment management or other agreements (e.g., the disclaimer is requested for tax purposes):
  - With regard to investment management agreements, consideration should be given to agreements with non-customary terms that extend beyond advisory services and into broader influence over the insurer's business such as termination provisions that would be onerous and implausible in practice, authority over the insurer's strategy and implementation for managing its assets, or an affiliated adviser becoming intertwined in the insurer's business operations.
  - As part of the approval of the disclaimer, if concerns are identified, consider requesting ~~require~~ the service agreements between the domestic insurer and the third party be submitted for Department review ~~approval~~ (not including all holding company filings).

Commented [Staff8]: Deleted in response to Capital Group and Sifma and ICI comment letters.

Commented [Staff9]: Added 1st bullet in response to Sifma comment letter. Edited 2nd bullet in response to Capital Group comment.

Inquiries to the Applicant

The following provides guidance on additional inquiries the regulator may make of the applicant(s) to gain a better understanding when reviewing disclaimers of control/affiliation.

1. Request any additional information needed to effectively evaluate the disclaimer application. Consider if sufficient information has been provided to understand the relationship of the disclaiming party.
2. Ensure the applicant addresses Board of Director membership, management positions, covenants in lending agreements (including a copy of the lending agreement), organizational charts to understand relationships, and material relationships that are in place with the company (e.g., consulting).
3. Ask for information about commitments regarding voting stock.
4. Ask the applicant(s) whether they have any agreements or understandings with any other individual or entity, written or verbal, limiting their control of the insurer.

Post-Disclaimer Considerations

Commented [Staff10]: Edited in response to Sifma comment.

The following are examples of considerations a state may deem appropriate after a disclaimer has been approved, dependent on the facts and circumstances of the approval.

- Additional disclosure requirements may be requested on an ongoing basis which may be part of the disclaimer approval.
- Review and monitor the Financial Statement for minority owner and disclaimer disclosures to make sure they are reporting Schedule Y Part 3 correctly.
- Consider if the disclaimer has an impact on who is designated the lead state for the group and therefore which state will perform holding company analysis in the future.
- The disclaiming person/entity~~should~~ may be asked to:
    - Provide notice before taking action on any of the rights and privileges of the non-voting shares.
    - Provide notice before transferring non-voting shares.
    - Provide notice before taking any position at the insurer or its affiliates.
    - Notify the state insurance regulator if the facts and circumstances for which the approval of the disclaimer was based on change~~, they must notify the state insurance regulator~~.
- Perform a review of annual statement related party disclosures (e.g., Schedule Y, Notes to the Financials, and the electronic column of the investment schedules) to ensure that despite the approval of a disclaimer of affiliation, the insurer is correctly reporting any disclaimed party as a related party for material transactions pursuant to SSAP No. 25.

August 30, 2024

Mr. Greg Chew, Chair
Financial Analysis Solvency Tools (E) Working Group
National Association of Insurance Commissioners (NAIC)
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Attn: Mr. Rodney Good, NAIC Support Staff via electronic mail filing

Re: July 16, 2024, Financial Analysis Handbook Exposures

Dear Mr. Chew:

UnitedHealthcare (UHC) appreciates the opportunity to provide comments in response to the proposed revisions to the Financial Analysis Handbook ("Handbook") exposed during the recent conference call held on July 16, 2024. Our comments focus only on the additions proposed to the ORSA Guidance and Form F Exemptions section of the Handbook.

UHC believes that the proposed updates are redundant to current guidance already in the Handbook and, in some instances, appear to be too prescriptive taking away the ability of a company to assess its "own" risk and solvency.

The Handbook in its current form gives the analyst adequate instruction and authority to ask the insurer or group about any risk factor in the following excerpts:

- *Review of Section II - Insurer's Assessment of Risk Exposure*
  "...The ORSA Guidance Manual and relevant material risk categories (e.g., credit, market, liquidity, underwriting, and operational risks)...In reviewing the information provided in this section of the ORSA, lead state analysts may need to pay particular attention to risks and exposures that may be emerging or significantly increasing over time."

- *Discussion of Capital Metrics Used*
  "...Discuss the method(s) used by the group in assessing group risk capital and their basis for such a decision. Identify the capital metric(s) used to estimate group risk capital, as well as the level of calibration selected... Discuss whether the capital metric(s) selected address all key risks of the group... Document the extent to which the lead state analyst believes the approach used by the insurer is reasonable for the nature, scale and complexity of the group and if this has any impact on the lead state analyst's assessment of the insurer's overall risk management..."

- *Impact on Stresses on Group Risk Capital*
  "...Evaluate the range and adequacy of any stress scenarios applied and the resulting impact on the group's ability to accomplish its business strategy, provide sufficient liquidity and meet the capital expectations of rating agencies and regulators..."

- *Overall Section III Assessment*
  "In addition, after summarizing the assessment of each individual element above, the lead state analyst should provide an overall assessment of the insurer's risk capital assessment process, including any concerns or areas requiring follow-up investigation or communication. The overall evaluation should focus on critical concerns associated with any of the individual elements noted above and should also address any other risk capital assessment concerns that may not be captured within these principles."

Additionally, the Handbook suggests that an insurer is expected to focus on risks it sees as material to its business instead of focusing on risks that are not material to its business. The following excerpt guides the analyst in this regard, including suggesting that the analyst consider if there are "material gaps":

- *Review of Section II – Insurers Assessment of Risk Exposure*
  "...Section II provides risk information on the entire insurance group, which may be grouped in categories similar to the NAIC's nine branded risk classifications. However, this is not to suggest the lead state analyst or lead state examiner should expect the insurer to address each of the nine branded risk classifications. In fact, in most cases, they will not align, but it is not uncommon to see some similarities for credit, market, liquidity, underwriting and operational risks. A fair number of insurer risks may not be easily quantified or are grouped differently than these nine classifications. Therefore, it is possible the insurer does not view them as significant or relevant. The important point is not the format, but for the lead state analyst or lead state examiner to understand how the insurer categorizes its own risks and contemplate whether there may be material gaps in identified risks or categories of risks..."

Because the Handbook currently includes the excerpts outlined above, UHC does not believe that the changes/additions to the Handbook around liquidity risk are needed and take away the ability of a company to assess its own risk and solvency as contemplated by the NAIC Risk Management and Own Risk and Solvency Assessment Model Act.

Thank you for your consideration of these comments. If you have any questions or need additional information, please contact me at Jeffrey_K_Martin@uhc.com or (813) 890-4569.

Respectively,

Jeff Martin
Director, NAIC Policy
UnitedHealthcare
Regulatory Financial Operations

Cc: Mollie Zito, UnitedHealthcare
Michael Barton, UnitedHealth Group
Kevin Ericson, UnitedHealthcare

Introduction

The process for assessing enterprise risk management (ERM) within the group will vary depending upon its structure and scale. Approximately 90 percent of the U.S. premium is subject to reporting an annual Own Risk Solvency Assessment (ORSA) Summary Report. However, all insurers are subject to an assessment of risk management during the risk-focused analysis and examination, and this review is a responsibility of the lead state. In addition, all groups are required to submit the Form F - Enterprise Risk Report under the requirements of the NAIC *Insurance Holding Company System Regulatory* Act (#440) unless they have been granted an exemption by the state. In addition, both the ORSA Summary Report and the Form F are subject to the supervisory review process, which contemplates both off-site and on-site examination of such information proportionate to the nature, scale and complexity of the insurer/group's risks. Those procedures are discussed in the following two sections. In addition, any risks identified throughout the entire supervisory review process are subject to further review by the lead state in either the periodic meeting with the insurer/group and/or any targeted examination work. When reviewing the ORSA and Form F, the lead state analyst should consider consistency between the documents, as well as information provided in the Corporate Governance Annual Disclosure (CGAD).

ORSA Summary Report

The NAIC *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) requires insurers above a specified premium threshold, and subject to further discretion, to submit a confidential annual ORSA Summary Report. Model #505 gives the individual insurer and the insurance group discretion as to whether the report is submitted by each individual insurer within the group or by the insurance group as a whole. Regardless of whether the ORSA is filed on an individual or group basis, any noninsurance operations that present material and relevant risks to the insurer should be included in the scope of the ORSA Summary Report. (See the NAIC *Own Risk Solvency Assessment Guidance Manual* (ORSA Guidance Manual) for further discussion).

- **Lead State:** In the case where the insurance group chooses to submit one ORSA Summary Report for the group, it must be reviewed by the lead state. The lead state is to perform a detailed and thorough review of the information and initiate any communications about the ORSA with the group. The suggestions below set forth some possible considerations for such a review. At the completion of this review, the lead state should prepare a thorough summary of its review, which would include an initial assessment of each of the three sections. The lead state should also consider and include key information to share with other domestic states that are expected to place significant reliance on the lead state's review. The lead state should share the analysis of ORSA with other states that have domestic insurers in the group. The group ORSA review and sharing with other domestic states should occur within 120 days of receipt of the ORSA filing.
- **Non-Lead State:** Non-lead states are not expected to perform an in-depth review of the ORSA, but instead rely on the review completed by the lead state. The non-lead states' review of the lead state's ORSA review should be performed only for the purpose of having a general understanding of the work performed by the lead state, and to understand the risks identified and monitored at the group-level so the non-lead state may better monitor and communicate to the lead state when its legal entity could affect the group. Any concerns or questions related to information in the ORSA or group risks should be directed to the lead state.
- **Single Insurer ORSA:** In the case where there is only one insurer within the insurance group, or the group decides to submit separate ORSA Summary Reports for each legal entity, the domestic state is to perform a detailed and thorough review of the information, which would include an initial assessment of each of the three sections and initiate any communications about the ORSA directly with the legal entity. Such a review should also be shared with the lead state (if applicable) so it can develop an understanding of the risks within the entire insurance group. Single insurer ORSA reviews should be completed within 180 days of receipt of the ORSA filing.

Throughout a significant portion of the remainder of this document, the term "insurer" is used to refer to both a single insurer for those situations where the report is prepared by the legal entity, as well as to refer to an insurance group. However, in some cases, the term group is used to reinforce the importance of the group-wide view. Similarly, throughout the remainder of this document, the term "lead state" is used before the term "analyst" with the understanding that in most situations, the ORSA Summary Report will be prepared on a group basis and therefore reviewed by the lead state.

Background Information

To understand the appropriate steps for reviewing the ORSA Summary Report, regulators must first understand the purpose of the ORSA. As noted in the ORSA Guidance Manual, the ORSA has two primary goals:

1. To foster an effective level of ERM at all insurers, through which each insurer identifies, assesses, monitors, prioritizes and reports on its material and relevant risks identified by the insurer, using techniques that are appropriate to the nature, scale and complexity of the insurer's risks, in a manner that is adequate to support risk and capital decisions.
2. To provide a group-level perspective on risk and capital, as a supplement to the existing legal entity view.

In addition, separately, the ORSA Guidance Manual discusses the regulator obtaining a high-level understanding of the insurer's ORSA and discusses how the ORSA Summary Report may assist the commissioner in determining the scope, depth and minimum timing of risk-focused analysis and examination procedures.

There is no expectation with respect to specific information or specific action that the lead state regulator is to take as a result of reviewing the ORSA Summary Report. Rather, each situation is expected to result in a unique ongoing dialogue between the insurer and the lead state regulator focused on the key risks of the group. For this reason, as well as others, the lead state analyst may want to consider additional support in the form of a broader review team as necessary in reviewing the ORSA Summary Report, subject to the confidentiality requirements outlined in statute. In reviewing the final ORSA filing prior to the next scheduled financial examination, the analyst should consider inviting the lead state examiner to participate on the review team. Regardless of which individuals are involved on a review team, the 120-day or 180-day timeliness standards are applicable to the review. Additionally, the lead state analyst and examiner may want to include the review team in ongoing dialogues with the insurer since the same team will be part of the ongoing monitoring of the insurer and an ORSA Summary Report is expected to be at the center of the regulatory processes.

These determinations can be documented as part of each insurer's ongoing supervisory plan. However, the ORSA Guidance Manual also states that each insurer's ORSA will be unique, reflecting the insurer's business model, strategic planning and overall approach to ERM. As regulators review ORSA Summary Reports, they should understand that the level of sophistication for each group's ERM program will vary depending upon size, scope and nature of business operations. Understandably, less complex insurers may not require intricate processes to possess a sound ERM program. Therefore, regulators should use caution before using the results of an ORSA review to modify ongoing supervisory plans, as a variety of practices may be appropriate depending upon the nature, scale and complexity of each insurer.

General Summary of Guidance for Each Section

The guidance that follows is designed to assist the lead state analyst in the review of the ORSA and to allow for effective communication of analysis results with the non-lead states. It is worth noting that this guidance is expected to evolve over the years, with the first couple of years focused on developing a general understanding of ORSA and ERM. It should be noted that each of the sections can be informative to the other sections. As an example, Section II affords an insurer the opportunity to demonstrate the robustness of its process through its assessment of risk exposure. In some cases, it's possible the lead state analyst may conclude the insurer did not

summarize and include information about its framework and risk management tools in Section I in a way that allowed the lead state analyst to conclude its effectiveness, but in practice by review of Section II, such a conclusion was able to be reached. Likewise, the lead state analyst may assess Section II as effective but may be unable to see through Section III how the totality of the insurer's system is effective because of a lack of demonstrated rigor documented in Section III. Therefore, the assessment of each section requires the lead state analyst to consider other aspects of the ORSA Summary Report. This is particularly true of Section I, because as discussed in the following paragraphs, the other two sections have very distinct objectives, whereas the assessment of Section I is broader.

Background information procedures are provided to assist the regulator in gaining an overall understanding of the ORSA Summary Report and assessing compliance with ORSA Guidance Manual reporting requirements (i.e., attestation, and entities in scope).

Section I procedures are focused on assessing the insurer's overall risk management framework. The procedures are presented as considerations to be taken into account when reviewing and assessing an insurer's implementation of each of the risk management principles highlighted in the NAIC's ORSA Guidance Manual. In assessing implementation, regulators should consider whether the design of ERM/ORSA practices appropriately reflects the nature, scale and complexity of the insurer.

Section II takes a much different approach. It provides guidance to allow the lead state analyst to better understand the range of practices they may see in ORSA Summary Reports. However, such practices are not intended to be requirements, as that would eliminate the "Own" aspect of the ORSA and defeat its purpose. As such, analysts should not expect or require insurers to organize or present their risks in a particular manner (i.e., by branded risk classification). Rather, the guidance can be used in a way to allow the lead state analyst to better understand the information in this section. Section II guidance has been developed around reviewing key risks assessed by the insurer, evaluating information provided on the assessment and mitigation of those risks and classifying them within the nine branded risk classifications outlined in the Handbook, which are used as a common language in the risk-focused surveillance process for ongoing tracking and communication. As such, the analyst should attempt to classify each key risk assessed by the insurer into a branded risk classification(s) for incorporation into general analysis documentation Insurer Profile Summary (IPS) or Group Profile (GPS) as appropriate. The branded risk classifications are intentionally broad in order to allow almost any risk of an insurer to be tracked within one or more categories, but the analyst may also use an "Other" classification as necessary to track exposures.

Section III is also unique in that it provides a specific means for assisting the lead state analyst in evaluating the insurer's determinations of the reasonableness of its group capital and its prospective solvency position on an ongoing basis. Section III of the ORSA Summary Report is intended to be more informative regarding capital than other traditional methods of capital assessment since it sets forth the amount of capital the group determines is reasonable to sustain its current business model rather than setting a minimum floor to meet regulatory or rating agency capital requirements.

Background Information

The ORSA Guidance Manual encourages discussion and disclosure of key pieces of information to assist regulators in reviewing and understanding the ORSA Summary Report. As such, the following considerations are provided to assist the regulator in reviewing and assessing the information provided in these areas.

- **Attestation** – The report includes an attestation signed by the chief risk officer (CRO) (or other executive responsible for ERM oversight) indicating that the information presented is accurate and consistent with ERM reporting shared with the board of directors (or committee thereof).
- **Entities in Scope** – The scope of the report is clearly explained and identifies all insurers covered. The scope of a group report also indicates whether material non-insurance operations have been covered. The lead state analyst could utilize Schedule Y, the Lead State report and other related tools/filings to review which entities are accounted for in the filing.

- **Accounting Basis** – The report clearly indicates the accounting basis used to present financial information in the report, as well as the primary valuation date(s).
- **Key Business Goals** – The report provides an overview of the insurer's/group's key business goals in order to demonstrate alignment with the relevant and material risks presented within the report.
- **Changes From Prior Filing(s)** – The report clearly discusses significant changes from the prior year filing(s) to highlight areas of focus in the current year review including significant changes to the ERM framework, risks assessed, stress scenarios, overall capital position, modeling assumptions, etc.

Review of Section I - Description of the Insurer's Risk Management Framework

The ORSA Guidance Manual requires the insurer to discuss the key principles below in Section I of the ORSA Summary Report. For purposes of evaluating the ORSA Summary Report, and moreover, the lead state analyst's responsibility to assess the insurer's risk management framework, the lead state analyst should review the ORSA Summary Report to ascertain if the framework meets the principles. Additional guidance is included to provide further information on what may be contemplated in assessing such principles.

Key Principles:

A. Risk Culture and Governance

B. Risk Identification and Prioritization

C. Risk Appetite, Tolerances and Limits

D. Risk Management and Controls

E. Risk Reporting and Communication

Documentation for Section I

When reviewing the ORSA Summary Report, the lead state analyst should consider the extent to which the above principles are present within the insurer. In reviewing these principles, examples of various considerations are provided for each principle in the following sections. The intent in providing these considerations is to assist the lead state analyst in assessing the risk management framework. However, these considerations only highlight certain elements associated with the key principles and practices of individual insurers that may vary significantly. The lead state analyst should document a summary of the review of Section I by outlining key information and developing an assessment of each of the five principles set forth in the ORSA Guidance Manual using the template located in the next section of this Handbook.

A. Risk Culture and Governance

It is important to note some insurers view risk culture and governance as the cornerstone to managing risk. The ORSA Guidance Manual defines this item to include a structure that clearly defines and articulates roles, responsibilities, and accountabilities, as well as a risk culture that supports accountability in risk-based decision making. Therefore, the objective is to have a structure in place within the insurer that manages reasonably foreseeable and relevant material risk in a way that is continuously improved. Key considerations in reviewing and assessing risk culture and governance might include, but are not limited to:

- **Roles and Responsibilities** - Roles and responsibilities of key stakeholders in risk and capital management are clearly defined and documented in writing, including members of the board (or committee thereof), officers and senior executives, risk owners, etc.
- **Board or Committee Involvement** – The board of directors or appropriate committee thereof demonstrates active involvement in the oversight of ERM activities through receiving regular updates from management on ERM monitoring, reporting and recommendations.
- **Strategic Decisions** – Directors, officers and other members of senior management utilize information generated through ERM processes in making strategic decisions.
- **Staff Availability and Education** – The insurer maintains suitable staffing (e.g., sufficient number, educational background, and experience) to support its ERM framework and deliver on its risk strategy. Staff is kept current in its risk education in accordance with changes to the risk profile of the insurer.
- **Leadership** – The chief risk officer (CRO), or equivalent position, possesses an appropriate level of

knowledge and experience related to ERM and receives an appropriate level of authority to effectively fulfill responsibilities. This includes clear and direct communication channels between the CRO and the BOD or appropriate committee thereof.

- **Compensation** – The insurer demonstrates that incentives, compensation and performance management criteria have been appropriately aligned with ERM processes and do not encourage excessive risk taking given the capital position of the insurer.
- **Integration** – The insurer integrates and coordinates ERM processes across functional areas of the insurer including human resources, information technology, internal audit, compliance, business units, etc.
- **Assessment** – The insurer's ERM framework is subject to regular review and assessment, with updates made to the framework as deemed necessary.

B. Risk Identification and Prioritization

The ORSA Guidance Manual defines this as key to the insurer. Responsibility for this activity should be clear, and the risk management function is responsible for ensuring the processes are appropriate and functioning properly. Therefore, an approach for risk identification and prioritization may be to have a process in place that identifies risk and prioritizes such risks in a way that potential reasonably foreseeable and relevant material risks are addressed in the framework. Key considerations in reviewing and assessing risk identification and prioritization might include, but are not limited to:

- **Resources** – The insurer utilizes appropriate resources and tools (e.g., questionnaires, external risk listings, brainstorming meetings, conference calls with regulators, etc.) to assist in the risk identification process that are appropriate for its nature, size and structure.
- **Stakeholder Involvement** – All key stakeholders (i.e., directors, officers, senior management, business unit leaders, risk owners, etc.) are involved in risk identification and prioritization at an appropriate level.
- **Prioritization Factors** – Appropriate factors and considerations are utilized to assess and prioritize risks (e.g., likelihood of occurrence, magnitude of impact, controllability, speed of onset, etc.).
- **Process Output** – Risk registers, key risk listings and risk ratings are maintained, reviewed and updated on a regular basis.
- **Emerging Risks** – The insurer has developed and maintained a formalized process for the identification and tracking of emerging risks.

C. Risk Appetite, Tolerances and Limits

The ORSA Guidance Manual states that a formal risk appetite statement, and associated risk tolerances and limits are foundational elements of a risk management framework for an insurer. While risk appetites, tolerances and limits can be defined and used in different ways across different insurers, this guidance is provided to assist the regulator in understanding and evaluating the insurer's practices in this area.

Risk appetite can be defined as the amount of specific and aggregate risk that an insurer chooses to take during a defined time period in pursuit of its business objectives. Articulation of the risk appetite statement ensures alignment of the risk strategy with the business strategy set by senior management and reviewed and evaluated by the board. Not included in the ORSA Guidance Manual, but widely considered, is that risk appetite statements should be easy to communicate, be understood, and be closely tied to the insurer's strategy.

After the overall risk appetite for the insurer is determined, the underlying risk tolerances and limits can be selected and applied to business units and specific key risks identified by the insurer. "Risk tolerance" can be defined as the aggregate risk-taking capacity of an insurer. "Risk limits" can be defined as thresholds used to monitor the actual exposure of a specific risk or activity unit of the insurer to ensure that the level of actual risk remains within the risk tolerance. The insurer may apply appropriate quantitative limits and qualitative statements to help establish boundaries and expectations for risks that are hard to measure. These boundaries may be expressed in terms of earnings, capital, or other metrics (growth, volatility, etc.). The risk tolerances/limits provide direction outlining the insurer's tolerance for taking on certain risks, which may be established and communicated in the form of the maximum amount of such risk the entity is willing to take. However, in many

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cases these will be coupled with more specific and detailed limits or guidelines the insurer uses.

Due to the varying level of detail and specificity that different insurers incorporate into their risk appetites, tolerances and limits, lead state regulators should consider these elements collectively to reach an overall assessment in this area and should seek to understand the insurer's approach through follow-up discussions and dialogue. Key considerations in reviewing and assessing risk appetites, tolerances and limits might include, but are not limited to:

- **Risk Appetite Statement** – The insurer has developed an overall risk appetite statement consistent with its business plans and operations that is updated on a regular basis and subject to appropriate governance oversight.
- **Risk Tolerances/Limits** – Tolerances and limits are developed for key risks in accordance with the overall risk appetite statement.
- **Risk Owners** – Key risks are assigned to risk owners with responsibility for risk tolerances and limits, including actions to address any breaches.

D. Risk Management and Controls

The ORSA Guidance Manual stresses managing risk as an ongoing ERM activity, operating at many levels within the insurer. This principle is discussed within the governance section above from the standpoint that a key aspect of managing and controlling the reasonably foreseeable and relevant material risks of the insurer is the risk governance process put in place. For many companies, the day-to-day governance starts with the relevant business units. Those units put mechanisms in place to identify, quantify and monitor risks, which are reported up to the next level based upon the risk reporting triggers and risk limits put in place. In addition, controls are also put in place on the backend, by either the ERM function or the internal audit team, which are designed to ensure compliance and a continual enhancement approach. Therefore, one approach may be to put controls in place to ensure the insurer is abiding by its limits. Key considerations in reviewing and assessing risk management and controls might include, but not limited to:

- **Lines of Accountability** – Multiple lines of accountability (i.e., business unit or risk owners, ERM function, internal audit) are put in place to ensure that control processes are effectively implemented and maintained.
- **Control Processes** – Specific control activities and processes are put in place to manage, mitigate and monitor all key risks.
- **Implementation of Tolerances/Limits** – Risk tolerances and limits are translated into operational guidance and policies around key risks through all levels of the insurer.
- **Indicators/Metrics** – Key risk indicators or performance metrics are put in place to monitor exposures, provide early warnings and measure adherence to risk tolerances/limits.

E. Risk Reporting and Communication

The ORSA Guidance Manual indicates risk reporting and communication provides key constituents with transparency into the risk-management processes as well as facilitates active, informal decisions on risk-taking and management. Transparency is generally available because of reporting that can be made available to management, the board, or compliance departments, as appropriate. However, the most important is how the reports are being utilized to identify and manage reasonably foreseeable and relevant material risks at either the group, business unit or other level within the insurer where decisions are made. Therefore, one approach may be to have reporting in place that allows decisions to be made throughout the insurer by appropriately authorized people, with ultimate ownership by senior management or the board. Key considerations in reviewing and assessing risk reporting and communication might include, but not limited to:

- **Training** – The importance of ERM processes and changes to the risk strategy are clearly communicated

to all impacted areas and business units through ongoing training.

- **Key Risk Indicator Reporting** – Summary reports on risk exposures (i.e., key risk indicators) and compliance with tolerances/limits are maintained and updated on a regular basis.
- **Oversight** – Summary reports are reviewed and discussed on a regular basis by the appropriate members of management, and when appropriate, directors.
- **Breach Management** – Breaches of limits and dashboard warning indicators are addressed in a timely manner through required action by management and, when appropriate, directors.
- **Feedback** – A feedback loop is embedded into ERM processes to ensure that results of monitoring and review discussions on key risks by senior management and the board are incorporated by business unit leaders and risk owners into ongoing risk-taking activities and risk management processes.

Overall Section 1 Assessment

After summarizing the information reviewed for each of the key principles individually, the lead state analyst should provide an overall assessment of the insurer's ERM framework, including any concerns or areas requiring follow-up investigation or communication. In preparing the assessment, the lead state analyst should understand that ORSA summary reports may not always align with each of these specific principles. Therefore, the lead state analyst must use judgment and critical thinking in accumulating information to support their evaluation of each of these principles. The overall evaluation should focus on critical concerns associated with any of the individual principles and should also address any other ERM framework concerns that may not be captured within these principles.

The lead state analyst should also be aware that the lead state examiner is tasked with supplementing the lead state analyst's assessment with additional onsite verification and testing. The lead state analyst should direct the lead state examiner to those areas where such additional verification and testing is appropriate and could not be performed by the lead state analyst. Where available from prior full scope or targeted examinations, information from the lead state examiner should be used as a starting point for the lead state analyst to update. Consequently, on an ongoing basis, the lead state analyst's update may focus on changes to ERM processes and the ORSA Summary Report since the prior exam in directing targeted onsite verification and testing.

The lead state analyst, after completing a summary of Section I, should consider if the overall assessment, or any specific conclusions, should be used to update either the ERM section of the GPS (if the ORSA Summary Report is prepared on a group basis) or information in the IPS (if the ORSA Summary Report is prepared on a legal entity basis). In addition, key information from the review should be incorporated into or referenced in the Risk Assessment Worksheet (RAW) during the next full analysis (quarterly or annual) of the insurer where relevant.

Review of Section II - Insurer's Assessment of Risk Exposure

Section II of the ORSA Summary Report is required to provide a high-level summary of the quantitative and/or qualitative assessments of risk exposure in both normal and stressed environments. The ORSA Guidance Manual ~~does not require the insurer to address specified risks but it does~~ provides examples of reasonably foreseeable and relevant material risk categories (e.g., credit, market, liquidity, underwriting, and operational risks). In reviewing the information provided in this section of the ORSA, lead state analysts may need to pay particular attention to risks and exposures that may be emerging or significantly increasing over time. To assist in identifying and understanding the changes in risk exposures, the lead state analyst may consider comparing the insurer's risk exposures and/or results of stress scenarios to those provided in prior years.

Section II provides risk information on the entire insurance group, which may be grouped in categories similar to the NAIC's nine branded risk classifications. However, this is not to suggest the lead state analyst or lead state examiner should expect the insurer to address each of the nine branded risk classifications. In fact, in most cases, they will not align, but it is not uncommon to see some similarities for credit, market, liquidity, underwriting and operational risks. A fair number of insurer risks may not be easily quantified or are grouped differently than these nine classifications. Therefore, it is possible the insurer does not view them as significant or relevant. The

important point is not the format, but for the lead state analyst or lead state examiner to understand how the insurer categorizes its own risks and contemplate whether there may be material gaps in identified risks or categories of risks.

Documentation for Section II

Prepare a summary and assessment of Section II by identifying and outlining key information associated with the significant reasonably foreseeable and material relevant (key) risks of the insurer per the ORSA Summary Report. Following the documentation on each key risk per the report, the lead state analysts should include an analysis of such risk. In developing such analysis, the lead state analyst is encouraged to use judgment and critical thinking in evaluating if the risks and quantification of such risks under normal and stressed conditions are reasonable and generally consistent with expectations. The lead state analyst should be aware that the lead state examiner is tasked to update the assessment by supplementing the lead state analyst's assessment with additional on-site verification and testing. The lead state analyst should direct the lead state examiner to those areas where such additional verification and testing is appropriate and could not be performed by the lead state analyst. Suggested information to be documented on each key risk, including supporting considerations, is outlined below:

- **Risk Title and Description** – Provide the title for each key risk as identified/labeled by the insurer as well as a basic description.
- **Branded Risk** – Provide information on the primary branded risk classification(s) that apply to the key risk and briefly discuss how they apply/relate.
- **Controls/Mitigation** – Summarize information known about the controls and mitigation strategies put in place by the insurer to address the key risk.
- **Risk Limits** – Provide information on any specific risk tolerances or limits associated with the key risk and how they are monitored and enforced.
- **Assessment** – Discuss how the key risk is assessed by the insurer, including whether the assessment is performed on a quantitative or qualitative basis. Describe the methodology used, the key underlying assumptions and the process utilized to set these assumptions.
- **Normal Exposure** – Summarize the insurer's normal exposure to this key risk based on budget information or historical experience.
- **Stress Scenario(s)** – Discuss the stress scenario(s) identified and applied to the key risk and how they were determined and validated by the insurer.
- **Stressed Exposure** – Provide information on the impact of the stress scenario(s) on the key risk and potential impact on the insurer's surplus position and business strategy/operations.
- **Inclusion on IPS/GPS** – Discuss whether the key risk will be recognized on the IPS/GPS of the insurer, including the risk component it will be incorporated into.
- **Regulator Review and Assessment** – Assess the adequacy of the risk assessment performed by the insurer on each key risk (including the appropriateness of controls/limits and reasonableness of methodology, assumptions and stress scenarios used) and whether any specific issues or concerns are identified that would require further investigation or follow-up communication.

After completing a summary and assessment for each key risk addressed in Section II, the lead state analyst should use the information to update the risk assessment in either the GPS (if the ORSA is prepared on a group basis) or the IPS (if the ORSA is prepared on a legal entity basis) and supporting documentation if deemed necessary. In addition, key information from the review should be incorporated into or referenced in the RAW during the next full analysis (quarterly or annual) of the insurer where relevant.

Overall Section II Assessment

The lead state analyst should complete an overall assessment of the information provided in Section II, including an evaluation of the insurer's risk assessment processes and whether all material and relevant risks were assessed

and presented at an appropriate level of detail. This should include consideration of whether there is consistency between the insurer's risk identification and prioritization process discussed in Section I and risks that are assessed and reported on in Section II (i.e., have all key risks been addressed). In addition, this should focus on critical concerns associated with the assessment of individual key risks as well as whether the insurer's overall assessment process (i.e., methodology, assumptions and stress scenarios) is adequate and well-supported.

Review of Section III - Group Assessment of Risk Capital

In reviewing Section III of the ORSA Summary Report, the lead state analyst should recognize this section is generally presented in a summarized form. Although this section requires disclosure of aggregate available capital compared against the enterprise's risk capital (i.e., the amount deemed necessary to withstand unexpected losses arising from key risks), the report may not provide sufficient detail to fully evaluate the group capital position. As such, the lead state analyst may need to request the assistance of staff actuaries when available in evaluating the reasonableness and adequacy of the stress tests selected, request additional detail from the insurer in order to understand and evaluate the group capital position and/or refer additional investigation to the financial examination function.

The ORSA Guidance Manual requires the insurer to estimate its prospective solvency under stressed conditions by identifying stress scenarios that would give rise to significant losses that have not been accounted for in reserves. Furthermore, the Manual requires the insurer to estimate its prospective solvency in Section III by projecting the aggregate capital available and comparing it against the enterprise's risk capital. Insurers may include information in the ORSA Summary Report developed as part of their strategic planning and may include pro forma financial information that displays anticipated changes to key risks as well as projected capital adequacy in those future periods based on the insurer's defined capital adequacy standard. In reviewing information on prospective solvency, the lead state analyst should carefully consider projected changes to the group capital position as well as significant shifts in the amount of capital allocated to different risks, which could signal changes in business strategy and risk exposures.

In addition to evaluating the adequacy of capital, the insurer should also discuss the effect of liquidity risk on its overall solvency, including calls on the insurer's cash position due to microeconomic factors—i.e., internal operational—and/or macro-economic factors; i.e., economic shifts. The insurer should assess its resilience against severe but plausible liquidity stresses and whether the current liquidity position is within any liquidity risk appetite and/or limits. The insurer should describe in the ORSA the policies and processes in place to manage liquidity risk, as well as contingency funding or other plans to mitigate potential liquidity stresses.

Documentation for Section III

Insurance groups will use different means to manage capital and they will use different accounting and valuation frameworks. For example, they may determine the amount of capital they need to fulfil regulatory and rating agencies' requirements, but also determine the amount of capital (risk capital) they need to absorb unexpected losses that are not accounted for in the reserves. The lead state analyst may need to request management to discuss their overall approach to capital management and the reasons and details for each approach so that they can be considered in the evaluation of estimated risk capital.

Many insurers use internally developed capital models to quantify the risk capital. In these cases, the ORSA Summary Report should summarize the insurer's process for model validation to support the quantification methodology and assumptions chosen to determine risk capital. The lead state analyst should use the model validation information to assess the reasonableness of the quantification methodology and assumptions used. If the ORSA Summary Report does not provide a summary of the model validation process, the lead state analyst should request copy of the validation report prepared by the insurer. With regard to the determination of the risk capital under stressed conditions, because the risk profile of each insurer is unique, there is no standard set of stress conditions that each insurer should run. However, the lead state regulator should be prepared to dialogue

with management about the selected stress scenarios if there is concern with the rigor of the scenario. In discussions with management, the lead state analyst should gain an understanding of the modeling methods used to project available and risk capital over the duration of the insurer's business plan as well as the potential changes to the risk profile of the insurer over this time horizon (i.e., changes to the list of key risks) based on the business plan. The aforementioned dialogue may occur during either the financial analysis process and/or the financial examination process.

The lead state analyst, after completing a summary of Section III, should assess the overall reasonableness of the capital position compared to the group's estimated risk capital. Additionally, the lead state analyst should also consider if any of the information, or any specific conclusions, should be used to update either the GPS or IPS.

An assessment of the reasonableness of group risk capital and the process to measure it should be provided by developing a narrative that provides the following for each individual element of the insurer's assessment of risk capital:

- **Discussion of Capital Metric(s) Used** – Discuss the method(s) used by the group in assessing group risk capital and their basis for such a decision. Identify the capital metric(s) used to estimate group risk capital, as well as the level of calibration selected. Consider whether the capital metric(s) utilized to assess the group's overall capital target are clearly presented and described. Metrics may consist of internally developed economic capital models (deterministic or stochastic) and/or externally developed models, such as regulatory capital requirements for risk-based capital (RBC) or A.M. Best's Capital Adequacy Ratio (BCAR). In discussing calibration, consider both the method used (e.g., Value at Risk, Tail Value at Risk) and its level to evaluate whether the results are calibrated to an appropriate confidence level. Discuss whether the capital metric(s) selected address all key risks of the group. Of particular importance is considering whether the metric used fits the approach used to determine the group's risk appetite. Document the extent to which the lead state analyst believes the approach used by the insurer is reasonable for the nature, scale and complexity of the group and if this has any impact on the lead state analyst's assessment of the insurer's overall risk management.
- **Group Risk Capital - By Risk and in Aggregate** – Provide information on the amount of risk capital determined for each individual key risk and in aggregate. In reviewing the results for each individual risk, evaluate whether all key risks are adequately accounted for in the metric by assessing the amount of capital allocated to each risk. Consider significant changes in group risk capital from the prior filing, the drivers of such change, and any decisions made as a result of such movement.
- **Impact of Diversification Benefit** – Discuss the impact of any diversification benefit calculated by the group in aggregating its group risk capital. Diversification benefit is typically calculated by aggregating individually modeled risk capital and then accounting for potential dependencies among those risks to allow for an offset or reduction in the total amount of required capital (group risk capital). In evaluating the group's diversification benefit, consider whether the benefit is calculated based on dependencies/correlations in key risk components that are reasonable/appropriate.
- **Available Capital** – Provide information on and discuss the amount of capital available to absorb losses across the group, recognizing that there may be fungibility issues relating to capital trapped within various legal entities and jurisdictions for which regulatory restrictions and supervisory oversight constrain the extent and timing of capital movement across the group. Describe management's strategy to obtain/deploy additional capital across the group should the need arise. Determine if there is any double counting of capital through the stacking of legal entities.
- **Excess Capital** – Discuss the extent to which the group available capital amount exceeds the group risk capital amount per the ORSA Summary Report. In evaluating the overall adequacy of excess capital, consider any concerns outlined above relating to the capital metric(s), group risk capital, impact of diversification and available capital. If the level of excess capital or its availability/liquidity is of concern, evaluate the group's ability to remediate capital deficiencies by obtaining additional capital or reducing risk where required. If further concerns exist, contact the group to discuss and communicate with department senior management

to determine whether additional investigation or regulatory action is necessary.

- **Impact of Stresses on Group Risk Capital** – Discuss whether additional stress scenarios have been applied to the model results to demonstrate the group's resiliency to absorb extreme unexpected losses, including severe but plausible liquidity stresses. This step is particularly important when reviewing the use of external capital models that may not be tailored to address the enterprise's specific exposures. Evaluate the range and adequacy of any stress scenarios applied and the resulting impact on the group's ability to accomplish its business strategy, provide sufficient liquidity and meet the capital expectations of rating agencies and regulators.
- **Governance and Validation** – Discuss and evaluate the group's model governance process and the means by which changes to models are overseen and approved. Consider whether members of senior management are adequately involved. Discuss the extent to which the group uses model validation (including validation of data inputs) and independent review to provide additional controls over the estimation of group capital.
- **Prospective Solvency Assessment** – Discuss the information provided by the group on its prospective solvency position, including any capital projections and liquidity considerations. Consider whether the business goals of the insurer and its strategic direction are adequately discussed and incorporated into the prospective solvency assessment. For example, are expected changes in risk profile presented and discussed? Also consider whether prospective solvency is projected across the duration of the current business plan. To the extent the prospective assessment suggests that the group capital or liquidity position will weaken, or recent trends may result in certain internal limits being breached, the lead state analyst should understand and discuss what actions the insurer expects to take as a result of such an assessment (e.g., reduce certain risk exposure, raise additional capital, implement contingency funding plans, etc.).

Overall Section III Assessment

In addition, after summarizing the assessment of each individual element above, the lead state analyst should provide an overall assessment of the insurer's risk capital assessment process, including any concerns or areas requiring follow-up investigation or communication. The overall evaluation should focus on critical concerns associated with any of the individual elements noted above and should also address any other risk capital assessment concerns that may not be captured within these principles.

The lead state analyst, after completing a summary of Section 3, should consider if the overall assessment, or any specific conclusions, should be used to update either the ERM section of the GPS (if the ORSA Summary Report is prepared on a group basis) or information in the IPS (if the ORSA Summary Report is prepared on a legal entity basis). In addition, key information from the review should be incorporated into or referenced in the RAW during the next full analysis (quarterly or annual) of the insurer if relevant.

Feedback to the Insurer

After completing a review of the ORSA Summary Report, the lead state should provide practical and constructive feedback to the insurer related to the review. Feedback plays a critical role in ensuring the compliance and effectiveness of future filings. Feedback also provides a means for asking follow-up questions or requesting additional information to facilitate the review and incorporation of ORSA information into ongoing solvency monitoring processes.

During the review, topics for feedback communication to the insurer can be accumulated on **Appendix A** of the template. The appendix encourages the lead state to accumulate positive attributes to reinforce the effectiveness of certain practices and information in the summary report. In addition, the appendix encourages the lead state to identify areas for constructive feedback to encourage the insurer to provide additional information or clarify the presentation of certain items in future filings. Finally, the appendix encourages the lead state to list requests for additional information that may be necessary to complete a review and evaluation of the insurer's ORSA/ERM processes.

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Suggested Follow-up by the Examination Team

After completing a review of the ORSA Summary Report, the lead state analyst should direct the lead state examiner to those areas that could benefit from focused inquiries and interviews during an on-site risk-focused examination. In some instances, the analyst may want the examiner to determine, through limited testing, if the data provided and processes described in the ORSA Summary Report are consistent with the insurer's ERM/ORSA operations. These items can be accumulated on **Appendix B** of the template for follow-up and communication. If there are specific reports, information and/or control processes addressed in the ORSA Summary Report that the lead state analyst feels should be subject to additional review and verification by the examination team, the lead state analyst is expected to provide direction as to its findings of specific items and/or recommended testing and such amounts should be listed in the template by the lead state analyst. During planning for a financial examination, the lead state examiner and lead state analyst should work together to develop a plan for additional testing and follow-up where necessary. The plan should consider that the lead state examiner may need to expand work to address areas of inquiry that may not be identifiable by the lead state analyst.

In addition to this specific expectation, during each coordinated financial condition examination, the exam team as directed by the lead state examiner and with input from the lead state analyst will be expected to review and assess the insurer's risk management function through utilization of the most current ORSA Summary Report received from the insurer. Also, the lead state analyst will ask the examination team to address the unresolved questions and concerns arising from the analyst's review of the ORSA documented in the template (see Appendix B), through focused inquiries and interviews and testing during an on-site risk-focused examination. Information included in the report and the operating effectiveness of various risk management processes can be supported/tested on a sample basis (e.g., reviewing certain supporting documentation from Section I; assessing the reasonableness of certain inputs into stress testing from Section II; and reviewing certain inputs, assumptions and outputs from internal capital models).

U.S.-Based Internationally Active Insurance Group Risk Management Assessment Considerations

While the considerations covered in this chapter are generally applicable to all insurers/insurance groups filing an ORSA Summary Report, there are additional risk management assessment considerations for the supervision of internationally active insurance groups (IAIGs) that are outlined in the ORSA Guidance Manual. As such, U.S. lead states functioning as group-wide supervisors should document their assessment of the specific IAIG risk management practices, as highlighted in **Appendix C** of the template. If such practices are already assessed and documented in the general review template, the documentation provided in this appendix can state and cross-reference to where those practices are covered.

To complete the IAIG assessment, the group-wide supervisor may need to request and review additional information from the head of the IAIG, which could include an ORSA Summary Report, CGAD, and/or additional information on risk management practices at the head of the IAIG level. The group-wide supervisor should utilize other filings and resources already available to the department, including holding company filings—i.e., Form B, Form F—and public information sources, before requesting additional information to complete the assessment.

In completing the assessment, the group-wide supervisor should consider whether certain elements are more appropriately assessed and addressed, as necessary, during an on-site examination and coordinate with the examination function. In addition, the analysis function should follow up on findings from the previous examination, as well as identify and assess significant changes in operations and risk management functions at the head of the IAIG since the last examination, as appropriate.

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Form F - Enterprise Risk Report

The 2010 revisions to Model #440 and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) introduced a new filing requirement for a Form F. The Form F requires the ultimate controlling person to identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The Form F may be completed using information contained in the financial statement, annual report, proxy statement, statement filed with a governmental authority, or other documents if such information meets the disclosure requirements. Form F is focused on disclosing the enterprise risk associated with the entire insurance holding company system including non-regulated entities. The Form F is filed with the lead state commissioner of the insurance holding company system for every insurer subject to registration under Model #440. Adoption of the applicable Form F and related confidentiality provisions outlined in the 2010 revisions to Model #440 is required for a state to be designated the lead state for Form F filings. Lead states and other domestic states receiving and sharing the Form F must have in place confidentiality agreements as prescribed in #Model 440.

Lead State Responsibility for Analysis of Form F
The Lead State should take primary responsibility for reviewing the Form F filing and should incorporate any takeaways, risks or concerns into the GPS. Takeaways, risks and concerns should be incorporated into the ERM summary in the GPS and/or the discussion of various branded risks, as deemed appropriate. There is no requirement or expectation to create a separate Form F checklist or create additional review documentation for sharing with another state or for internal documentation purposes.

If the Form F highlights any issues or risks that are only relevant to a particular insurance entity in the group, the Lead State should notify the domestic state of the issue and share the relevant information from the Form F with that state in a timely manner.

Non-Lead State Reliance on the Lead State Analysis of Form F
The Form F must be reviewed by the lead state and significant findings incorporated into the GPS. The non-lead state is encouraged to review the ERM summary and other information provided by the lead state in the GPS to access relevant information shared through Form F. There is no expectation of additional information shared by the lead state in this area, unless Form F highlights issues or risks that are only relevant to a particular insurance entity in the group. In that case, the non-lead state(s) should rely on the Lead State to proactively provide this information in a timely manner.

If there are material concerns noted in the GPS and additional information is needed, the non-lead state should request additional information from the lead state or company, if available. Such information could include additional information from the Form F filing, if relevant.

Upon the receipt of any additional information, the non-lead state should document any material concerns regarding enterprise risk that could impact the financial condition of the domestic insurer and conclude whether any of the risks identified pose an immediate material risk to the insurer's policyholder surplus or risk- based capital position, insurance operations (e.g., changes in writings, licensure, and organizational structure), balance sheet, leverage, or liquidity.

NAIC Enterprise Risk Report (Form F) Implementation Guide
In March 2018, the Group Solvency Issues (E) Working Group adopted *the NAIC Enterprise Risk Report (Form F) Implementation Guide,* which is located at:

https://content.naic.org/sites/default/files/inline-files/committees_e_isftf_group_solvency_related_form_f_guide.pdf

As outlined in the Guide, it is intended to assist insurers and regulators in maximizing the usefulness of the Form F by proposing best practices for consideration in preparing and reviewing filings. Therefore, while the Guide does not constitute authoritative guidance for information to be included in a Form F filing, filers are requested to consider the best practices outlined within the Guide when preparing their Form F filing. By adhering to the best

practices outlined within the Guide, registrants will be able to reduce the extent of regulator follow-up and correspondence necessary to utilize the information provided, which should lead to a more effective and efficient process. The regulators' goal in developing this document was to provide some consistency and uniformity across states in reviewing and utilizing information obtained through the Form F. Therefore, it is recommended that states utilize the best practices outlined in the Guide to support their review and feedback process.

Insurance holding company systems are expected to provide a Form F filing to the appropriate regulator on an annual basis, unless they have been granted an individual exemption from the reporting provisions. Situations where it might be appropriate to consider granting an exemption could include the following:
- An ORSA Summary Report has been filed with the commissioner at the ultimate controlling person (UCP) level and addresses all enterprise risk exposures that would be disclosed in a Form F filing.
- Based on the very limited size, structure and nature of an insurance holding company system, the Form F filing would not provide additional valuable information to the commissioner.

PROCEDURES #1 - 2 provides a guide to assist analysts in reviewing the Form F filing for completeness and help guide analysts through each of the major items of information required by Form F. Analysts should review Form F in conjunction with a review of Form B and should document any nondisclosure of information. As noted above, concerns should be documented in the GPS, as there is no requirement or expectation for the analyst to create a separate Form F checklist or create additional review documentation.

PROCEDURES #3 - 7 provides a guide to assist analysts in evaluating the risks described within Form F. Analysts should consider whether any enterprise risks not reported in Form F exist, and for all risks identified both within Form F and by analysts, analysts should review information available and document any concerns. Analysts should also evaluate whether the risks identified result in an impact to the insurer's financial condition (e.g., surplus, RBC, insurance operations, balance sheet, leverage, and liquidity. Risks and concerns should be documented in the GPS.

To: Greg Chew, Chair of Financial Analysis Solvency Tools (E) Working Group

From: Jamie Walker, Chair of Group Solvency Issues (E) Working Group

Date: September 3, 2024

Re: Referral on Guidance for Recovery and Resolution Planning

The International Association of Insurance Supervisors (IAIS) has proposed revisions to Insurance Core Principle (ICP) 12 (Exit from the Market and Resolution) and ICP 16 (Enterprise Risk Management for Solvency Purposes) related to recovery and resolution. It is anticipated that the IAIS will adopt the proposed revisions to ICPs in December 2024.

In its review of the *Financial Analysis Handbook* (Handbook), the Group Solvency Issues (E) Working Group (GSIWG) identified this topic of recovery and resolution is included in guidance within the chapter VI.L. Supervisory Colleges, of the Handbook. GSIWG recommends the guidance in the Handbook be updated to reflect international standards for recovery planning and resolution planning in the proposed ICP revisions, and the U.S. approach to recovery and resolution planning requirements.

The GSIWG recommends the Financial Analysis Solvency Tools (E) Working Group consider the draft guidance provided in the accompanying attachment for public exposure and adoption into the Handbook, subject to the IAIS's adoption of the proposed ICP revisions.

If you have any questions, please contact NAIC Staff, Jane Koenigsman (jkoenigsman@naic.org).

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**************PRECEDING TEXT NOT SHOWN**************

- **Crisis Management Group**[i] – The group-wide supervisor establishes a crisis management group (CMG) for the IAIG, with the objective of enhancing preparedness for, and facilitating the recovery and resolution of, the IAIG[ii].
  - There should be clear membership conditions, and members should include the group-wide supervisor, other relevant involved supervisors, and relevant resolution authorities, if possible.
  - The CMG should keep under active review the process for sharing information within the CMG and with host resolution authorities not represented, the processes for recovery and resolution planning for the IAIG, and the resolvability of the IAIG.
  - The group-wide supervisor, in consultation with the CMG, should determine whether to require that the IAIG develop a formal recovery plan[iii] to establish in advance the options to restore the financial position and viability of the IAIG in a crisis, as well as how and when the plan should be updated on an ongoing basis. The role, priorities, and approach of any CMG should be proportional to eachthe group's organization, capital structure, characteristics, and financial condition.
    - Regardless of whether a formal recovery plan is required, tThe ORSA Summary Report should discuss at a high level the severe stresses that could trigger a recovery planmeasures and the recovery options available.
    - The group-wide supervisor should determine whether the information provided in the ORSA Summary Report or other ERM reporting satisfies the requirement for a recovery plan for an IAIG. If the requirement is not satisfied based on that determination, the group-wide supervisor should require a stand-alone recovery plan that is in addition to the recovery information provided through ERM/ORSA.
    - The recovery plan should be utilized by the CMG and the IAIG to take actions for recovery if the IAIG comes under severe stress.
    - It is recommended that the group-wide supervisor consider the IAIG's nature, scale, and complexity when setting recovery plan requirements, including the form, content, and detail of the recovery plan and the frequency for reviewing and updating the plan.
    - The head of the IAIG should maintain ensure that the IAIG's management information systems that are able to produce and communicate, on a timely basis, information that is relevant necessary for the preparation and execution of to the recovery plan, and for the resolution plan if there is one. on a timely basis.The GWS should ensure that the management information systems are capable of being operated effectively by the receiver, if receivership becomes necessary.

[i] For additional guidance, refer to the *Receiver's Handbook for Insurance Company Insolvencies* Exhibit 8-1, [insert chapter/appendix reference] and the *Troubled Insurance Company Handbook* (regulator only publication) Chapter 5 and Appendices G-J [insert chapter/appendix reference].
[ii] ICP CF 25.7.a.
[iii] Refer to ICP CF 16.156 and the IAIS Application Paper on Recovery Planning for more background information and possible best practice guidance regarding governance, monitoring, updating the recovery plan, and key elements of a recovery plan (e.g, stress scenarios, trigger frameworks to identify emerging risks, recovery options, communication strategies, and governance). (https://www.iaisweb.org/home)

  - ~~Regardless of whether a formal recovery plan is required, the ORSA Summary Report should discuss at a high level the severe stresses that could trigger a recovery plan and the recovery options available.~~

- With regard to ~~R~~resolution plans[iv] ~~are put in place at IAIGs where~~ the group-wide supervisor and/or resolution authority, in consultation with the CMG, should ~~deems necessary. Where a resolution plan is required, the group-wide supervisor and/or resolution authority, in coordination with the IAIG CMG, should:~~have a process to regularly ~~D~~determine whether a resolution plan is necessary, including consideration of factors such as the size, risks, activities and complexity of the IAIG[v] ~~.~~.
- Where a resolution plan is required, the group-wide supervisor and/or resolution authority, in coordination with the IAIG CMG[vi]:
  - Ensures that the plan covers at least the group's material entities.
  - Requires relevant legal entities within the IAIG to submit necessary information for the development of resolution plan.
  - ~~The head of the IAIG should maintain management information systems that are able to produce and communicate information relevant to the resolution plan on a timely basis.~~
  - Regularly undertakes resolvability assessments to evaluate the feasibility and credibility of resolution strategies, in light of the possible impact of the IAIG's failure on policyholders and the financial system and real economy in the jurisdictions in which the IAIG operates.
  - Requires the IAIG to take prospective actions to improve its resolvability.
- The group-wide supervisor puts in place a written coordination agreement[vii] between the members of the IAIG CMG, which covers the following:
  - Roles and responsibilities of the respective members of the IAIG CMG.
  - The process for coordination and cooperation, including information sharing among members of the IAIG CMG.

[iv] Refer to ICP CF 12.2, ICP 12.4, ICP CF 12.4.a ~~and 12.3~~ and the Application Paper on Resolution Powers and Planning for more background information and possible best practice guidance, including the approach to determining if resolution plans are needed and key elements of a plan (e.g., resolution strategies, financial stability impacts, governance, communication, and impact on guaranty fund systems). (https://www.iaisweb.org/home)

[v] Per ICP CF 12.4.a.1, factors to be considered are set out in ICP 12.4

vi ICP CF 12.4.b

vii Refer to the IAIS Application Paper on Supervisory Colleges, Nov. 2021, and the Application Paper on Resolution Powers and Planning, June 2021.

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October 28, 2024

Ralph Villegas, Manager I, Life Financial Analysis
Rodney Good, Property/Casualty and Title Financial Analysis
NAIC Financial Analysis Solvency Tools (E) Working Group

Dear Mr. Villegas and Mr. Good,

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide feedback on the FASTWG exposures that would provide updates to the *Financial Analysis Handbook* and FAH guidance regarding capital maintenance agreements, surplus notes, and recovery and resolution planning. Our comments pertain to the *FAH Guidance on Surplus Notes* and the *FAH Guidance on Recovery and Resolution Planning*.

Regarding the *FAH Guidance on Surplus Notes*, we oppose the timeframe for insurers to issue subordinated indebtedness and receive funding within 15 days, we oppose the requirement for a surplus floor in surplus notes, and the sequencing of multiple notes with the same floor and payment terms. We request that FASTWG remove vague references from the FAH that can be misinterpreted. Finally, we request that the FAH guidance is subordinate to state statutes; where there are inconsistencies between FAH guidance and state statutes, the statutes must predominate.

(1) **Timeframe** - the exposure requires the insurer to issue the subordinated indebtedness and receive funding within 15 days of the date the order of the commissioner is entered approving the subordinated indebtedness and to provide the insurance department with written evidence that the subordinated indebtedness has been funded. It is unrealistic for an insurer issuing a surplus note to the marketplace (unaffiliated investors) since the timing

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

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of the transaction is a function of market health/dynamics. In one insurer's experience, the insurer has about 90 days to complete their issuance, and the time limit is a function of the lack of "staleness" in their financial statements. Their offering documentation goes stale after a certain amount of time, and the insurer needs to refresh the financial data in the documentation. This requires the insurer to return to their regulator for its reapproval of the renewed documents. Moreover, this timeframe requirement imposes restraints on an insurer's enterprise cash management practices by placing time limits on intercompany issuances of surplus notes that may not align with the insurer's situation. ACLI urges that the 15-day time limits should be removed from the handbook.

(2) **Surplus Floor** - The exposure states that the purpose of the surplus floor, as determined by the insurance department policy, is to ensure that policyholders are protected against hazardous financial conditions that could develop if the floor is too low to provide for the maintenance of adequate capital and surplus. However, not all insurers have surplus floors and believe that surplus floors would be unnecessary since there are regulators with complete control over all payments of principal and interest on all outstanding surplus notes. Since the payment requires regulator's preapproval, the existence of a surplus floor is unnecessary. ACLI urges any references to "surplus floor" to be removed. We also urge to remove the sentence "The primary aim of the analyst's review process is to determine that restrictive language is contained in the surplus note which will protect the policyholders by providing for the maintenance of an adequate level of policyholder surplus", which we believe is analogous to a reference to "surplus floor".

(3) **Multiple Notes/Sequence Repayment** - For multiple notes with the same floor and payment terms, special subordination language in the agreement may be necessary to specify which note will be paid first. One insurer has noted it has multiple surplus notes outstanding and that none of them are specific to the sequencing of surplus note repayment. None of the notes are senior/junior to the others, and the regulator would decide how the notes would be repaid in the unlikely event the insurer was unable to repay the notes. Additionally, the existence of the prioritization of surplus note repayments would be disturbing to investors who purchase notes. When investors buy a surplus note from an issuer, the investor knows that the notes are all *pari passu* from a given issuer. Specifying that a priority of one note over another would significantly alter the debt market for surplus notes. ACLI urges the removal of language specifying which surplus notes need to be paid first.

(4) **Review Procedures, Paragraph 6** – Paragraph 6 directs the analyst to make certain inquiries into the identity of the ultimate holder of the surplus notes. This might be appropriate when the holder is an affiliated insurer or a parent of the insurer. However, for larger surplus notes issuances that are being offered in a capital markets transaction, the notes are typically placed by investment banks or other initial purchasers and then sold on to a large, dispersed group of purchasers. In these instances, insurers do not always know the identity of the purchasers until immediately prior to or after the transaction has closed. Moreover, trading of surplus notes in the secondary market are difficult to track and usually the surplus note issuer does not have a full accounting of the investors in its notes. We would request language making it more clear that paragraph 6(c) would apply if the insurer issues the notes to one or more investment banks or other initial purchasers in a capital markets transaction. (i.e., request language in the note requiring approval of the commissioner before any payment of principal or interest can be made and specifying that the request for payment must be filed at least 30 days prior to the requested payment date).

(5) **Vague Language** – The exposure utilizes vague language. For example, the exposure requires a signed and notarized affidavit that attests that there are no "side agreements" in place. The exposure also states that surplus notes must state that there are no "conditions" placed on an insurer. This vague language presents challenges when drafting surplus notes by creating uncertainty as to the interpretation of such language.

(6) **Inconsistency with State Statutes** – The Financial Analysis Handbook mentions that the referenced requirements are intended to be "sample" requirements that can be adapted by each state. This needs to be emphasized so that each State does not feel obligated to require language in surplus notes that is absent from State statutes. For example, the exposure requires a signed and notarized affidavit that attests that the insurer will adhere to the timeframe requirements listed in (1) above. While some States, like Texas, have these requirements codified within their statutes and regulations (See 28 TAC s 7.7), many States do not.

Regarding the *FAH Guidance on Recovery and Resolution Planning,* we oppose the proposed revisions in the section on **Crisis Management Group** that would automatically require an IAIG to develop a recovery plan. ACLI believes that both recovery and resolution plan supervisory requirements should not be applied mechanically. Instead, only when a process involving an activities-based risk assessment that uses clear criteria, as defined by standards or guidelines developed by the supervisor and/or resolution authority, indicates the existence of a micro or macro-prudential risk, that is not mitigated by the existing supervisory process and/or an insurer's ERM framework and contingency plans, should a supervisor, using its judgment, including input from a CMG where applicable, require company action on resolution and recovery plans.

We, therefore, urge this Working Group to make the following edits to the proposed revisions in the section on **Crisis Management Group**:

(1) In the first sentence of the third bullet, restore the phrase "determine whether to"
(2) In the second sub-bullet of the third bullet:
 (a) begin the first sentence with "If the group-wide supervisor determines that an IAIG is required to develop recovery plan,"
 (b) delete "for a recovery plan for an IAIG" at the end of the first sentence
 (c) delete the entire second sentence.
(3) In the fifth sub-bullet of the third bullet:
 (a) add the phrase "if one is required" after "recovery plan" in the first sentence
 (b) replace "if there is one" with "if one is required" after "resolution plan" in the first sentence

Thank you once again for your consideration of our comments.

Sincerely,

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IV.A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations

**********************TEXT REMOVED TO CONSERVE SPACE*******************************

G. Income Statement, Surplus, and Capital and Surplus Notes

**********************TEXT REMOVED TO CONSERVE SPACE*******************************

Capital and Surplus Notes

The components of surplus can include common capital stock, preferred capital stock, gross paid-in and contributed surplus, surplus notes, unassigned funds (or retained earnings), and special surplus funds (usually established through an appropriation of unassigned funds). Each state has, by statute, established a minimum required amount of surplus for insurers. In some states, these minimum amounts are based on the lines of business written, while in other states the minimum amounts are based on the type of insurer. In addition, the RBC requirements must also be met.

Insurers may issue capital or surplus notes as a source of financing growth opportunities or to support current operations. Surplus notes (sometimes referred to as "surplus debentures" or "contribution certificates") have the characteristics of both debt and equity. Surplus notes resemble debt in that they are repayable with interest and sometimes, depending on the requirements of the domiciliary state insurance department, include maturity dates and/or repayment schedules. However, key provisions of the surplus notes make them tantamount to equity. These provisions include approval requirements as to form and content and the requirement that interest may be paid, and principal may be repaid only with the prior approval of the domiciliary state insurance department. SSAP No. 41R - Surplus Notes requires that interest on surplus notes is to be reported as an expense and a liability only after payment has been approved. Accrued interest that has not been approved for payment should be reflected in the Notes to Financial Statements. Provided that the domiciliary state insurance department has approved the form and content of the surplus notes and has approval authority over the payment of interest and repayment of principal, surplus notes are considered to be surplus and not debt. The proceeds from the issuance of surplus notes must be in the form of cash, cash equivalents, or other assets having a readily determinable value satisfactory to the domiciliary state insurance department. Information regarding surplus notes must be reported in the Annual Financial Statement, Notes to Financial Statements #13.

Insurers may also issue capital notes, which are reported as a liability by the insurer, and are therefore treated as debt instruments (although in liquidation rank with surplus notes) and are subordinate to the claims of policyholders, claimants, and general creditors. 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,

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but instead should be reflected in the Annual Financial Statement, Notes to Financial Statements #11, similar to surplus note interest payments that have not been approved.

Capital and surplus notes may have the effect of enhancing surplus or providing funds only on a temporary basis. Capital and surplus notes may be issued to either an affiliated entity or a non-affiliated entity. The person or entity that holds the capital or surplus note may expect repayment on a scheduled basis and may exert pressure on the insurer to generate cash in order to be able to make the payments. When reviewing a request to issue a capital or surplus note to non-affiliated entities, analysts should be aware that non-affiliated entities, such as third-party banks, may require higher interest rates than an affiliated person/entity. As noted, pressure exerted by a third-party holder of the capital or surplus note on the insurer may make it more difficult for the state insurance regulator to disapprove an interest payment on the capital or surplus notes. Failure to make interest payments on third-party notes may impact credit ratings (i.e., AM Best).

As a result, analysts should be cautious when reviewing insurers that rely heavily on these notes. Capital and surplus notes are not inherently bad. They have provided regulators with flexibility in dealing with problem situations to attract capital to insurers whose surplus levels are deemed inadequate to support current operations. They provide a source of capital to mutual and other types of non-stock entities who do not have access to traditional equity markets and provide an alternative source of capital to stock reporting entities.

The primary aim of the analyst's review process is to ~~determine that restrictive language is contained in the surplus note which will protect the policyholders by providing for the maintenance of an adequate level of policyholder surplus and subordinating the rights of the capital or surplus note holder(s) to the claims of the policyholders in the event of liquidation.~~ensure that surplus notes, as outlined in SSAP No. 41R(3), are subject to strict control by the commissioner and contain the following provisions for classification as surplus rather than debt:

- Subordination to policyholders;
- Subordination to claimant and beneficiary claims;
- Subordination to all other classes of creditors other than surplus note holders; and
- Interest payments and principal payments require prior approval of the commissioner of the state of domicile.

State insurance departments may establish rules or guidance for when a state must complete its approval/disapproval ~~(i.e., deemer date)~~ for a capital or surplus note request. Timely review and processing of these requests is essential to ensure the insurer's financial stability and regulatory compliance. The review of a surplus note should be completed within [days set forth by the state's insurance department rules, e.g., 30 days]. However, it's essential to note that state laws supersede these general guidelines. Analysts should always refer to the specific requirements outlined by the relevant state insurance department when reviewing surplus notes for approval.

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Review Procedures of an Insurer's Request to Issue Capital or Surplus Notes

1. Review the application to verify that all of the information required under the state's statutory rules or guidance have been provided (the following are examples that may differ from your states' rules).
    a. Identity of all parties to the transaction.
    b. The nature and purpose of the transaction, including a description of how the subordinated indebtedness relates to the future business plans of the insurer.
    c. A description of the consideration to be received by the insurer in exchange for the issuance of the subordinated indebtedness.
    d. A description of how the value of the consideration was determined.
    e. A statement as to whether any officers or directors of a party are pecuniarily interested in the transaction.
    f. A copy of the proposed written surplus note (or capital note) agreement.
    g. Request copies of any other side agreements with the holder of the note including any other documents prepared and distributed that describe the surplus note and its purpose, as it relates to non-affiliated notes.
    h. Include a payment schedule for future principal and interest payments. Note, that payment schedules are more common in non-affiliated surplus notes agreements.
    i. A signed and notarized affidavit of an executive officer of the insurer that states: "The insurer is aware of the requirements of the insurance department regarding notices to the insurance department relating to the payment of interest or the repayment of principal corresponding to subordinated indebtedness and agrees to comply with such requirements. ~~The insurer agrees no other side agreements are in place. The insurer agrees to issue the subordinated indebtedness and receive funding within 15 30 days (for affiliated notes and potentially longer for unaffiliated notes depending on the marketplace for unaffiliated investors) of the date the order of the commissioner is entered approving the subordinated indebtedness and to provide the insurance department with written evidence that the subordinated indebtedness has been funded." ~~The insurer agrees that all ~~material~~ agreements governing the terms of the surplus notes have been shared with the commissioner. The insurer agrees to issue the subordinated indebtedness and receive funding within a reasonable time after the date the order of the commissioner is entered approving the subordinated indebtedness, not to exceed (i) 30 days for affiliated notes and (ii) 90 days for unaffiliated notes; provided, that if the insurer fails to issue the subordinated indebtedness and receive funding within the applicable timeframe, the insurer shall not issue any capital notes or surplus notes that were previously approved until the insurer applies for and receives an updated approval from the commissioner.
    j. The note includes the following terms:
        i. Surplus floor, ~~as determined by the insurance department policy~~if required by insurance department regulations. The purpose of a floor is to ensure that policyholders are protected against hazardous financial conditions that could develop if the floor is too low to provide for the maintenance of adequate capital and surplus.
        ii. Repayment. Provisions for repayment should be clearly set forth in the agreement.

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iii. Receivership. In the event of liquidation any payment of interest or repayment of principal under the agreement shall be in accordance with the department's Insurer Receivership Act. The written agreement should include specific language as required by the insurance department. For example:
  - "This surplus note is subject to the provisions of [insert state law], which binds the company and its successors and assigns. If action is taken against the company or its assets under the [insert state law], this surplus note shall be paid in accordance with the applicable [chapter or provision of the law]."

iv. For a note with a sinking fund. If the subordinated indebtedness includes a provision for the payment or repayment only out of a sinking fund established by the insurer by setting aside a specified amount during a specified period, all payments must be made from the established sinking fund subject to the minimum surplus stated in the written agreement, and such amount accumulated and held in the sinking fund shall be a legal liability and financial statement liability of the insurer.

k. ~~The agreement must state that there are no conditions placed on the insurerthis surplus note constitutes the entire agreement between the parties with respect to the herein and there are no additional representations or agreements.~~ Either (i) the agreements governing the surplus notes and provided to the commissioner shall state, or (ii) the insurer shall represent to the commissioner, that such agreements provided to the commissioner, ~~taken together,~~ constitute the entire agreement between the parties with respect to the surplus notes issuance.

2. Assess the purpose and impact of the proposed transaction on the insurer.

3. Verify that the note complies with SSAP No. 41(4) which provides that proceeds received by the issuer must be in the form of cash or other admitted assets having readily determinable values and liquidity satisfactory to the commissioner.
   a. What asset is the insurer receiving in exchange for issuance of the note?
      - The preferred asset is cash.
      - If not cash, the asset must comply with the investment limitations prescribed by the state insurance department.
      - The purchaser of the note should not give a partnership as consideration to the insurer.
      - The Insurer cannot pledge stock in exchange for consideration as that would involve a change in control and require a Form A filing.

   b. Assess the impact of non-cash assets on the mix of assets in the insurer's portfolio. Does the insurer maintain a high concentration in a class of assets that raises regulatory concerns?
   c. Will the proceeds of the note increase investment risk? Consider diversification, asset quality and cash flow needs of the insurer.

4. Verify that the note complies with SSAP No. 41(5) which provides that (1) accrued interest may not be added to principal and (2) interest shall not accrue on unpaid interest.

5. Assess the interest rate on the note. Ask the insurer for evidence that the rate is a market rate if that information is not provided in the application.
    a. Note some states' laws cap interest rates on capital and surplus notes.
    b. Floating interest rates are not appropriate for capital and surplus notes.

6. If the insurer is applying for approval to issue a capital note or surplus note to:
    a. an affiliated insurer, verify that the holder has sufficient excess policyholder surplus available for transfer to the insurer. Verify whether the holder will be able to record the debenture as an admitted asset and understands the reporting requirements pursuant to SSAP No. 41R (paragraphs 9 to 13).
    b. a nonaffiliated insurer, verify whether the holder will be able to record the debenture as an admitted asset pursuant to SSAP No. 41R (9), (10) & (11). Consider whether the holder has sufficient excess policyholder surplus if the note is not admitted.
    c. ~~-~~If the insurer issues the notes to one or more investment banks or other initial purchasers in a capital markets transaction~~a nonaffiliated investment pool or if the insurer is a nonprofit legal services corporation~~, request language in the note requiring approval of the commissioner before any payment of principal or interest can be made and specifying that the request for payment must be filed at least 30 days prior to the requested payment date [Notes: Refer to the state's requirement when a nonaffiliated investment pool is the holder, or when the insurer is a nonprofit legal services corporation, or any other unique situations defined in the state's requirements].
    d. its parent, request information about the source of the funds. It is not uncommon for the parent to borrow the money from a bank, and the parent's bank note will mirror the terms of the surplus note. Request a copy of the parent's note. If the parent is borrowing money from a bank to loan to the insurer, this is a red flag that the parent may be dependent on the insurer for the cash flow necessary to service the bank note. Ask the insurer about the parent's sources of revenue available to service the bank note. Review closely the insurer's ability to service this parent company debt. It may be necessary to request projections demonstrating the parent's debt service.
    e. other relationship (i.e., another person or entity not included in a-d above) It is important to understand the parties involved and the relationship between the parties and the insurer.

7. Consider the insurer's current financial condition and operating trends (RBC ratio, net premium to surplus ratio, net income, or loss, increasing or decreasing surplus, increasing, or decreasing premium production).
    a. How much of the insurer's surplus is represented by the capital or surplus note?
        i. If the note is with an affiliate or parent, review the reasons why surplus is being requested in the form of a capital or surplus note rather than through a capital and surplus contribution.

ii. Assess the insurer's ability to generate sufficient income to repay note, in particular in situations where the note is being issued to a non-affiliate.
iii. Note that Reciprocal insurer's surplus is often 100% in the form of surplus notes.

b. Does the insurer have any earned surplus or possibly an earned surplus deficit?
c. Ensure the note does not include provisions that would pledge the insurance company's stock.
d. Confer with the assigned financial analyst and/or your department supervisor if any of the financial information raises questions/concerns.

8. Verify the terms of any other capital or surplus notes currently outstanding.
   a. What is the surplus floor, if required by insurance department regulations, and payment date(s) for the other notes?
   b. Gain an understanding of the order in which the surplus notes will be paid off if there are more than one, and they contain special subordination language. Make certain that any older notes do not contain a lower surplus floor, if required by insurance department regulations, and payment dates that could trigger the insurer to pay out the surplus obtained from the new note. This does not preclude an insurer from using the proceeds of a new surplus note to pay off an existing surplus note that is maturing, if approved by the commissioner as part of the review of the surplus note and transaction.
   c. For multiple notes with the same floor and payment terms, ~~special subordination language in the agreement may be necessary to specify which note will be paid first~~understand if there is special subordination language in the agreement regarding order of payment on the notes. This does not require special subordination language be included in the surplus note.

9. Collaborate with the supervisor and other relevant department staff to discuss issues that could not be resolved during the review process and develop a possible course of action.

Review of Amendments of Capital and Surplus Notes

1. Review the amendment using the procedures above.

Review of Requests for Principal/Interest Payments on Capital and Surplus Notes

Each principal and interest payment request may be required to be reviewed and approved by the state insurance department in advance of the payment, under state law. Review your state's law to determine those situations when prior state insurance department approval is required. For example:

- The proposed payment does not conform to a payment schedule contained in the note agreement, or the note does not provide for a payment schedule.
- If the insurer is a county mutual, when making payments of principal or interest on a loan from a policyholder.
- If the insurer is a reciprocal or inter-insurance exchange, when making payments of principal or interest on money advanced from its attorney in fact.
- Payments on notes issued to investment pools.

Consider the following when reviewing an application for approval to make a capital or surplus note payment:

1. Utilize similar considerations as with the review of dividend payment requests.

2. Consider the financial impact of the proposed payment and the insurer's overall financial condition in order to evaluate the adequacy of the insurer's policyholder surplus.
    - Consider risk-based capital, premiums to surplus ratio, trends in writings, profitability, and business plans.
    - Request a pro-forma financial statement that reflects the insurer's financial position after the payment is made.
    - Review the total consideration being paid through dividends along with the payment of the surplus note, to gain an understanding of the financial impact of the aggregate of payments being made to the holder of the note.
    - Will the company retain sufficient surplus after the payment to meet its floor requirement as stated in the note agreement?

3. Identify the source of funds to make the payment and the impact on the insurer's liquidity.

4. Review the request against the payment schedule that was provided to the regulator when the capital or surplus note was originally requested and approved.

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V.C. Domestic and/or Non-Lead State Analysis – Form D Procedures

**********************TEXT REMOVED TO CONSERVE SPACE******************************

Assessment of Form D – Prior Notice of a Transaction

**********************TEXT REMOVED TO CONSERVE SPACE******************************

17. For affiliated capital or surplus notes, amendments or requests for payment of principal or interest, utilize the review procedures as outlined in this Handbook, IV.A. Supplemental Analysis Guidance, Section G. – Income Statement, Surplus and Capital and Surplus Notes.

V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

**********************TEXT REMOVED TO CONSERVE SPACE******************************

Form D – Prior Notice of a Transaction

PROCEDURES #1-1~~9~~6 assist analysts in reviewing the Form D filing for completeness and help guide analysts through major items of information required by Form D.

PROCEDURE #17. Capital or surplus notes may be issued to either affiliated or non-affiliated entities. Where an affiliated capital or surplus note is requested, amended or a request for payment is made, refer to the review procedures as outlined in this Handbook, IV.A. Supplemental Analysis Guidance, Section G. – Income Statement, Surplus and Capital and Surplus Notes, for further guidance.

PROCEDURES #1~~7~~8ix – 1~~7~~8xiii assist analyst in reviewing captive reinsurance transactions other than those subject to Actuarial Guideline 48. Refer to the guidance in chapter III.B.9.b. Strategic Risk – Analyst Reference Guide, procedure 9cc for an explanation of potential risks. Where risks are noted at the time of the Form D review or if follow-up is recommended, consider requesting any follow-up be conducted as part of the next financial condition examination to review against expected results.

**********************TEXT REMOVED TO CONSERVE SPACE******************************

Additional Procedures on Key Risk Areas – Insurance Holding Company System

**********************TEXT REMOVED TO CONSERVE SPACE******************************

Financial Position

11. Review the insurance holding company's statement of shareholders' equity. (ST, OP)
    a. Has equity decreased from the prior year or deteriorated over the past three years? If "yes," describe the reason(s) for the decline.
    b. Does the net worth of the insurer(s) represent the total net worth or the majority of the net worth of the insurance holding company system?
    c. Is the net worth of the insurance holding company system less than the net worth of the insurer(s)?
12. If publicly traded, review the changes in the insurance holding company's outstanding common stock. Document and understand the nature and business purpose of the following: new stock issuance; stock repurchase, stock split, short sales, or change in major exchange listings. (ST)
13. Have any insurer(s) of the insurance holding company paid extraordinary dividends upstream? If "yes":
    a. Assess the nature of the dividends and the amount of dividends paid in relation to prior year surplus to determine the materiality of the insurance company dividends. (OP, ST)
    b. Compare current year extraordinary dividends to prior year dividends to identify any excessive trends in payments. (ST)
14. Do any insurer(s) in the group have capital and surplus notes? If "yes":
    a. Assess the aggregate of capital and surplus notes issued to the parent, affiliates, related parties, or non-affiliates.
    b. Have any new capital or surplus notes been issued, amended or paid in the past year?

**************PRECEDING TEXT NOT SHOWN**************

- **Crisis Management Group**[i] – The group-wide supervisor establishes a crisis management group (CMG) for the IAIG, with the objective of enhancing preparedness for, and facilitating the recovery and resolution of, the IAIG[ii].
  - There should be clear membership conditions, and members should include the group-wide supervisor, other relevant involved supervisors, and relevant resolution authorities, if possible.
  - The CMG should keep under active review the process for sharing information within the CMG and with host resolution authorities not represented, the processes for recovery and resolution planning for the IAIG, and the resolvability of the IAIG.
  - The role, priorities, and approach of any CMG should be proportional to the group's organization, capital structure, characteristics, and financial condition.
  - The group-wide supervisor, in consultation with the CMG, should determine whether to require that the IAIG develop a recovery plan[iii] to establish in advance the options to restore the financial position and viability of the IAIG in a crisis, as well as how and when the plan should be updated on an ongoing basis. The role, priorities, and approach of any CMG should be proportional to theeach group's organization, capital structure, characteristics, and financial condition.
    - Regardless of whether a formal recovery plan is required, As stated in the *ORSA Guidance Manual*[iv], "the ORSA Summary Report should discuss at a high level the severe stresses that could trigger a recovery plan measures and the recovery options available." In the US, the information provided in the ORSA Summary Report or other ERM reporting should generally satisfy the requirement to develop a recovery plan for an IAIG.[v] However, the U.S. group-wide supervisor, in consultation with the CMG, should determine through an activities-based approach, whether or not to require a stand-alone recovery plan that is in addition to the recovery information provided through ERM/ORSA.
    - The group-wide supervisor should determine whether the information provided in the ORSA Summary Report or other ERM reporting satisfies the requirement for a recovery plan for an IAIG. If the requirement is not satisfied based on that determination, the group-wide supervisor should require a stand-alone recovery plan that is in addition to the recovery information provided through ERM/ORSA.

[i] For additional guidance, refer to the *Receiver's Handbook for Insurance Company Insolvencies* Exhibit 8-1, [insert chapter/appendix reference] and the *Troubled Insurance Company Handbook* (regulator only publication) Chapter 5 and Appendices G-J [insert chapter/appendix reference].
[ii] Refer to ICP CF 25.7.a.
[iii] Refer to ICP CF 16.16 and the IAIS Application Paper on Recovery Planning for more background information and possible best practice guidance regarding governance, monitoring, updating the recovery plan, and key elements of a recovery plan (e.g, stress scenarios, trigger frameworks to identify emerging risks, recovery options, communication strategies, and governance). (https://www.iaisweb.org/home)
[iv] 2022 *ORSA Guidance Manual*, page 14. https://content.naic.org/sites/default/files/publication-orsa-guidance-manual.pdf
[v] ICP CF 16.16.a requires recovery plans for IAIGs. In the U.S., existing available recovery information is considered first in determining a recovery plan requirement.

- ~~The group-wide supervisor, in consultation with the CMG, should determine whether to require that the IAIG develop a formal~~ A recovery plan[vi] ~~to~~ establishes in advance the options to restore the financial position and viability of the IAIG in a crisis, as well as how and when the plan should be updated on an ongoing basis.
- The recovery plan should be utilized by the CMG and the IAIG to take actions for recovery if the IAIG comes under severe stress.
- It is recommended that the group-wide supervisor consider the IAIG's nature, scale, and complexity when setting recovery plan requirements, including the form, content, and detail of the recovery plan and the frequency for reviewing and updating the plan.
- The head of the IAIG should ~~maintain~~ ensure that the IAIG's management information systems ~~that~~ are able to produce ~~and communicate~~, on a timely basis, information that is relevant ~~necessary for the preparation~~to the recovery plan (as determined—see above.) and necessary for the execution of recovery actions~~to the recovery plan~~[vii]. Similarly, management information systems should be able to produce information on a timely basis for resolution authorities, for purposes of preparing for resolution and taking resolution actions[viii]. ~~, and for the resolution plan if there is one. on a timely basis.~~The group-wide supervisor ~~(GWS)~~ should ensure that the management information systems are capable of being operated effectively by the receiver, if receivership becomes necessary.
- ~~Regardless of whether a formal recovery plan is required, the ORSA Summary Report should discuss at a high level the severe stresses that could trigger a recovery plan and the recovery options available.~~

○ With regard to ~~R~~resolution plans[ix] ~~are put in place at IAIGs where~~ the group-wide supervisor and/or resolution authority, in consultation with the CMG, should ~~deems necessary. Where a resolution plan is required, the group-wide supervisor and/or resolution authority, in coordination with the IAIG CMG, should:~~have a process to regularly ~~D~~determine whether a resolution plan is necessary, including consideration of factors such as the size, risks, activities and complexity of the IAIG[x] ~~-~~.

○ Where a resolution plan is required, the group-wide supervisor and/or resolution authority, in coordination with the IAIG CMG[xi]:
  - Ensures that the plan covers at least the group's material entities.
  - Requires relevant legal entities within the IAIG to submit necessary information for the development of resolution plan.

[vi] Refer to ICP CF 16.1~~5~~6.a and the IAIS Application Paper on Recovery Planning for more background information and possible best practice guidance regarding governance, monitoring, updating the recovery plan, and key elements of a recovery plan (e.g, stress scenarios, trigger frameworks to identify emerging risks, recovery options, communication strategies, and governance). (https://www.iaisweb.org/home)
[vii] Refer to ICP CF 16.16.b, ICP CF 16.16.b.1 and ICP CF 16.16.b.2
[viii] Refer to ICP CF 12.3.a
[ix] Refer to ICP CF 12.2, ICP 12.4, ICP CF 12.4.a ~~and 12.3~~ and the Application Paper on Resolution Powers and Planning for more background information and possible best practice guidance, including the approach to determining if resolution plans are needed and key elements of a plan (e.g., resolution strategies, financial stability impacts, governance, communication, and impact on guaranty fund systems). (https://www.iaisweb.org/home)
[x] Per ICP CF 12.4.a.1, factors to be considered are set out in ICP 12.4
[xi] Refer to ICP CF 12.4.b

- ~~The head of the IAIG should maintain management information systems that are able to produce and communicate information relevant to the resolution plan on a timely basis.~~
- Regularly undertakes resolvability assessments to evaluate the feasibility and credibility of resolution strategies, in light of the possible impact of the IAIG's failure on policyholders and the financial system and real economy in the jurisdictions in which the IAIG operates.
- Requires the IAIG to take prospective actions to improve its resolvability.

- The group-wide supervisor puts in place a written coordination agreement[xii] between the members of the IAIG CMG, which covers the following:
  - Roles and responsibilities of the respective members of the IAIG CMG.
  - The process for coordination and cooperation, including information sharing among members of the IAIG CMG.

[xii] Refer to the IAIS Application Paper on Supervisory Colleges, Nov. 2021, and the Application Paper on Resolution Powers and Planning, June 2021.

Financial Analysis Handbook Guidance for Parental Guarantees and/or Capital Maintenance Agreements

III.B.9. Strategic Risk Assessment

**********************TEXT REMOVED TO CONSERVE SPACE*******************************

~~Procedure #11X assists analysts in a~~Assess~~ing~~ current and prospective risk related to existing Parental Guarantees and/or Capital Maintenance agreements.

Parental Guarantees and Capital Maintenance Agreements are commitments aimed at providing assurance that the insurer will be able to meet minimum financial obligations if financial or liquidity issues arise. These documents should be carefully reviewed along with the financial background of the entity required to fund the guarantee or agreement. Analysts may also inquire of the insurer if a contingency plan is in place in the event the parental guarantee or capital maintenance agreement is not honored. Review and assess any parental guarantees, capital maintenance agreements or other commitments in place and determine if concerns exist regarding financial support or failures to act on these commitments. Analysts should thoroughly review the terms related to the agreement to gain a clear understanding of what is covered in the agreement (e.g., limit on lines of business, commitment to pay policyholder claims, commitment to maintain RBC level, etc.) and the impact to the insurer.

Additional information on Capital and Surplus notes can be found in IV.A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations.

Analysts should also consider the following:

- Expected source and form of liquidity should guarantees be called upon.
- If the parental guarantee or capital maintenance agreement specifically address the concerns identified and provide adequate support to the insurer. o If concerns exist, consider requesting additional information, as necessary, to understand the level of commitment.
- Whether the document contains detailed requirements or expectations for capital support.
- The financial stability of the parent holding company to determine if the parent is adequately capitalized to support maintenance of capital in the insurer above certain thresholds.

If a holding company analysis group profile summary (GPS) is available, analysts should review the GPS for insight into the parent company or ultimate controlling person (UCP) and its ability to meet the financial demands of the guarantee currently or prospectively. Review pertinent data on the holding company and its organizational structure as well as the operations and financial condition of the holding company or UCP. Determine if there are liquidity or other concerns identified within the GPS that warrant additional information from the company.

Procedures

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11. Evaluate the adequacy of the insurer's total capital and surplus position in light of its business/strategic plans and risk exposures

- x. Review Annual Financial Statement, Notes to Financial Statements, Note #14 to identify any parental/affiliated guarantees, of any form, in place between the company and any member within its holding company system, or non-affiliate.
  - If guarantees are in place, review the ratio of capital notes or surplus notes to total capital and surplus to understand the significance of the note(s).

Additional Review Procedures:

ADDITIONAL PROCEDURES, including prospective risks, are also available iIf the level of concern warrants further review, as determined by analystsconsider:

- Review and discuss with the company and evaluate the potential effect of capital notes or surplus notes on the insurer's surplus position.
- If the insurer is subject to ORSA reporting requirements, there may be a great deal of information on the insurer's capital/surplus position to be reviewed and evaluated in the ORSA Summary Report, as outlined in procedure #11p. Other possible procedures to perform if concerns are identified are outlined in procedures #11q–#11x. For example,
- Review 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, analysts should consider rReviewing the information in the Annual Financial Statement, Notes to Financial Statements #11 and Note #13. If either capital and surplus notes were issued or repaid, or if interest was paid during the year, analysts should consider determineing that these transactions were approved by the domiciliary state insurance department.
- In addition, iIf surplus notes represent a significant portion of surplus, analysts should consider recalculating important ratios, excluding the surplus notes, to determine their effect on the ratio results. Other steps to consider include the r
- Review of the detail of unrealized gains (losses),.
- assessment of any parental guarantees in place and the review ofGain an understanding of other components of surplus.

V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

**********************TEXT REMOVED TO CONSERVE SPACE********************************

Form A – Statement of Acquisition of Control of or Merger with a Domestic Insurer

PROCEDURES #7-8 provide steps to ensure that information provided on purchase considerations in the Form A filing is in compliance with application requirements. In addition, the steps provide guidance for assessing the purchase considerations including source of funds & consideration, debt financing, and voting securities.

PROCEDURES #7 - Review of a Parental Guarantee or Capital Maintenance Agreement

Analysts should consider the following when reviewing a parental guarantee or capital maintenance agreement (CMA) that may be included with a Form A filing:

- The agreement should clearly outline:
  - The parties or insured covered under the agreement should be clearly outlined in the agreement.
  - The parents' obligation to provide capital in order to maintain an adequate level of capital or minimum RBC Ratio level (e.g., ##.#% of ACL).
- Review the terms of the agreement including the effective date, renewal terms and termination provisions. Determine whether the agreement has an expiration date or dollar limit threshold on capital, or if a pre-approved alternative funding method will be provided. Understand the minimum level of RBC % that is expected to be maintained under this agreement.
- Ensure that any modifications or demands under this agreement should be reviewed and approved by the domiciliary insurance department.
- If the parental guarantee or CMA specifically addresses the concerns identified and provides adequate support to the insurer.
- If concerns exist, consider requesting additional information, as necessary, to understand the level of commitment.
- Evaluate the financial stability of the parent holding company (or other affiliated entity providing the guarantee such as an intermediate holding company), to determine if the parent is adequately capitalized to support/maintain the capital in the insurer above minimum thresholds. Evaluate the impact of providing a parental guarantee or CMA on any debt covenants of the parent, if applicable.

Situations when it may be appropriate to request an Insurer/Group develop and submit a parental guarantee or CMA to the state insurance regulator:

- When an applicant has submitted a new Form A application for change in control of an insurer, if deemed necessary.
- When the insurer has triggered Hazardous Financial Condition or an RBC action level.
- When an insurer has applied for either primary or foreign licensure in your state.
- When there are material concerns identified with other affiliated agreements within the group.

Reliance on a CMA or Parental Guarantee

- States should exercise caution in relying on a parental guarantee or CMA for regulator actions such as licensure approval.
- Domestic states should proactively communicate to other licensed state(s) when a parental guarantee or CMA has been approved (or denied), modified or terminated.

**********************TEXT REMOVED TO CONSERVE SPACE********************************

Form D – Prior Notice of a Transaction

PROCEDURES #1-1*~~6~~*8 assist analysts in reviewing the Form D filing for completeness and help guide analysts through major items of information required by Form D.

PROCEDURES #17ix – 17xiii assist analyst in reviewing captive reinsurance transactions other than those subject to Actuarial Guideline 48. Refer to the guidance in chapter III.B.9.b. Strategic Risk ~~Repository~~ – Analyst Reference Guide, procedure 9cc for an explanation of potential risks. Where risks are noted at the time of the Form D review or if follow-up is recommended, consider requesting any follow-up be conducted as part of the next financial condition examination to review against expected results.
PROCEDURE #18. For a parental guarantee or capital maintenance agreement Form D, utilize the procedures and guidance in Chapter V.F - Form A, to complete the review.

V.B. Domestic and/or Non-Lead State Analysis – Form A Procedures
**********************TEXT REMOVED TO CONSERVE SPACE*******************************

Purchase Consideration

7. Analyze the source, nature, and amount of consideration used (or to be used) in effecting the merger or acquisition of control and assess the ability of the entity to fund the insurance company.

a. Determine fairness (equivalency) of total amount to be paid to total value to be received, including derivation of price and value of target under standard valuation methodologies or to book value.

b. Consider quality of consideration, giving careful scrutiny to payments other than cash or cash equivalents which are disfavored particularly when any funds are being transferred to the target.

c. Consider fairness opinions and actuarial appraisals, if provided.

d. Consider source, type and valuation basis of funds to be used for consideration.
    i. If funds are from a regulated entity, confirm the existence and valuation of such assets with that entity's regulator.

e. Where the applicant issues or assumes debt obligations or is required to fulfill other future obligations as a result of the purchase or through existing agreements, review the holding company's cash flow projections to ensure that cash flows appear adequate to cover such obligations without relying heavily on cash flows from the insurer.

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

g. If the Form A involves a parental guarantee agreement or capital maintenance agreement, the analyst should utilize the guidance and procedures noted in the Analyst Reference Guide chapter V.F. Domestic and/or Non-Lead State Analysis – Form A, to review the agreement.

V.C. Domestic and/or Non-Lead State Analysis – Form D Procedures
**********************TEXT REMOVED TO CONSERVE SPACE*******************************

18. Form D – Prior Notice and Application for Approval of Certain Transactions

- For a parental guarantee or capital maintenance agreement Form D filing, utilize the procedures and guidance in Chapter V.F - Form A, to complete the review, including a review of the time frame, maximum amount of the guarantee, and any provisions that may impact the guarantee.

III.A.5. Risk Assessment (All Statement Types) - IPS Example
VI.C.1. Group-Wide Supervision – Group Profile Summary Example

Include the following within the examples of an IPS (holding company impact section) and GPS (overview or strategic risk section).

Sample text:

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

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: Greg Chew (VA), Chair, Financial Analysis Solvency Tools (E) Working Group

FROM: Amy Malm, Chair, Risk-Focused Surveillance (E) Working Group

DATE: October 10, 2024

RE: Runoff Insurer Guidance

In spring of 2024, the Risk-Focused Surveillance (E) Working Group received a referral from the Financial Analysis (E) Working Group (FAWG) recommending additional best practices in the oversight of solvent runoff insurers. Because the recommendations were relevant to both financial analysis and financial exams, the topic was referred to the Risk-Focused Surveillance (E) Working Group so that guidance could be developed together for both functions.

During its July 17 virtual meeting, the Working Group discussed proposed additions to NAIC handbooks to incorporate the best practices recommended by FAWG. The proposed revisions were then exposed for a 45-day public comment period, with comments received from various interested parties as a result of the exposure. During its Oct. 10 virtual meeting, the Working Group discussed the comments received, as well as an updated draft of the proposed guidance that was modified to address the comments received. During that meeting, the Working Group agreed to finalize the proposed analysis guidance and refer it to the Financial Analysis Solvency Tools (E) Working Group for consideration of adoption. The proposed edits to the NAIC's *Financial Analysis Handbook* are provided in **Attachment One** of this memorandum.

As the proposed revisions have been thoroughly reviewed and subject a public comment period, we recommend they be considered for adoption without additional public exposure or significant modifications, to ensure the guidance remains consistent with guidance proposed for the NAIC's *Financial Condition Examiners Handbook*.

If there are any questions regarding the proposed recommendations, please contact us or NAIC staff (Bruce Jenson at *bjenson@naic.org*) for clarification. Thank you for your consideration.

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J. Insurers in Run-Off

Run-off may be either a voluntary or state mandated course of action where the insurer ceases writing new policies on a portion of business, or all business written. A company in run-off should prepare a run-off plan outlining how it will manage its resources in this stage of its operations. During run-off, the insurer typically continues collecting premiums on mandatory policies for a statutorily mandated period and ~~to~~ through policy expiration dates. The degree and timing of the reduction in premiums should be closely monitored through the projections provided within the run-off plan. The specific content of the run-off plan may vary depending upon the line and nature of business in run-off and the financial condition of the insurer; however, at minimum, the plan should include the size of the operations during run-off, employee retention plans, consideration of key decision points (such as when employees may be terminated, whether loss portfolio transfers may occur, or whether companies be merged or sold), and key performance indicators and metrics for the run-off (e.g., cashflow projections and Asset Liability Management plans). The run-off of claims becomes the focus of attention until the last dollar of exposure is paid. The risk exposures for insurers in run-off are likely to be different than that of an insurer writing new business; therefore, it may be necessary for an analyst to narrow the focus of the annual analysis and ongoing oversight of the insurer. Insurers that are no longer actively writing new business but continue to service policies and run-off long term claim liabilities often require customized solvency monitoring procedures and considerations. In addition to analysis outlined in the branded risk assessments. ~~The focus of the analysis of a run-off insurer may include, but not be limited to, the following:~~

Scope: Please note that the following guidance pertains to *solvent* run-off insurers, as the Handbook guidance is not applicable to those companies in receivership[1]. In particular, the below guidance most directly applies to insurers whose entire company is in run-off. Some elements of the guidance may be applicable in other run-off situations (e.g., one block of business is in run-off), and the examiner/analyst should use judgment in determining which elements may be relevant and in applying them to the risk-focused process.

The focus of the analysis of a run-off insurer may include, but not be limited to, the following:

Run-Off Plan (ST, OP)~~.~~

- Analysts should obtain a copy of the run-off plan at the beginning of the run-off process and determine whether the plan is reasonable. The evaluation may include:
    - ~~-~~Consider the overall planning process and related assumptions built into the run-off projections.
    - ~~e~~Evaluate the effectiveness of the insurer's run-off plan by tracking the company's progress against its plan. ~~and determine whether the plan is determined to be reasonable. While reviewing the plan, analysts should:~~ Analyze and document any variances in projected exposures, claims counts, and cash flow needs.
    - ~~Consider the overall planning process and related assumptions built into the run-off projections.~~
    - Review the plan to ensure it covers size of operations during the run-off, employee retention plans, consideration of key decision points, and key performance indicators and metrics for the run-off, including cashflow projections and Asset Liability Management plans.
    - Assess the management team and its retention of staff to determine if they possess the expertise to achieve a successful run-off.
    - Gain an understanding of the insurer's record-keeping processes, with special attention paid to claims records and data sources, including that the data is in a usable format and that the insurer has the

[1] For further guidance on run-off of insurers deemed to be financially troubled, refer to the NAIC *Troubled Insurance Company Handbook* (regulator only publication). For further guidance on insurers in receivership, refer to the NAIC *Receiver's Handbook for Insurance Company Insolvencies*.

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ability to transfer claims data to guaranty funds in the event of receivership, as needed in a timely manner.[2]

- Gain an understanding of the insurer's use of service providers and third-party administrators, including plans for continuity of services as operations shrink over time.
- ~~Analyze and document any variances in projected exposures, claims counts, and cash flow needs.~~
- Consider expense reduction, reinsurance, plans for collection of outstanding premium and reinsurance recoverables, potential recovery of statutory deposits, policy buy-back, novation, and claim settlements.
- The insurer's investment portfolio should reflect a conservative strategy to preserve invested assets to meet runoff obligations. Any aggressive strategies may require analysts to discuss the insurer's investment philosophy to ensure that the matching of assets and liabilities are maximized given available capital.

Corporate Governance and Operations (OP, ST)

- Employee Retention: Insurers in run-off are faced with unique challenges in maintaining effective oversight and staffing in circumstances of decreasing resources. Some areas of corporate governance that may be more critical for an insurer in run-off include employee compensation and retention, succession planning, and adequate oversight of critical functions by the Board of Directors and senior management. Evaluating the suitability of key management becomes of increased importance in an environment of high turnover and changing responsibilities. Employee retention may be more difficult for a run-off insurer to manage, it is important to ensure that the company maintains qualified officers with sufficient knowledge and experience throughout the course of the run-off.
  - Closely monitor employee turnover and request additional reporting on any changes in senior officers throughout the run-off period.
  - An analyst may want to consider the need for an insurer in run-off to retain essential IT staff.

Capital and Liquidity Management (LQ, ST, OP)~~.~~

- The ability to manage capital and liquidity risk can be of heightened importance to run-off insurers given limited resources and flexibility. An objective of an insurer in run-off is to manage its assets and liabilities and maintain sufficient cash flow to ensure claim payments are met. Ideally, the insurer will reduce liabilities over time while ensuring its balance sheet maintains liquid assets to pay claims. An insurer in run-off would generally be expected to maintain a conservative strategy in order to preserve the ability of invested assets to meet run-off obligations. An aggressive strategy may warrant additional scrutiny.
  - To assess liquidity and surplus adequacy, ~~analysts should~~ evaluate the insurer's liquidity ratio and surplus to asset ratio.
  - ~~Analysts should d~~Document any material fluctuations in the liquidity and surplus to asset ratio and apply stress testing to assess the capital needs of the insurer.
  - ~~Analysts should also c~~Consider the allocation of long v. short tail lines of business in run-off ~~in order~~ to gain a sense of the length of tail ~~in order~~ to assess future cash flow needs.
  - Monitor investment income in relation to operating expenses, using pro forma projections and reconciling differences. If operating expenses exceed investment income, the resulting losses could quickly erode policyholder surplus and create liquidity issues.
  - Inquire of the insurer:

[2] For further guidance on data transfer formats, such as Uniform Data Standards (UDS) for property and casualty insurers in receivership, refer to the NAIC *Receiver's Handbook for Insurance Company Insolvencies*.

- Information regarding the insurer's analysis performed to determine future cash flow needs and stress testing to assess its capital needs.
- Request pro forma projections.

Loss and Loss Adjustment Expense (LAE) Reserves (RV, ST).

- Loss reserves are the largest liability reported by an insurer and one of the most critical pieces of data in assessing an insurer that has entered run-off. Many run-off insurers are thinly capitalized. Given the materiality of this liability, a slight variance in reserves can have a significant impact on the insurer's ability to continue as a going concern. As a result, there is increased importance placed on highly accurate reserve estimations as well as close monitoring of loss reserves.
  - For property/casualty (P/C) insurers, much of the analytical work is done by a review of Schedule P. Loss reserve accuracy can be assessed by analyzing reserve development by line of business and accident year. In addition, it's critical to review claims counts and assess the trending and severity by reviewing this data within Schedule P.
  - Life insurers at times enter run-off, however, more frequently a block of business will enter run-off. Typically, with regard to Life run-off blocks, another life insurer will manage that run-off while managing other active blocks of business, closely monitoring asset adequacy.
  - Given the importance of reserve estimations, consider conducting independent reserve estimations and reviews more frequently or calling a targeted exam before the next full scope exam would be scheduled to have the examiner conduct independent reserve estimations.

Legal Risk (LG)

- Legal risks have the potential to be more significant to run-off insurers given their limited ability to adjust pricing or take other actions to address legislative changes, changes in case law, or litigation activity with the ability to significantly impact loss reserves. Therefore, it may be appropriate to:
  - Require regular legal risk update reports.
  - Involve those with legal knowledge and expertise in monitoring the company.
  - Monitor the impact of legal risks more closely on run-off companies.

Reinsurance Risks (ST & CR)

- Run-off insurers can benefit from carefully monitoring and applying reinsurance coverage in place to ensure that covered losses are identified and collected. In addition, reinsurance recoverable amounts and the credit risk associated with reinsurance can often be material to the solvency position of run-off insurers. Therefore, regulators should closely monitor insurer operations in this area.

Regulatory and Stakeholder Communications

- As the run-off plan proceeds and the block of business shrinks, the domiciliary regulator should establish a plan to effectively and timely communicate its analysis of the run-off insurer.
  - Identify key stakeholders in the run-off process, including other state regulators and receivership/guaranty fund contacts[3].
  - Ensure that sufficient confidentiality measures are in place to govern and protect communications with other stakeholders.
  - Develop a plan to communicate appropriate information in a timely and effective manner throughout the course of the run-off.

Insurance Business Transfers (IBT's) and Corporate Divisions (CD's)

[3] The optional memorandum of understanding with P/C guaranty funds template is available on the NAIC website at: https://content.naic.org/sites/default/files/committee_related_documents/2022_PreLiquidation_PC_MOU.docx

Over the past few years, states have begun enacting statutes which provide opportunities for solvent insurers considering run-off of certain lines or their entire book of business to restructure their run-off with finality. These processes can be broken down into two categories generally referred to as insurance business transfer ("IBT") and corporate division ("CD").

An insurance business transfer (IBT) represents a transaction designed to transfer existing insurance obligations of one insurer (transferring insurer) to a second insurer (assuming insurer) without policyholder consent, subject to ~~approval~~ regulatory approval and court approval. While policyholder consent is not required, notice to policyholders, key stakeholders and the general public is required, and concerns regarding the transaction will be considered in the regulatory and/or court approval process. Following an IBT, the assuming insurer becomes directly liable to policyholders and the transferring insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the transferring insurer.

A corporate division (CD) is a division of one dividing insurer into two or more resulting insurers. The dividing insurer's assets and liabilities are allocated between or among the resulting insurers without requiring affirmative policyholder consent. Following a CD, the resulting insurer(s) becomes directly liable to policyholders and the dividing insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the dividing insurer.

Refer to the work of the Restructuring Mechanisms (E) Working Group, including the draft "Restructuring Mechanisms White Paper" and the draft regulatory "Best Practices Procedures for IBT/Corporate Divisions" currently proposed, for additional information specific to IBTs and CDs that may warrant consideration in the analysis and solvency oversight of these entities.

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Legal Risk Assessment

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

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

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

~~The following discussion provides suggested data, benchmarks and procedures the analyst can consider in his/her review.~~ In analyzing legal risk, the analyst may analyze a wide range of risk exposures related to the insurer's compliance with laws and regulations. An analyst's risk-focused assessment of legal risk should take into consideration the following areas (but not be limited to):

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

~~Discussion of Annual Procedures~~GENERAL GUIDANCE

~~**Using the Repository**~~

~~The~~ To assess legal risk, ~~repository is a list of possible quantitative and qualitative~~consider the procedures, including specific data elements, metrics and benchmarks in this chapter. The following is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

The placement of ~~the following data and~~ procedures, metrics and data ~~in the~~within legal risk ~~repository~~ is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting ~~results~~financial determinations of the analysis. For example, k~~K~~ey insurance operations or lines of business ~~, for~~

example, may have related risks addressed in different repositoriescategories. Therefore, the analysts may need to review other repositoriesrisks in conjunction with legal risk.

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

and procedures from which the analyst may select to use in his/her review of legal risk. Analysts are not expected to document every respond to all procedures, data or benchmark result.s listed in the repository. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document completion the applicable details within of the analysis. Results of legal risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the Risk Assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.

The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

In using procedures in the repository, the Aanalysts should review the results complete their legal risk assessment in conjunction with:

- A review of the Supervisory Plan and, Insurer Profile Summary and the prior period analysis.
- Communication and/or coordination with other internal departments-.are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures in the repository.
-
- The analyst should also consider Tthe 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 following is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

The placement of the following data and procedures in the legal risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, the analyst may need to review other repositories in conjunction with legal risk.

ANALYSIS DOCUMENTATION: Results of legal risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the Risk Assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.

Quantitative and Qualitative Data and ProceduresANNUAL LEGAL RISK ASSESSMENT

Market Conduct

PROCEDURE #1 directs the analyst to identify and assess legal risks emerging from market conduct practices of the insurer that could have an impact on financial position and prospective solvency. 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.

Impact of Market Conduct Examination/Material Findings

Determine if concerns exist regarding Market Conduct, including complaints, market conduct actions, communication with market conduct staff, etc., that could have an impact on financial position and prospective solvency. If concerns exist, communicate risks/issues to the state insurance department's Market Conduct Unit to investigate further. For example, large fines levied by states, suspensions or revocations of licenses, market conduct exam settlements (whether financial or other), or other regulatory actions taken based on market conduct violations may have a material impact on the financial solvency of the insurer. Additionally, if a recently concluded market conduct examination resulted in regulatory requirement to perform remediation (E.g., reprocessing denied claims) the financial impact may be material to the insurer.

Procedures

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

Additional Review Considerations

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

- Describe the actual or projected financial impact of any settlements, fines, or remediation to operations and surplus.

- Determine if the insurer has met state statutes and regulations regarding timely payment of claims.

In so doing, the analyst is encouraged 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 iSite+, 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. Quantitative results from some of these tools are presented within the repository to simplify the review process, including counts of regulatory actions, aggregates of regulatory fines and references to market conduct examinations that have taken place over the last couple of years. Analysts should review any market conduct issues identified by market analysis staff (such as the Market Analysis Chief or the Collaborative Action Designee) or iSite+ 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.

Litigation, Legal and Government Expenses

PROCEDURE #2 directs the analyst to identify and evaluate risks related to expenses paid for litigation, other legal issues and/or government lobbying.

High Litigation, Legal and Government Expenses

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

Procedures/Data

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

Additional Review Considerations

- Compare legal expenses with industry averages (Industry aggregate totals are available in the NAIC publication *Statistical Compilation of Annual Statement Information).*
- Review Annual Financial Statement, Schedule P – Part 1 for Defense and Cost Containment Expenses, Notes to Financial Statements Note #23 for Reinsurance Recoverable in Dispute and Note #14G for Contingencies and identify any legal concerns.
- Review the Annual Financial Statement including the Notes to Financial Statements, Audited Financial Report, and Examination findings and follow-up monitoring and identify if there were any legal concerns.

- Upon review of the Notes to Financial Statements, determine whether the insurer was a party to any significant litigation not in the normal course of business? If so, review and understand a description of the litigation and any contingent liabilities for accrued legal expenses.
- Inquire of the insurer:
  - Negative financial impact on the insurer and/or group should the litigation not be ruled in favor of the insurer
  - Negative reputational impact of litigation to the insurer and/or group
  - Negative impact of litigation to shareholders and/or policyholders

~~This procedure includes quantitative metrics identifying individual legal expense payments of significance, situations where investigation and settlement of policy claims make up the bulk of legal expenses and unusual payments for government lobbying. While these metrics might identify a need for further investigation in this area, the analyst should take other steps to identify and assess litigation and other legal risks as outlined in the procedure. Comparing legal expenses to prior years and industry averages might identify an upward trend that should be investigated.on significant legal cases the company is involved in. If significant cases are identified, additional follow-up and correspondence with the company may be necessary to assess their potential impact on prospective solvency.~~

~~In addition, a detailed review of the financial statements, and notes to the financial statements in particular, may disclose information on significant legal cases the company is involved in. If significant cases are identified, additional follow-up and correspondence with the company may be necessary to assess their potential impact on prospective solvency.~~

~~**Fraud**~~

~~***PROCEDURE #3*** directs the analyst to identify and evaluate the impact of any fraudulent activity on the financial position and prospective solvency of the company. If fraud, allegations of fraud or ongoing investigations are identified, the analyst is encouraged to document his/her understanding and assessment of the ongoing issues and to contact the company regarding its plans to address the situation.~~

~~The procedure encourages the analyst to review financial statements, review news reports, correspond with other insurance department units (e.g., Fraud, Market Conduct, etc.), review regulatory actions (through RIRS) and contact other state insurance regulators with authority over the businesses of the insurer to identify any instances of fraud or ongoing investigations.~~

Material Fraudulent Activity/Investigation Results

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

Review Considerations~~If fraud, allegations of fraud or ongoing investigations are identified, the analyst is encouraged to document his/her understanding and assessment of the ongoing issues and to contact the company regarding its plans to address the situation.~~

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

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

~~Compliance with Code of Ethics Standards~~

~~***PROCEDURE #4*** directs the analyst to identify and evaluate risks related to the insurer's compliance with code of ethics standards. This procedure references information provided in the General Interrogatories of the Annual Statement related to the code of ethics. The analyst is encouraged to use this information, as well as information provided in the Corporate Governance Annual Disclosure (CGAD) (if filed on an insurance entity basis), to identify and assess risks in this area. If the CGAD is filed on a group basis, rely on the information provided in the GPS for group risks or provided by the lead state if risks apply to the insurance entity. If concerns regarding an insurer's failure to implement or abide by a code of ethics are identified, the analyst should correspond with the company to address these concerns and/or identify other compensating controls in place.~~

Failure to Comply with Code of Ethics Standards

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

Procedures/Data

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

Additional Review Considerations

- Review the Corporate Governance Annual Disclosure (CGAD) and identify any concerns.
  - If the CGAD is filed on an insurance entity bases, verify that the information provided in the CGAD filing on ethics policies does not conflict with the information reported in the General Interrogatories.

- If the CGAD is filed on a group basis, rely on the information provided in the GPS for group risks or provided by the lead state if risks apply to the insurance entity and verify that the information does not conflict with the information reported in the General Interrogatories.

rely on the information provided in the GPS for group risks or provided by the lead state if risks apply to the insurance entity.

Compliance with State Laws and Reporting

PROCEDURE #5 directs the analyst to assess the insurer's compliance with NAIC reporting practices, internal policy, laws, regulations and prescribed practices**Failure to Comply with State Laws and Reporting**

Assess the insurer's compliance with NAIC reporting practices, internal policy, laws, regulations and prescribed practices. The analyst should determine whether there are any legal or regulatory impediments that could affect the insurer's operations or result in a significant legal liability. If a compliance violation is found, the analyst should specify the violation and the impact.

Procedures/Data

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

Additional Review Considerations

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

- Outcome of any department communication with the insurer and/or with the other regulatory authority who issued the revocation or suspension
- Resolution of any non-compliance issues or resolution plans of the insurer

- If the insurer has been issued any consent orders or agreements by other regulators/jurisdiction, identify or perform the following:
  - Request a copy of the consent order or agreement from the other regulator/jurisdiction
  - Reason(s) stated for the consent order or agreement
  - Outcome of any department communication with the insurer and/or with the other regulatory authority
  - Resolution of any non-compliance issues or plans of the insurer

Failure to Comply with State Investment Laws

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

Review Considerations

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

Failure to Comply with Affiliated Management and Service Agreements

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

Review Considerations

- Determine whether management and service agreements between affiliates either submitted and/or approved are in conformity with regulatory requirements and verify that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
- Determine whether the amount of the shareholder dividend was at a level that required prior regulatory approval or notification. If so, determine whether the insurer obtained proper prior regulatory approvals.

Failure to Comply with Transactions Involving Other Jurisdictions

Assess the insurer's compliance with transactions involving other jurisdictions.

Review Considerations~~. This assists the analyst in determining whether there are any legal or regulatory impediments that could affect the insurer's operations or result in a significant legal liability.~~

- If the insurer redomesticated to your state, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to

approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.

- If the insurer engaged in a transaction(s) to redomesticate a subsidiary offshore, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.
- If the insurer engaged in any transactions to acquire a subsidiary domiciled in a non-U.S. jurisdiction, determine whether the insurer failed to comply with any regulatory requirements or stipulations expected to be met subsequent to the acquisition and identify any legal implications that represent risk to the insurer due to the acquisition.

Failure to Comply with Federal Regulatory Agencies

Identify and assess compliance with other federal regulatory agencies. In addition to the HHS and the CMS oversight of health insurance, insurers may be subject to regulation by the Federal Reserve, U.S. Securities and Exchange Commission (SEC), U.S. Department of the Treasury and other federal regulatory bodies depending upon the nature, scope and extent of the insurer's or insurance group's activities.

Review Considerations

- Review General Interrogatories, Part 1, #8 and determine whether the insurer is subject to regulation by a federal regulatory agency. If so, consider contacting the applicable federal regulatory agency to request any information about the results of that agency's oversight, including any issues identified, federal compliance violations, fraud investigations and regulatory actions.

Failure to Comply with the Federal Affordable Care Act (Health Business Only)

~~This procedure references information provided in the General Interrogatories of the Annual Statement related to whether any certificates of authority, licenses or registrations of the insurer have been suspended or revoked. This assists the analyst in determining whether there are any legal or regulatory impediments that could affect the insurer's operations or result in a significant legal liability. In addition, qualitative procedures are suggested to assist the analyst in identifying issues of noncompliance with other regulatory requirements, including the specific procedures described below.~~

~~***PROCEDURE #5D*** asks the analyst to identify through Notes to the Financial Statement, the iSite+ Validation Exceptions tool and through any corrections of reporting errors potential issues with the reliability of financial reporting that may require follow-up discussions with the insurer. Potential missing data, data that does not conform with standards, or any crosscheck errors could materially impact the outcome of an analysis and corrective measures may need be taken by the insurer prior to proceeding with an analysis.~~

~~***PROCEDURE #5F*** offers follow-up analysis and actions the analyst may consider if the insurer is in violation of any state statutes or regulations. It is critical that the analyst determine the extent of the non-compliance and document the issue, resolution, communication by the insurer, and the outcome. The analyst should complete a detailed written explanation of the violation to ensure proper documentation should non compliance issues recur.~~

~~***PROCEDURES #5G AND #5H*** offer follow-up analysis and actions the analyst may consider if the insurer has had a certificate of authority, license, or registration suspended or revoked by any government entity during the period or if the insurer has been issued a consent order or agreement. If the action was taken by another state or regulatory body, the analyst should contact that regulator for details regarding the action.~~

~~***PROCEDURE #6*** directs the analyst to assess the insurer's compliance with state investment laws. 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. In addition, the analyst may review affiliated investments for compliance with state law and review the results of the most recent examination regarding investment compliance.~~

~~***PROCEDURE #7*** directs the analyst to consider a review affiliated management and service agreements for compliance with state requirements. As material affiliated transactions are generally subject to regulatory review and approval (including extraordinary dividends), the analyst should evaluate the company's compliance with regulatory requirements in this area. The steps listed here are intended to assist the analyst in identifying potential agreements or transactions to check for compliance.~~

~~***PROCEDURE #8*** directs the analyst to assess the insurer's compliance with transactions involving other jurisdictions. Transactions that may be affected by compliance requirements include redomestication, as well as mergers and acquisitions. The steps listed here are intended to assist the analyst in identifying potential transactions to check for compliance.~~

~~**Compliance with the Federal Affordable Care Act**~~

~~***PROCEDURE #9*** directs the analyst to i~~Identify and assess compliance ~~with~~ with the federal Affordable Care Act (ACA), Medical Loss Ratio (MLR), MLR Rebate calculations and other ACA requirements. If the insurer is not subject to the ACA, it is recommended to skip the following procedures.

For purposes of reviewing the SHCE, the analyst should refer to the Annual Financial Statement Instructions for details on reporting requirements for health entities in run-off or that only have assumed and no direct business, and health entities that have no business that would be reported in the columns for Comprehensive Health Care, Mini-Med Plans, Expatriate Plans, and Medicare Advantage Part C and Medicare Part D Stand-Alone Plans. If the health entity's SHCE was reviewed or is under review by examination staff, the analyst should contact the examiner-in-charge (EIC) to inquire about any material examination findings.

Review Considerations

- Determine whether the insurer filed the Supplemental Health Care Exhibit (SHCE) and the SHCE Expense Allocation Report filed in accordance with the Annual Statement Instructions.
- Review the Notes to the Financial Statement (primarily Note #24), the SHCE – Part 1, and the final rebate reporting to the U.S. Department of Health and Human Services (HHS). If the amount of MLR rebate liability reported is material, determine whether there are concerns regarding the insurer's liability for rebates.
- Compare the MLR rebate liability, as provided in the SHCE, and the actual rebate calculation in the HHS Medical Loss Ratio Reporting Form. If any material differences were identified, consider requesting an explanation of the differences from the insurer.
- During the review of the health care business pursuant to the federal Public Health Service Act and all applicable filings, identify any unusual items or areas of concern, not previously noted, that indicate further review is necessary.
- If concerns exist, contact the federal Centers for Medicare & Medicaid Services (CMS) to request information about CMS sanctions or supervision by the CMS and MLR audits.

Preliminary Medical Loss Ratio Concerns (Health Business Only)

The following procedures are only applicable to insurers that write insurance premiums subject to the ACA. The ACA requires health entities to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). Concerns in this area should be reviewed in conjunction with the pricing and underwriting risk assessment.

Procedures/Data

- Determine whether there are concerns regarding the components of the insurer's Preliminary MLR:
  - Review the Preliminary MLR from the SHCE by line of business (either the national Preliminary MLR or the state-level MLR) (or the thresholds applicable under state law) for individuals or small group employers with a ratio less than 80% or large group employers with a ratio less than 85%. For Medicare plans, determine whether the preliminary MLR is less than 85%.
  - Review the change in Preliminary MLR for a material increase or decrease from the prior year by line of business (either the national Preliminary MLR or the state-level MLR).
  - In the analyst's review of the components of the Preliminary MLR, review and assess any material differences between the unadjusted and adjusted amounts for premium and claims. Compare Health Premium Earned to Adjusted Premium Earned by line of business.
  - In the analyst's review of the components of the Preliminary MLR, review and assess any material differences between the unadjusted and adjusted amounts for premium and claims. Compare Incurred Claims excluding prescription drugs to Total Incurred Claims by line of business.
  - Identify any components that appear unusual, or that increased or decreased materially from the prior year that would indicate further review is warranted. If so, request additional information from the insurer.

Additional Review Considerations
- Review the 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.
  - During the review of the health care business pursuant to the Public Health Service Act and all applicable filings, identify any unusual items or areas of concern, not previously noted, that indicate further review is warranted.
  - After completing analysis in this area, if specific concerns are identified regarding MLR compliance, the analyst is encouraged to contact the CMS to request information on CMS sanctions and remediation, as well as CMS supervision and regulatory concerns (including MLR audits).
  - ~~requirements embedded within the federal Affordable Care Act (ACA). This procedure references information provided in the Annual Statement related to whether the insurer filed the Supplemental Health Care Exhibit (SHCE) and reported premium revenues subject to the ACA. If the insurer filed the SHCE, the analyst should consider performing procedures outlined in #9 and #10. Procedures listed under #9 include consideration of whether the SHCE was filed in accordance with Annual Statement Instructions, whether medical loss ratio (MLR) rebate liabilities are material and/or consistent with what is reported to the U.S. Department of Health and Human Services (HHS), and whether the insurer is subject to sanctions, oversight or audit by the federal Centers for Medicare & Medicaid Services (CMS). For purposes of reviewing the SHCE, the analyst should refer to the Annual Financial Statement Instructions for details on reporting requirements for health entities in run-off or that only have assumed and no direct business, and health entities that have no business that would be reported in the columns for Comprehensive Health Care, Mini-Med Plans, Expatriate Plans, and Medicare Advantage Part C and Medicare Part D Stand-Alone Plans. If the health entity's SHCE was reviewed or is under review by examination staff, the analyst should contact the examiner-in-charge (EIC) to inquire about any material examination findings.~~

    ~~***PROCEDURE #10*** is only applicable to insurers that write insurance premiums subject to the ACA and directs the analyst to determine whether there are concerns regarding components of the insurer's preliminary MLR calculations. The ACA requires health entities to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the MLR.~~

The ACA requires health entities to spend at least 80% of premium for individual and small group policies or 85% 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

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analyst should be aware that individual states can and may require a higher MLR pursuant to state law. If the health entity fails to meet these standards, the health entity will be required to provide a rebate to policyholders. The purpose of the SHCE is to assist state and federal regulators in identifying and defining elements that make up the MLR as described in Section 2718(b) of the Public Health Service Act (PHSA) and for purposes of submitting a report to the HHS Secretary required by Section 2718(a) of the PHSA. During the review of the Preliminary MLR, the analyst should also consider how the individual state's Preliminary MLR compares to the grand total (refer to the Financial Profile Report).

Beginning in 2014, a similar MLR requirement applies to Medicare Advantage Plans and Medicare Part D Stand-Alone Plans. The health entity must spend at least 85% of premium (with certain adjustments) on clinical services and quality improvement, or rebate premium to the HHS.

In some cases, it may be more useful to use the Preliminary MLR that is calculated by totaling the data from all SCHEs submitted by a company to the states where it has business. This national Preliminary MLR will reduce the impact of potential issues with statistical credibility of claims experience and allocation of various expenses over states and lines of business.

For lines of business in a given state with exposures of less than 1,000 life-years looking at a 5-year trend is of very limited usefulness since in such cases, claims experience is not considered credible and is subject to greater variability. More than 1,000 life years, the experience is considered credible, but still subject to large variations until exposures are well above 1,000 life years.

The MLR is not calculated in the traditional sense where medical expenses are simply divided by premiums. Premiums are adjusted for certain taxes and expenses. The numerator in the calculation will include health improvement expenses and fraud and abuse detection and recovery expenses in addition to medical expenses. The expenses for fraud and abuse detection and recovery are limited by the amount actually recovered.

The MLR calculated on the SHCE is a preliminary calculation and will not be used in determining rebates. Health entities will report information concerning rebate calculations directly to the HHS. The numbers that will be utilized for rebate purposes include revisions for claim reserve run-off subsequent to year end, statistical credibility concerns and other defined adjustments.

The analyst should review completeness or consistency validation exceptions on iSite+ that may indicate if the SHCE has not been prepared and submitted for each jurisdiction in which the company has written direct comprehensive major medical business in accordance with the *Annual Statement Instructions*.

The aggregation of data reported on the SHCE is by state, by market (individual, small group, large group) and by licensed entity. In other words, each health insurance issuer needs to meet the minimum loss ratio targets in each state, and market.

The NAIC iSite+ Financial Profile Report for the SHCE should be reviewed and significant fluctuations investigated. For example, how does the percentage change from the prior year in incurred claims ~~(Line 2.1)~~ compare to total incurred claims ~~(line 5.0)~~?

In addition, the analyst should ensure that the Supplemental filing was made providing a description of the methods utilized to allocate "Improving Healthcare Quality Expenses" to each state and to each line and column on the SHCE Part 3. When reviewing this Supplemental filing the analyst should consider whether the detailed descriptions of the Quality Improvement expenses were included and whether such descriptions conform to the definitions provided in the Annual Statement Instructions.

Note that the preliminary MLR included in this SHCE (for any given state) is not the MLR that is used in calculating the federal mandated rebates. The MLR used in the rebate calculation (i.e., the ACA MLR) will differ for two reasons. First, the ACA MLR will reflect the development of claims and claims reserves between December 31 of the Statement Year and March 31 of the following year. The second and far more important reason is that the ACA MLR includes a credibility adjustment that is based on the number of covered lives and certain benefit provisions of the coverages provided. The adjustment takes the form of an addition of

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percentage points to the calculated MLR. The ACA MLR is then used to determine whether 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.

~~After completing analysis in this area, if specific concerns are identified regarding MLR compliance, the analyst is encouraged to contact the CMS to request information on CMS sanctions and remediation, as well as CMS supervision and regulatory concerns (including MLR audits).~~

~~**Legal Compliance with Federal Regulatory Agencies**~~

- ~~***PROCEDURE #11*** directs the analyst to identify and assess compliance with other federal regulatory agencies. This procedure references information provided in the General Interrogatories of the Annual Statement related to whether the insurer is subject to regulation by a federal regulatory agency. In addition to the HHS and the CMS oversight of health insurance, insurers may be subject to regulation by the Federal Reserve, U.S. Securities and Exchange Commission (SEC), U.S. Department of the Treasury and other federal regulatory bodies depending upon the nature, scope and extent of the insurer's or insurance group's activities. If the insurer is subject to federal regulation, the analyst is encouraged to contact the applicable federal agency (as appropriate) to inquire about the insurer and assess any issues raised.~~

Failure to Comply with Audit Committee Requirements

Assess compliance with audit committee requirements. As mandated by the *Annual Financial Reporting Model Regulation*, every insurer required to file an audited financial report is also required to have an audit committee that is directly responsible for the appointment, oversight and compensation of the auditor. Insurers with less than $500 million in direct and assumed premium may apply for a waiver from this requirement based on hardship. Based on various premium thresholds, a certain percentage of the audit committee members must be independent from the insurer. However, if domiciliary law requires board participation by otherwise non-independent members, such law shall prevail, and such members may participate in the audit committee.

Procedure/Data

- Review General Interrogatories, Part 1, #10.5 and #10.6 to determine whether the insurer failed to establish an Audit Committee in compliance with the domiciliary state insurance laws and any explanation.
- Review General Interrogatories, Part 1, #10.1, #10.2, #10.3 and #10.4 to determine whether the insurer has been granted any exemptions under Sections 7H, or 18A of the NAIC *Annual Financial Reporting Model Regulation* and if so, review any information about the exemption.

Additional Review Considerations

- Determine whether the Audit Committee membership meets independence requirements of the domiciliary state insurance laws.
- Review the Corporate Governance Annual Disclosure (CGAD):

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- If filed on an insurance entity basis, determine whether the information provided in the CGAD on auditor independence identified any concerns or conflict with information reported in the Annual Financial Statement, General Interrogatories, Part 1, #10.
- If filed on a group basis, determine whether the information provided in the GPS or provided by the lead state identified any auditor independence concerns or conflict with information reported in the Annual Financial Statement General Interrogatories, Part 1, #10.

Management's Discussion and Analysis Report

~~Management's Discussion and Analysis Report~~

~~***PROCEDURE #12***~~ ~~directs the analyst to~~ AAassess the insurer's compliance with the Management's Discussion and Analysis (MD&A) report requirements and ~~to~~ identify any legal risks noted in the report. To assist the analyst in conducting the review, an optional MD&A review workpaper is included in the Handbook ~~at III.B.2.c.~~and available to download from iSite+. The MD&A workpaper breaks down analysis of the MD&A into two distinct steps: 1) Compliance Analysis; and 2) Assessment. For purposes of simplifying the review of the MD&A, guidance for consideration in performing both of these steps has been included within this reference guide.

Procedures (Compliance and Assessment)

- In considering compliance, the analyst should determine whether the MD&A addresses the two-year period covered in the insurer's Annual Financial Statement and discusses any material changes.
- In addition, the analyst should determine whether the insurer prepared the MD&A on a non-consolidated basis, which is required unless one of the following conditions were met: 1) the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or a 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves, and the insurer ceded substantially all of its direct and assumed business to the pool (an insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if it has less than $1 million total direct plus assumed written premiums during a calendar year that is not subject to a pooling arrangement, and the net income of the business not subject to the pooling arrangement represents less than 5% of the company's capital and surplus); or 2) the insurer's state of domicile permits audited consolidated financial statements.
- Additional compliance requirements apply to the overall completeness of the MD&A, including elements as described below:
  - Overall material historical and prospective disclosure – Insurers should supply information necessary to assess the insurer's financial condition, including a short and long-tailed analysis of the business of the insurer.
  - Results of operations – Insurers should provide a description of any unusual or infrequent events or transactions or any significant economic changes that materially affected the amount of reported net income or other gains/losses in surplus. Insurers should also describe any known trends or uncertainties that have had or are reasonably probable to have a material favorable or unfavorable impact on premiums, net income, or other gains/losses in surplus. If the insurer knows of events that will cause a material change in the relationship between expenses and premium, the change in the relationship shall be disclosed. To the extent that the Annual Financial Statement discloses material increases in premium, reporting entities should provide a narrative discussion of the extent to which such increases are attributable to increases in prices, increases in the volume or ~~amount~~number of existing products being sold, or the introduction of new products.
  - Prospective information – Insurers are encouraged to supply forward-looking information. The MD&A may include discussions of known trends or any known demands, commitments, events, or uncertainties that will result in or that are reasonably likely to result in the reporting entity's liquidity improving or deteriorating in any material way. Further, descriptions of known material trends in the insurer's capital

resources and expected changes in the mix and cost of such resources should be included. Disclosure of known trends or uncertainties that the insurer reasonably expects will have a material impact on premium, net income, or other gains/losses in surplus is also encouraged.

- <u>Material changes</u> – Insurers are required to provide adequate disclosure of the reasons for material year-to-year changes in line items, or discussion and quantification of the contribution of two or more factors to such material changes. An analysis of changes in line items is required:
  - W~~w~~here material
  - W~~w~~here the changes diverge from modifications in related line items of the Annual Financial Statement
  - W~~w~~here identification and quantification of the extent of contribution of each of two or more factors is necessary to an understanding of a material change
  - W~~w~~here there are material increases or decreases in net premium~~.~~

- <u>Liquidity, asset/liability matching and capital resources</u> – Insurers are required to discuss both short-term and long-term liquidity and capital resources. Short-term liquidity shall include a discussion of the nature and extent of restrictions on the ability of subsidiaries to transfer funds to the reporting entity in the form of cash dividends, loans, or advances, and the impact, if any, such restrictions may have on the ability of the reporting entity to meet its cash obligations. The discussion of long-term liquidity and long-term capital resources must address material expenditures, significant balloon payments or other payments due on long-term obligations, and other demands or commitments, including any off-balance sheet items, to be incurred beyond the next 12 months, as well as the proposed sources of funding required to satisfy such obligations. Also, identify and separately describe internal and external sources of liquidity, and briefly discuss any material unused sources of liquid assets. Insurers should describe any known material trends, favorable or unfavorable, in ~~its~~<u>their</u> capital resources, and indicate any expected material changes in the mix and relative cost of such resources.

- <u>Loss reserves</u> – The MD&A should include a discussion of those items that affect the insurer's volatility of loss reserves, including a description of those risks that contribute to the volatility.

- <u>Off-balance sheet arrangements</u> – Insurers should consider the need to provide disclosures concerning transactions, arrangements, and other relationships with entities or other persons that are reasonably likely to materially impact liquidity or the availability of or requirements for capital resources. Material sources of liquidity and financing, including off-balance sheet arrangements and transactions with limited purpose entities, should be discussed.

- <u>Participation high-risk transactions and investments</u> – The insurer should disclose and discuss participation in high-yield financing, highly leveraged transactions, or non-investment grade loans and investments, if such participation or involvement has had or is reasonably likely to have a material effect on financial condition or results of operations. For each such participation or involvement or grouping thereof, there shall be identification consistent with the Annual Financial Statement schedules or detail, description of the risks added to the reporting entity, associated fees recognized or deferred, amount (if any) of loss recognized, the insurer's judgment whether there has been material negative effects on the insurer's financial condition, and the insurer's judgment whether there will be a material negative effect on the financial condition in subsequent reporting periods.

- <u>Preliminary merger/acquisition negotiation</u> – The insurer should disclose and discuss its involvement in any merger/acquisition negotiations, to the extent they are likely to have a material effect on financial condition or operations.

- In reviewing the items disclosed in the MD&A filing, the analyst should assess their potential impact on the insurer's financial condition and prospective solvency by placing and discussing risk information within the appropriate branded risk classification.

Audited Financial Report

~~**Audited Financial Report**~~

~~***PROCEDURE #13*** directs the analyst to~~ A~~a~~ssess the insurer's compliance with Audited Financial Report requirements and ~~to~~ identify any legal risks noted in the report.

Risks identified in the Audited Financial Report may include:

- Audited Financial Opinion other than unmodified
    - E.g., Going Concern
- Material differences or material audit adjustments
    - E.g., material differences to the filed Annual Financial Statement and/or resulted in material audit adjustments that will be made to the current or next financial filing
- Material internal control weakness, and the impact of a corrective action plan
- Potential impact of items in the report on the insurer's financial condition and prospective solvency
    - Consider placing and discussing specific risk information within the appropriate branded risk classification.

To assist the analyst in conducting the review, an optional Audited Financial Report review workpaper is included in the Handbook ~~at III.B.2.b~~and available to download from iSite+. This workpaper highlights both compliance and assessment considerations, as discussed below:

Audited F~~f~~inancial R~~r~~eport C~~c~~ompliance – The financial statements are required to be prepared in conformity with statutory accounting practices prescribed or otherwise permitted by the domiciliary state insurance department. In addition, the financial statements should be prepared on a stand-alone basis, unless the insurer has made written application to the domiciliary commissioner to file audited consolidated or combined financial statements if the insurer is a part of a group of insurance companies that utilizes a pooling or 100% reinsurance agreement.

Procedure

- If the insurer is filing financial statements on a consolidated or combined basis, the analyst should determine whether the domiciliary commissioner approved the insurer's application to file on a consolidated or combined basis, and whether a consolidating or combining worksheet has been included with the financial statements. This worksheet should show amounts for each insurer separately, including explanations for consolidating and eliminating entries, and reconciliations for any differences between the amounts shown for an individual insurer and the amounts per the insurer's Annual Financial Statement.

Audited F~~f~~inancial R~~r~~eport D~~d~~etailed A~~a~~ssessment – In addition to reviewing for compliance, the analyst should review information provided in the financial statements to assist in risk identification and detailed assessment. One key step in this area is to determine the type of audit opinion that was issued by the independent certified public accountant (CPA). The opinion may be an unmodified or a modified opinion; however, there are three types of modified opinions: qualified, adverse and disclaimer of opinion.

- Unmodified Opinion – The auditor should express an unmodified opinion when the auditor concludes that the financial statements are presented fairly, in all material respects, in accordance with the applicable financial reporting framework.

- Modified Opinion – The auditor should modify the opinion in the auditor's report, if the auditor concludes that, based on the audit evidence obtained, the financial statements as a whole are materially misstated or is unable to obtain sufficient appropriate audit evidence to conclude that the financial statements as a whole are free from material misstatement. There are three types of modified opinions: qualified, adverse and disclaimer of opinion, as explained below:
  - The auditor should express a qualified opinion when:
    1. The auditor, having obtained sufficient appropriate audit evidence, concludes that misstatements, individually or in the aggregate, are material but not pervasive to the financial statements; or
    2. The auditor is unable to obtain sufficient appropriate audit evidence on which to base the opinion, but the auditor concludes that the possible effects on the financial statements of undetected misstatements, if any, could be material but not pervasive.
  - The auditor should express an adverse opinion when the auditor, having obtained sufficient appropriate audit evidence, concludes that misstatements, individually or in the aggregate, are both material and pervasive to the financial statements.
  - The auditor should disclaim an opinion when the auditor is unable to obtain sufficient appropriate audit evidence on which to base the opinion, and the auditor concludes that the possible effects on the financial statements of undetected misstatements, if any, could be both material and pervasive.

Procedures

- If a modified opinion is issued, the analyst should document the reasons for the modification and assess the impact of the modification on the insurer's financial position and prospective solvency.
- In addition to reviewing and assessing the opinion, the analyst should also determine whether total assets, net income, and surplus per the Audited Financial Report agree with the amounts per the insurer's Annual Financial Statement.
  - If differences exist, the independent CPA is required to include in the Notes to Financial Statements a reconciliation of the differences between the Audited Financial Report and the Annual Financial Statement along with a written description of the nature of these differences.
  - If differences are identified, the analyst should document these differences and the reasons for the differences based on a review of the independent CPA's reconciliation in the Notes to Financial Statements.
  - The analyst should also consider the impact of the audit adjustments made by the independent CPA on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (i.e., complete additional procedures for items impacted by the audit adjustments) on the Annual Financial Statement information.

Additional Review Considerations

- If further concerns exist, the analyst should consider performing one or more of the following procedures:
  - Obtain and review a copy of the signed management representation letter, which acknowledges that management is responsible for the presentation of the financial statements and has considered all uncorrected misstatements and concluded that any uncorrected misstatements are immaterial. The analyst should review the entire management representation letter to determine whether ~~if~~ there are representations that would impact the insurer's solvency.
  - Obtain and review all recorded and unrecorded audit adjustments along with supporting documentation regarding the adjustments or explanations from the external auditor. The analyst may use the information regarding audit adjustments to identify risk or internal control weaknesses to determine what the impact of significant audit adjustments might be on the insurer's solvency.

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- Obtain and review the internal control-related matters presentation materials, including the Management Letter, prepared by the external auditor for the audit committee's review. Note the external auditor is required to provide written communication to the audit committee of all significant deficiencies or material weaknesses known. The comments from the external auditors may be used as guidance as to areas that may require additional investigation and the analyst's view of this documentation.
- Obtain and review any other audit work papers deemed appropriate or necessary (e.g., Statement on Auditing Standards (SAS) No. 99 Consideration of Fraud in a Financial Statement Audit). This documentation should impact the analysts' consideration of risk inherent within the entity and impact the overall risk assessment and analysis procedures completed by the analyst. Further, obtain copies of all legal letters and determine the status of all pending litigation and the impact that potential settlements might have on the insurer's solvency.

CPA Letter of Qualifications – The analyst should perform procedures in this area whenever there has been a change in the independent CPA from the prior year, although it may be completed annually whether or not there has been a change in independent CPA. The analyst should determine if the independent CPA furnished to the insurer, in connection with and for inclusion in the filing of the Audited Financial Report, a Letter of Qualifications which includes all of the statements listed in the procedure.

Procedures

- If any of the statements are missing from the letter, the analyst should contact the CPA firm to discuss and address.
- In addition, the analyst should determine whether the CPA retained for review by the domiciliary state insurance department all audit work papers prepared during the audit, unadjusted journal entries, letter of representation, management's letter and any communications between the CPA and the insurer related to the audit.

Change in CPA – The insurer is required to notify the domiciliary state insurance department within five business days when the insurer's independent CPA is dismissed or resigns. The insurer is also required to furnish a separate letter within 10 business days of the previous notification stating whether, in the 24 months preceding such event, there were any disagreements with the former independent CPA on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, and which disagreements, if not resolved to the satisfaction of the former independent CPA, would have caused the CPA to make reference to the disagreement in connection with the opinion. In addition, the insurer is further required to furnish a letter from the former independent CPA stating whether the independent CPA agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he or she does not agree.

Procedure

- The analyst should determine whether the CPA who issued an opinion on the insurer's financial statements in the current period is the same CPA who issued the opinion in the prior year. If not, the analyst should determine whether all required reports were filed with the state insurance department as outlined above and assess the impact of the change in CPA on the insurer.

Reports on Iinternal Ccontrols – In addition to the Audited Financial Report, insurers are required to furnish the domiciliary state insurance department with a written Management's Report of Internal Control Over Financial Reporting by the independent CPA describing material weaknesses in the insurer's internal control structure as noted by the independent CPA during the audit, if applicable. Such a report is required regardlessregardless of whether material weaknesses have been identified. In those instances where material weaknesses are noted,

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the insurer is also required to provide a description of remedial actions taken or proposed to correct the material weaknesses if such actions are not described in the CPA's report.

Effective for audits as of 12/31/21December 31, 2021, and thereafter, the NAIC's Model Audit Rule Implementation Guide requests that the name of the current lead audit partner and the year at which he or she began serving in that capacity be included in the internal control report, so it can be provided to regulators but kept confidential. Such information may be useful in verifying compliance with audit partner qualification and rotation requirements.

Management of insurance companies with more than $500 million in direct and assumed premiums are also required to file with the state insurance department an assessment of internal control over financial reporting. This report states whether or not management is confident the internal controls are effective in providing accurate statutory financial statements.

Procedures

- If material weaknesses are identified or management cannot attest to effective internal controls over financial reporting, the analyst should consider performing additional procedures as highlighted in the worksheet.
- The analyst should consider the financial impact of any corrective actions the insurer is undertaking to correct those weaknesses.

Additional Review Considerations

- Upon review of the Audited Financial Report and Management's Report of Internal Control Over Financial Reporting, if material risks were noted or weaknesses in internal controls were reported, identify what corrective actions are planned to resolve the issues.
- Inquire of the insurer:
  - Letter of Representation
  - Schedule of all recorded and unrecorded audit adjustments
  - Internal control related presentation materials including Management's Comment Letter
  - Any other audit work papers deemed appropriate or necessary (i.e., Statement of Auditing Standards (SAS) 99 Fraud and Legal Representations Letters)
  - If internal control weaknesses are noted and no corrective action plan is proposed, contact the insurer and request detailed information regarding the insurer's remediation and corrective action plan to resolve the weaknesses.

Audit Committee

PROCEDURE #14 directs the analyst to assess compliance with audit committee requirements. As mandated by the *Annual Financial Reporting Model Regulation*, every insurer required to file an audited financial report is also required to have an audit committee that is directly responsible for the appointment, oversight and compensation of the auditor. Insurers with less than $500 million in direct and assumed premium may apply for a waiver from this requirement based on hardship. Based on various premium thresholds, a certain percentage of the audit committee members must be independent from the insurer. However, if domiciliary law requires board participation by otherwise non-independent members, such law shall prevail and such members may participate in the audit committee. This procedure references information provided in the General Interrogatories of the Annual Statement related to whether the insurer has established an audit committee in accordance with state insurance laws and requires the insurer to report if it has been granted any exemptions in

this area. In assessing compliance with these requirements, the analyst is encouraged to compare other information received on the corporate governance practices of the insurer, including the CGAD (if filed on an insurance entity basis), to information provided in the interrogatories. Note, if the CGAD is filed on a group basis, the analyst should rely on the information provided in the GPS or provided by the lead state if material risks are only relevant to specific insurance entities.

Additional Analysis and Follow-Up Procedures Applicable to Legal Risk

EXAMINATION FINDINGS direct the analyst to consider a review of the recent examination report, summary review memorandum and communication with the examination staff to identify if any legal risk issues were discovered during the examination.

Examination Findings

Review the most recent examination report and the Summary Review Memorandum (SRM) for any findings regarding legal risks. If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

Inquire of the Insurer

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

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

- **Policies and Strategies for Compliance with State, Federal and International Laws and Regulations:**
  - Information on how the legal/compliance function ensures compliance with relevant laws and regulations

- **News, Press Releases and Industry Reports:**
  - The financial impact of any legal issues on the insurer and/or group's operations and surplus
  - Disclosures of financial impact to the public and agent distribution force
  - The insurer's efforts to mitigate any impact of the risk. For ORSA filers, this may be identified in the ORSA Summary Report for certain risks.
  - Policies and procedures in place to mitigate adverse publicity
  - Revised business plan

- **Legal Risk Assessment by Management:**
  - How the insurer assesses its legal risk and reports it to senior management
  - The involvement of legal counsel in changes to existing products and development of new products
  - The degree to which compliance programs are utilized to control, monitor and report legal risk

Own Risk and Solvency Assessment (ORSA) Summary Report

If the insurer is required to file ORSA or part of a group that is required to file ORSA, determine whether the ORSA Summary Report analysis conducted by the lead state indicated any of the following:

- Legal risks that require further monitoring or follow-up
- Mitigating strategies for existing or prospective legal risks

Holding Company Analysis

Determine whether the Holding Company analysis conducted by the lead state indicated any of the following:

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- Legal risks impacting the insurer that require further monitoring or follow-up
- Mitigating strategies for existing or prospective legal risks impacting the insurer

INQUIRE OF THE INSURER directs the analyst to consider requesting additional information from the insurer if legal risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of legal risk for specific topics where concerns have been identified.

***OWN RISK AND SOLVENCY ASSESSMENT* (ORSA)** directs the analyst to obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing legal risks faced by the insurer.

HOLDING COMPANY ANALYSIS directs the analyst to obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

Example Prospective Risk Considerations

The table provides the analyst with example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general discription of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the legal risk category.

Discussion of Quarterly ProceduresLegal Risk Assessment

The qQuarterly lLegal rRisk Repository procedures are designed to identify the following.:

1) Concerns with market conduct, including complaints, market conduct actions, communication with market staff, etc.
2) Concerns with litigation, legal, or government expenses
3) Material fraudulent activity and the financial impact to the insurer
4) Concerns with the insurer's compliance with code of ethics standards
5) Compliance concerns with NAIC reporting practices, internal policy, laws, regulations and prescribed practices
6) Concerns with the insurer's compliance with the state's investment laws
7) Compliance concerns with affiliated management and service agreements
8) Concerns with the insurer's compliance with transactions involving other jurisdictions
9) Whether the insurer is subject to regulation by other Federal regulatory agencies

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

Market Conduct Examination/Material Findings

Determine if concerns exist regarding Market Conduct, including complaints, market conduct actions, communication with market conduct staff, etc., that could have an impact on financial position and prospective solvency. If concerns exist, communicate risks/issues to the state insurance department's Market Conduct Unit to investigate further. For example, large fines levied by states, suspensions or revocations of licenses, market conduct exam settlements (whether financial or other), or other regulatory actions taken based on market conduct violations may have a material impact on the financial solvency of the insurer. Additionally, if a recently concluded market conduct examination resulted in regulatory requirement to perform remediation (E.g., reprocessing denied claims) the financial impact may be material to the insurer.

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Procedures/Data

- Review any market conduct information available from the NAIC market analysis tools available on iSite+:
  - (Market Analysis Profile (MAP),
  - Examination Tracking System (ETS), Market Analysis Review System (MARS),
  - Regulatory Information Retrieval System (RIRS) Regulatory Actions, including the Special Activities Database (SAD),
  - Market InitiativeAction Tracking System (MIATS), including market conduct examination tracking,
  - Market Conduct Annual Statement (MCAS), and the
  - Complaints database).
- Note any unusual items or negative trends for the following items that translate into financial risks or indicate further review is needed:
  - Count of Regulatory Actions
  - Aggregate of Regulatory Fines
  - Market Conduct Examination Called or Concluded

- In reviewing the items disclosed in the Market Conduct Examination and other Market Conduct findings, the analyst should assess their potential impact on the insurer's financial condition and prospective solvency by placing and discussing risk information within the appropriate branded risk classification, if not a legal matter.

Additional Procedures

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

High Litigation, Legal and Government Expenses

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

Procedures

- Review the Quarterly Financial Statement including the Notes to Financial Statements, and Examination findings and follow-up monitoring to determine whether any legal concerns were identified.

- Upon review of the Notes to Financial Statements, determine whether the insurer was a party to any significant litigation not in the normal course of business. If so, review and understand a description of the litigation and any contingent liabilities for accrued legal expenses.

Material Fraudulent Activity/Investigation Results

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

Procedures

- Review the Quarterly Financial Statement, including the Notes to Financial Statements, Examination findings (i.e., Exhibit G – Consideration of Fraud) to identify if any fraud concerns were disclosed.
- Contact the state insurance department's Fraud Unit (if applicable) to see if the state insurance department has concluded any fraud investigations involving the insurer? If so, identify the following:
  - Nature and scope of the investigation and its findings
  - Regulatory and/or corrective actions required of the insurer
  - Insurer's plan to address the fraudulent activity
  - Financial impact of the investigation and corrective actions
- Review news/media reports, information from the insurer or other information available to the analyst that may indicate the insurer is under investigation by any regulatory body other than the state insurance department. If so, identify the nature and scope of the investigation and impact on the insurer to determine whether further information should be requested from the other regulatory body.
- Review Regulatory Actions (through RIRS) to identify whether any regulatory actions taken by other states were identified as fraud. If so, and if not communicated to the state insurance department, contact the reporting state insurance department to obtain information regarding the regulatory action.
- Contact other regulatory agencies that have regulatory authority over the business of the insurer (e.g., federal agencies where the insurer is engaged in government contracts) to identify whether any regulatory authorities have concluded any fraud investigations involving the insurer, its management or board of directors. If so, request the following information:
  - Nature and scope of the investigation and its findings
  - Regulatory and/or corrective actions required of the insurer
  - Insurer's plan to address fraudulent activity
  - Financial impact of the investigation and corrective actions
- If the above analysis indicates concerns related to current or prior fraud, inquire of the insurer regarding its internal processes and controls for preventing fraud.

Failure to Comply with Code of Ethics Standards

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

Procedures/Data

- Review the following and identify any concerns with the insurer's compliance with the code of ethics.
  - General Interrogatories, Part 1, #9.1 to identify if senior officers are subject to code of ethics standards.

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  - General Interrogatories, Part 1, #9.2 to identify if the code of ethics has been amended.
  - General Interrogatories, Part 1, #9.3 to identify if the code of ethics has been waived.

Additional Procedures

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

Failure to Comply with State Laws and Reporting

Assess the insurer's compliance with NAIC reporting practices, internal policy, laws, regulations and prescribed practices. The analyst should determine whether there are any legal or regulatory impediments that could affect the insurer's operations or result in a significant legal liability. If a compliance violation is found, the analyst should specify the violation and the impact.

Procedures/Data

- Review General Interrogatories, Part 1, #7.1 and #7.2 and identify if any certificates of authority, licenses or registrations have been suspended or revoked.

Additional Procedures

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

  - Reason(s) stated for the revocation or suspension
  - Outcome of any department communication with the insurer and/or with the other regulatory authority who issued the revocation or suspension
  - Resolution of any non-compliance issues or resolution plans of the insurer
- If the insurer has been issued any consent orders or agreements by other regulators/jurisdiction, identify or perform the following:
  - Request a copy of the consent order or agreement from the other regulator/jurisdiction
  - Reason(s) stated for the consent order or agreement
  - Outcome of any department communication with the insurer and/or with the other regulatory authority
  - Resolution of any non-compliance issues or plans of the insurer

Failure to Comply with State Investment Laws

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

Procedures

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

Failure to Comply with Affiliated Management and Service Agreements

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

Procedures/Data

- Review General Interrogatories, Part 1, #1.1 to determine whether the insurer experienced any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile as required by the Model Act. If so, determine whether the insurer made the appropriate filing of a Disclosure of Material Transactions with the state of domicile.

Additional Procedures

- Determine whether management and service agreements between affiliates either submitted and/or approved are in conformity with regulatory requirements and verify that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
- Determine whether the amount of the shareholder dividend was at a level that required prior regulatory approval or notification. If so, determine whether the insurer obtained proper prior regulatory approvals.

Failure to Comply with Transactions Involving Other Jurisdictions

Assess the insurer's compliance with transactions involving other jurisdictions.

Procedures

- If the insurer redomesticated to your state, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.
- If the insurer engaged in a transaction(s) to redomesticate a subsidiary offshore, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.
- If the insurer engaged in any transactions to acquire a subsidiary domiciled in a non-U.S. jurisdiction, determine whether the insurer failed to comply with any regulatory requirements or stipulations expected to be met subsequent to the acquisition and identify any legal implications that represent risk to the insurer due to the acquisition.

Failure to Comply with Federal Regulatory Agencies

Identify and assess compliance with other federal regulatory agencies. In addition to the HHS and the CMS oversight of health insurance, insurers may be subject to regulation by the Federal Reserve, U.S. Securities and Exchange Commission (SEC), U.S. Department of the Treasury and other federal regulatory bodies depending upon the nature, scope and extent of the insurer's or insurance group's activities.

Procedures

- Review General Interrogatories, Part 1, #8 and determine whether the insurer is subject to regulation by a federal regulatory agency. If so, consider contacting the applicable federal regulatory agency to request any information about the results of that agency's oversight, including any issues identified, federal compliance violations, fraud investigations and regulatory actions.

~~Liquidity Risk Assessment~~

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

The ~~objective of the~~ Liquidity Risk Assessment ~~analysis~~ is focused primarily on overall liquidity, liquidity of investments, receivables, and cash flow from operations. ~~The following discussion of procedures provides suggested data, benchmarks and procedures analysts can consider in his/her review.~~ In analyzing liquidity risk, analysts may analyze specific types of investments and receivables held by insurers. An analyst's risk-focused assessment of liquidity risk should take into consideration the following areas (but not be limited to):

- Liquidity ratios/metrics
- Liquidity of certain investments, including private placement bonds and common stock, highly structured investments, investments on Schedule BA, and affiliated investments
- Liquidity of certain receivables, including health care receivables and special deposits
- Cash flow from operations
- Stockholder dividends
- Surrender and withdrawal activity for life insurers

~~Overview of Investments~~

Refer to IV.A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations for general information and a primer on derivatives.

~~Overview of Cash Flows~~

~~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, analysts should analyze the liquidity of the balance sheet in its entirety 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.~~

~~Liquidity of Health Entities~~

~~There are a number of situations that can elevate the risk of a negative impact on a health entity's cash flow and liquidity including the credit risk of receivables, the level of borrowed money and other liabilities, and dividends to shareholders. For example, if a health entity relies heavily on risk transfer arrangements with provider groups and the parties involved in the arrangements are unable to meet their obligations, the collectability of those obligations could negatively impact the liquidity of the health entity. Credit risk is a concern for other receivables as well, including amounts due from affiliates and reinsurance receivables. An analyst should be aware of the domiciliary state's requirements for downstream risks such as provider groups and reinsurance. Other situations involve significant increases in liabilities such as unpaid claim reserves or borrowed money, which can increase the health entity's short-term cash requirements. Additional cash would also be needed in order for the health entity to pay dividends to a parent company or other shareholder.~~

~~Health entities have a shorter benefit payout period than other insurers, and consequently understanding the need for liquidity is an important issue for management. Because a health entity writes short-tail business, it will generally have a shorter average maturity on its bonds and hold more cash and short-term investments than other insurers. The key liquidity risks to a health entity include substantial declines in enrollment, underpricing, and spikes in claims. If this were to occur, the entity's cash outflows for claims payments would exceed its inflows from newly received premiums. However, a health entity with a relatively stable enrollment and claims experience within expectations may feel it can safely accept some durational mismatch between its assets and liabilities and may invest in more long-term invested assets in order to increase its investment yield. Those health entities writing long-tailed business may also own long-term invested assets to support those lines' liabilities.~~

~~DISCUSSION OF ANNUAL PROCEDURES~~GENERAL GUIDANCE

~~Using the Repository~~

~~The~~ To assess liquidity risk, ~~repository is a list of possible quantitative and qualitative~~consider the procedures, including specific data elements, metrics and benchmarks ~~and procedures from which analysts may select to use in his/her review of liquidity risk~~in this chapter.

The placement of the following data and procedures in the liquidity risk ~~repository~~ is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different ~~repositories~~risk categories. Therefore, analysts may need to review other ~~repositories~~risk assessments in conjunction with liquidity risk.

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

Analysts are not expected to ~~respond~~ document ~~to all~~every procedure~~s~~, data, or benchmark results ~~listed in the repository~~. Rather analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document ~~completion of~~of the applicable details within the analysis. Results of liquidity risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. ~~The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.~~

~~In using procedures in the repository, a~~Analysts should ~~review the results~~complete their liquidity risk assessment in conjunction with

- A review of the Supervisory Plan and Insurer Profile Summary and the prior period analysis.
- Communication and/or coordination with other internal departments are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures ~~in the repository~~.

- 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 placement of the following data and procedures in the liquidity risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with liquidity risk.~~

~~***ANALYSIS DOCUMENTATION:*** Results of liquidity risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.~~

~~QUANTITATIVE AND QUALITATIVE DATA AND PROCEDURES~~ANNUAL LIQUIDITY RISK ASSESSMENT

~~Liquidity of Investment Portfolio and~~ Insufficient Overall Liquidity (or Illiquid Assets are Significant)

~~*Property & Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*1, 2, 3, 4*~~	~~*1, 2, 3, 4, 5*~~	~~*1, 2, 3, 4, 5*~~

~~***EXPLANATION:*** The procedures assist analysts in E~~Eevaluat~~ing~~e the insurer's ~~overall~~ liquidity position, and examine its ability to meet financial obligations as they come due, including claim payments, operational expenses, and other financial commitments. Less liquid assets may be unavailable to pay policyholder claims as they are not as easily or quickly marketable. ~~The primary method of accomplishing this is to review~~The assessment of liquidity involves a detailed analysis of changes in the insurer's liquid assets, ~~and results of liquidity ratios/metrics.~~

~~***ADDITIONAL REVIEW CONSIDERATIONS:*** Assess how the insurer's~~asset-to-liability ratios, and liquidity trends ~~over years~~. ~~An analyst may also consider liquidity results c~~Comparison~~ed to~~ with industry averages ~~(some ratios are included in the Financial Profile Report)~~ and peer companies ~~that have similar business mix, asset size, and asset composition.~~offers valuable insights into the insurer's liquidity standing within its market segment.

Procedures / Data

- Analyze the insurer's liquidity position by reviewing the following metrics and data elements:
  - Change in liquid assets
    - ~~*#1b* alerts analysts to fluctuations in total liquid assets.~~ A significant increase in ~~a health entity's~~an insurer's total liquid assets could indicate that ~~the health entity~~it has been unable to collect on receivables. If the change is significant, an analyst may consider a more detailed review of the change in the asset mix from the prior period to determine the cause of the fluctuation.
  - Ratio of restricted assets to total cash and invested assets
    - Assessment of materiality of restricted assets is intended to determine if any liquidity concerns exist regarding the level of assets not under the insurer's exclusive control. Analysts should review General Interrogatories and Notes to the Financial Statement #5 to determine the reason the assets are not under the insurer's exclusive control (e.g., loaned to others, subject to repurchase or reverse repurchase agreements, pledged as collateral, placed under option agreements) and who holds the assets in order to evaluate whether there are liquidity concerns.

Analysts should also consider the potential for pledging additional assets, as in variation margin requirements for derivatives transactions.

- Ratio of adjusted liabilities to liquid assets (P/C)
  - ~~***FOR PROPERTY/CASUALTY (P/C) INSURERS:***~~ The P/C liquidity ratio calculation ~~(#1a)~~ compares the insurer's adjusted liabilities with its liquid assets (IRIS ratio #9) available to fund ~~such~~ future liabilities ~~in the future~~. Affiliated holdings are ~~removed~~ excluded from liquid assets because ~~these investments~~they are considered less liquid and may not be readily converted to cash ~~for paying claims~~. In addition to assessing the insurer's current liquidity ratio, ~~Analysts~~ analysts should ~~also consider~~ review~~ing~~ the five-year trend ~~of liquidity~~ within the Financial Profile Report. ~~and identifying any s~~Significant fluctuation~~s~~ should be noted and the underlying cause~~(s)~~ ~~for those fluctuations~~analyzed.
- Ratio of capital and surplus and AVR to total assets less separate accounts (Life/A&H)
  - For life insurers, ~~: *#1g* 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, it is not captured within the annual financial statements. In order to obtain this information, regulators must request that reporting entities complete the forms. As noted in the *Examiners Handbook*, requests for reporting entities to complete these templates may occur at any time and are not limited to instances of comprehensive statutory examinations. Analysts should communicate with the examiner to determine if the insurer has recently submitted responses to the stress liquidity inquiries and templates or if a request should be made to the insurer for the information.
- Ratio of total liabilities to liquid assets (Health)
  - ~~***FOR HEALTH ENTITIES:***~~
  - ~~*#1* assists analysts in evaluating the health entity's overall balance sheet liquidity.~~ The primary method in evaluating a health entity's liquidity ~~of~~ is ~~accomplishing~~ accomplished ~~this is to compare~~ comparing ~~the health entity's~~its liabilities with its liquid assets available to fund such liabilities in the future. However, as previously mentioned, various other comparisons can be used to help assess liquidity or potential liquidity concerns. Liquid assets in this calculation include all bonds but exclude affiliated investments.
  - ~~*#1a and 1g* assist analysts 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.
  - ~~*#1b* alerts analysts 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.~~
- Ratio of liquid assets and receivables to current liabilities (Health)
  - ~~#1c~~This ratio measures the health entity's ability to pay current obligations with current assets including marketable securities. Results of less than 200 percent may not pose a serious threat to the health entity if it has access to other assets that can be liquidated. This ratio excludes non-investment grade bonds and affiliated investments but includes certain receivables not included in the two procedures above.

- Ratio of aggregate write-ins for other than invested assets to capital and surplus (Health)

Additional Review Considerations

- Review the trends over years in the liquidity ratios noted above and not any unusual fluctuations or negative trends between years.
- Compare the results of liquidity ratios noted above with industry or peer group averages to identify any significant deviations.
- Review the Annual Supplemental Investment Risks Interrogatories. Note any unusual items or areas that would indicate inadequate liquidity.
- Request and review the insurer's most recent investment plan. Determine if the investment plan is adequate to meet the liquidity needs of the insurer's liability structure.
- If there are concerns regarding liquidity or cash flows:
  - For a P/C insurer, consider having a cash flow analysis performed by an actuary.
  - For a Life/A&H or Health insurer, review the Statement of Actuarial Opinion for comments regarding cash flow testing performed and the results obtained.
- If an examination is in progress or recently completed, communicate with the examiner to determine if the insurer has recently provided responses to the stress liquidity inquiries and templates included in the NAIC *Financial Condition Examiners Handbook*. If such has occurred, review this information to ascertain whether the analyst's liquidity concerns have been alleviated. If not, request the insurer to submit responses to these inquiries.
- If restricted assets are material, gain an understanding and assess the types of investments and products that may require collateral to be posted (e.g., derivatives, guaranteed investment contracts (GICs), Federal Home Loan Bank, etc.).
- If concerns are identified regarding overall liquidity of the asset portfolio, identify and assess other sources of liquidity available to the insurer. Request information from the insurer if necessary.
- Assess the impact of market conditions through consideration of industry and economic events (i.e., news, industry analytics). Is the analyst aware of any market conditions that may threaten the liquidity of insurers' investment portfolios (e.g., market dislocation or other events that could affect liquidity of assets classes such as structured securities, structured notes, Schedule BA assets, non-investment grade bonds)?

Risk of Insufficient Liquidity for Health Entities

There are a number of situations that can elevate the risk of a negative impact on a health entity's cash flow and liquidity including the credit risk of receivables, the level of borrowed money and other liabilities, and dividends to shareholders. For example, if a health entity relies heavily on risk transfer arrangements with provider groups and the parties involved in the arrangements are unable to meet their obligations, the collectability of those obligations could negatively impact the liquidity of the health entity. Credit risk is a concern for other receivables as well, including amounts due from affiliates and reinsurance receivables. An analyst should be aware of the domiciliary state's requirements for downstream risks such as provider groups and reinsurance. Other situations involve significant increases in liabilities such as unpaid claim reserves or borrowed money, which can increase the health entity's short-term cash requirements. Additional cash would also be needed in order for the health entity to pay dividends to a parent company or other shareholder.

Health entities have a shorter benefit payout period than other insurers, and consequently understanding the need for liquidity is an important issue for management. Because a health entity writes short-tail business, it will

generally have a shorter average maturity on its bonds and hold more cash and short-term investments than other insurers. The key liquidity risks to a health entity include substantial declines in enrollment, underpricing, and spikes in claims. If this were to occur, the entity's cash outflows for claims payments would exceed its inflows from newly received premiums. However, a health entity with a relatively stable enrollment and claims experience within expectations may feel it can safely accept some durational mismatch between its assets and liabilities and may invest in more long-term invested assets in order to increase its investment yield. Therefore, the analyst should consider reviewing the Pricing/Underwriting Risk Assessment in conjunction with Liquidity. Those health entities writing long-tailed business may also own long-term invested assets to support those lines' liabilities.

Z-Score Analysis (Health Only)

The Z-Score analysis included in the Annual Financial Profile. The Z-Score is a way to measure and monitor financial performance by analyzing specific ratios over a period of time. If a result of less than 2.6 occurs, analysts should consider reviewing the individual ratios within the Z-Score. An unstable trend of the Z-Score or a low Z-Score may indicate increased risk to the solvency of the health entity and analysts should take a closer look at each of the ratio results in the Financial Profile. There are four ratios in the Z-Score; however, the Z-Score places the most emphasis on working capital and earnings. The following briefly explains each ratio within the Z-Score, although more detail is available in the link to the *Z-Score Document* on iSite+.

- *Working Capital to Total Assets* measures the ability of a health entity to manage working capital, which is fundamental for all business. While a health entity may have sufficient surplus, they may have insufficient working capital to pay claims due to related party transactions and other non-liquid long-term investments. Analysts should also consider that while working capital may be above the threshold, it may still not provide a sufficient cushion for significant unexpected losses. Refer to the discussion of procedure #1c above.
- *Retained Equity to Total Assets* reflects the age of the business and the philosophy of management. This assumes that a more mature business would normally have more capital and surplus. Companies that have been in business fewer years and have insufficient management experience tend to have higher failure rates.
- *Earnings Before Interest & Taxes (EBIT) to Total Assets* measures a health entity's earnings performance. This ratio is weighted the highest for several reasons including the following: 1) significant shifts in earnings may indicate a highly risky industry with unstable cash flows; 2) health entities must balance consumer demands with cost management; and 3) Medicare and Medicaid programs and other outside factors can have a significant impact on the health entity's financial condition.
- *Capital and Surplus to Total Liabilities* is the leverage measure within the Z-Score and is the inverse of the traditional debt to equity ratio.

Procedures / Data

- Total Z-Score.
- Decrease in Z-Score from the prior year where the total Z-Score is 6.0 or less in the current year.
- Decrease in the Z-Score over the past three years if the Z-Score is 6.0 or less in the current year.
- Ratio of working capital to total assets.
- Review the working capital to total assets ratio for the past years and assess any unusual fluctuations or negative trend.

Impact of Volatility in the Value ~~and Maturity~~ of Bond Portfolio on Liquidity

Impact of Maturity of Bond Portfolio on Liquidity

Bond holdings are a substantial component of most insurers' investment portfolios. Their value and maturity can significantly affect an insurer's liquidity. Bond prices fluctuate due to factors like interest rate changes, issuer creditworthiness, and economic conditions. A decline in bond values can reduce an insurer's overall assets and potentially impact its liquidity. The maturity of an insurer's bond portfolio is also crucial. Short-term bonds offer more predictable cash flows as they approach redemption, benefiting insurers needing to meet regular claims payments or other liquidity demands. Longer-term bonds are more sensitive to interest rate changes. Bond prices and interest rates have an inverse relationship. Rising interest rates can decrease the value of existing bonds, potentially affecting an insurer's liquidity.

Procedures

- Review the Annual Financial Statement, Schedule D – Part 1A – Section 2 and identify any material fluctuations/trends.
- Determine if the the maturity of the insurer's bond portfolio aligns with its most recent investment plan and adequately matches future liabilities.
- Review the Annual Financial Statement, Schedule D – Part 1 and determine the extent to which the fair value of bonds varies from the statement value. Assess the impact of such variance on the insurer's overall liquidity.
- Review the Annual Financial Statement, including Notes to Financial Statements – Note #5 to assess if there are liquidity concerns due to a material exposure to highly structured bonds, including RMBS, loan-backed and structured securities and structured notes.

Exposure to Private Placement Bonds~~ (#3):~~

Significant investments in privately-placed bonds may cause concerns regarding the insurer's liquidity because some of these investments cannot be resold, while those that can be resold have restrictions on whom they can be sold to, including restrictions under securities laws. There is no structured market for privately-placed bonds like there is for publicly-traded bonds. Therefore, even if the privately-placed bonds can be sold, it may be difficult to find a willing buyer.

Procedures / Data

- Ratio of private-placement bonds owned to policyholder surplus (P/C), to capital and surplus plus AVR (Life/A&H) and to capital and surplus (Health)
- Increase in private placement bonds from the prior year

Additional R~~r~~eview C~~c~~onsiderations~~ for Private Placement Bonds:~~

- Review Annual Financial Statement, Schedule D – Part 1A – Section 1 to determine the amount, issue type, NAIC designations, maturity distribution of privately-placed bonds owned, and the amount of privately placed bonds that are freely tradeable under U.S. Securities and Exchange Commission (SEC) Rule 144 or qualified for resale under SEC Rule 144A.
- For significant privately-placed bonds rated by a chief revenue officer, review the issuer's rating or request the Securities Valuation Office's assessment of the designation to evaluate the issuer's financial position and ability to repay its debt.

Exposure to Other Invested Assets (Schedule BA)

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Other Invested Assets (or Schedule BA Assets) are long-term investments not clearly or normally categorized within other asset schedules. These investments often involve a higher degree of complexity or illiquidity. Examples include joint ventures and partnerships, structured securities, oil and gas production, mineral rights, surplus debentures, collateralized and non-collateralized loans, and other specialized investments. While generally considered less liquid, the liquidity of Schedule BA Assets can vary significantly based on market conditions and the specific nature of each asset.

Specific liquidity risks related to BA Assets may include:

- Significant amount of Schedule BA assets held with commitments/ collateral requirements—Schedule BA assets may include commitments for additional funding, which is common in private equity funds. Schedule BA assets may have the potential to be required to post additional collateral, similar to variation margin for derivatives.
- Expected cash flows from Schedule BA assets and types of other structured bonds—Certain Schedule BA assets and highly structured bonds, including RMBS, LBaSS, and structured notes, may include liquidity risks where expected cash flows do not match the actual cash flows.
- Significant amount of BA Assets held with resale restrictions—Illiquidity of certain assets may be due to provisions of the asset, such as restrictions on resale. (E.g., certain BA assets, such as investment hedge funds, may have time restrictions on when investment can be sold/liquidated.)

Procedures / Data

- Ratio of Schedule BA Assets to policyholder surplus (P/C), to capital and surplus plus AVR (Life/A&H) and to capital and surplus (Health)
- Increase in Schedule BA Assets from the prior year

Additional Review Considerations

- Review Annual Financial Statement – Schedule BA to detrmine whether the insurer invested in any assets, such as hedge funds or private equity funds, that may include restrictions on an investor's ability to liquidate the assets, commitments for additional funding (common in private equity funds), or have the potential to be required to post additional collateral.

~~Z-Score Analysis (For Hhealth) **entities:** #4 requires analysts to review~~

~~Tthe Z-Score analysis included in the Annual Financial Profile. The Z-Score is a way to measure and monitor financial performance by analyzing specific ratios over a period of time. If a result of less than 2.6 occurs, analysts should consider reviewing the individual ratios within the Z-Score. An unstable trend of the Z-Score or a low Z-Score may indicate increased risk to the solvency of the health entity and analysts should take a closer look at each of the ratio results in the Financial Profile. There are four ratios in the Z-Score; however, the Z-Score places the most emphasis on working capital and earnings. The following briefly explains each ratio within the Z-Score, although more detail is available in the link to the *Z-Score Document* on iSite+.~~

- ~~*Working Capital to Total Assets* measures the ability of a health entity to manage working capital, which is fundamental for all business. While a health entity may have sufficient surplus, they may have insufficient working capital to pay claims due to related party transactions and other non-liquid long-term investments. Analysts should also consider that while working capital may be above the threshold, it may still not provide a sufficient cushion for significant unexpected losses. Refer to the discussion of procedure #1c above.~~
- ~~*Retained Equity to Total Assets* reflects the age of the business and the philosophy of management. This assumes that a more mature business would normally have more capital and surplus. Companies that have~~

been in business fewer years and have insufficient management experience tend to have higher failure rates.

- *Earnings Before Interest & Taxes (EBIT) to Total Assets* measures a health entity's earnings performance. This ratio is weighted the highest for several reasons including the following: 1) significant shifts in earnings may indicate a highly risky industry with unstable cash flows; 2) health entities must balance consumer demands with cost management; and 3) Medicare and Medicaid programs and other outside factors can have a significant impact on the health entity's financial condition.
- *Capital and Surplus to Total Liabilities* is the leverage measure within the Z-Score and is the inverse of the traditional debt to equity ratio.

Restricted Assets (Life #1c, P/C #1c, Health #1d): Assessment of materiality of restricted assets is intended to determine if any liquidity concerns exist regarding the level of assets not under the insurer's exclusive control. Analysts should review General Interrogatories and Notes to the Financial Statement #5 to determine the reason the assets are not under the insurer's exclusive control (e.g., loaned to others, subject to repurchase or reverse repurchase agreements, pledged as collateral, placed under option agreements) and who holds the assets in order to evaluate whether there are liquidity concerns. Analysts should also consider the potential for pledging additional assets, as in variation margin requirements for derivatives transactions.

Review the working capital to total assets ratio for the past years and assess any unusual fluctuations or negative trend.

Private Placement Bonds (#3): Significant investments in privately-placed bonds may cause concerns regarding the insurer's liquidity because some of these investments cannot be resold, while those that can be resold have restrictions on whom they can be sold to, including restrictions under securities laws. There is no structured market for privately-placed bonds like there is for publicly-traded bonds. Therefore, even if the privately-placed bonds can be sold, it may be difficult to find a willing buyer.

Exposure to Illiquidity of Collateral Loans (Life/A&H)

Determine whether there are concerns due to the level of investment in collateral loans.

Procedures / Data

- Ratio of collateral loans to capital and surplus plus AVR
- Increase in the ratio of collateral loans to cash and invested assets from the prior year

Additional Review Considerations

- Review Annual Financial Statement, Schedule BA – Part 1 and Schedule DA – Part 1 and perform the following for each collateral loan:
  - Determine whether the collateral for the loan is an acceptable asset
  - Determine whether the collateral loan is to an officer, parent, subsidiary, or affiliate

Additional review considerations for Private Placement Bonds: Review Annual Financial Statement, Schedule D – Part 1A – Section 1 to determine the amount, issue type, NAIC designations, maturity distribution of privately-placed bonds owned, and the amount of privately-placed bonds that are freely tradeable under U.S. Securities and Exchange Commission (SEC) Rule 144 or qualified for resale under SEC Rule 144A.

Exposure to Restricted Assets within the Securities Lending Program, or Liquidity of Reinvested Collateral within the Securities Lending Program (P/C and Life/A&H)

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*

5	6	N/A

EXPLANATION: The procedure assists analysts in Ddetermineing if concerns exist regarding the materiality of securities lending activity and the nature of the reinvested collateral.

Procedures / Data

- Does the reporting entity engage in securities lending transactions?
  - Ratio of securities lending collateral reinvested to total assets
  - Aggregate total collateral received

Additional Review Considerations

- Review Annual Financial Statement investment schedules, General Interrogatories, and Notes to Financial Statements to gain an understanding of the scope of the securities lending program and restricted assets, and to understand how the cash collateral is reinvested (Schedule DL).

Illiquidity of Separate Account Assets, or
Negative Economic Impacts on Liquidity of Separate Accounts (Life/A&H)

Property/Casualty #	Life/A&H/Fraternal #	Health #
N/A	7	N/A

EXPLANATION: The procedure assists analysts in Ddetermineing the materiality of separate account assets in order to determineand the potential impact on the liquidity of the insurer in the event of large withdrawals from separate accounts. Liquidity risks related to separate accounts can include:

- Illiquidity of separate account assets—Risk that liquid assets are insufficient to meet surrender benefits, resulting in insufficient cash flows.
- Negative economic impact on separate account liquidity—Risk that market decline results in the need for policyholder cash, resulting in the potential negative impact or a "run on the bank" scenario.

Procedures / Data

- Does the reporting entity engage in securities lending transactions with separate account transactions?
  - Ratio of total separate account assets to total assets
  - Aggregate total collateral received

Additional Review Considerations

- Review the investment schedules, General Interrogatories and Notes to the Financial Statements to gain an understanding of the scope of the securities lending program and restricted assets, and to understand how the cash collateral is reinvested (Schedule DL).
- Does the reporting entity report Federal Home Loan Bank (FHLB) funding agreements within the separate account(s)? If so, assess the materiality of the FHLB agreements.

Exposure to Affiliated Investments

Property & Casualty #	Life/A&H/Fraternal #	Health #
6	8	6

EXPLANATION: Thise procedure assists analysts in determining whetherinvolves assessing the significance of investments in affiliated companiess are significant. AThe procedure measures the extent to which capital and surplus relies on assets that are due from affiliated entities because affiliated investments are often illiquid.,

which can negatively affect the insurer's overall liquidity, especially when they constitute a significant portion of its portfolio. Investments in parent, subsidiaries, or affiliates (PSA) may not be marketable and unavailable to pay policyholder claims. Excessive affiliated investments ~~and receivables may indicate the insurer 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~~may also divert capital from other opportunities with potentially higher returns. Therefore, a thorough analysis of the business purpose and benefits of such investments is essential. When affiliated investments are substantial, ~~A~~analysts ~~may consider~~should carefully review~~ing and understanding~~ the financial statements of the affiliate to gain a comprehensive understanding of its financial health and potential risks.

Procedures / Data

- Ratio of affiliated investments to policyholder surplus (P/C), to capital and surplus plus AVR (Life/A&H) and to capital and surplus (Health)
- Change in total affiliated investments from the prior year
- Change in any category of affiliated investments from the prior year

Additional Review Considerations

- If the Company owns interest in the capital stock of another insurance company, review Schedule Y to determine if the investment was properly disclosed.
- Review the results of the Holding Company Analysis completed by the lead state to determine if any concerns exist regarding affiliated entities.
- Review Annual Financial Statement, Notes to Financial Statements, Note #10 and Note #14 to identify if the insurer is subject to any guarantees or other commitments to (PSA). If the guarantee or commitment is material to the insurer, assess the nature of the agreement and the financial strength of the PSA.

Exposure to Other Less Liquid Receivables (Health)

~~*Property/Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*N/A*~~	~~*N/A*~~	~~*7*~~

~~***EXPLANATION***: Thei~~s ~~procedures assist analysts in r~~Review~~ing~~ the assets of a health entity that may have limited marketability~~.~~, such as furniture, equipment, and software.

~~***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.

Statement of Statutory Accounting Principles (SSAP) *No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities* describes health care delivery assets as those assets that are used in connection with the direct delivery of health care services in facilities owned or operated by the health entity. SSAP No. 73 further provides that these types of assets shall be admitted provided they meet the definitions of health care delivery assets as set forth in the SSAP. As a result of this accounting guidance, it is possible that a health entity with these types of assets will have a much different mix of assets than other health entities that do not use these types of assets in its operations. It should be noted that the depreciation period for health care delivery assets is limited to three years, which varies from the depreciation period for similar assets that are non-admitted.

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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.

~~***ELECTRONIC DATA PROCESSING EQUIPMENT AND SOFTWARE:***~~

As discussed in SSAP *No. 16R—Electronic Data Processing Equipment and Software,* electronic data processing (EDP) equipment and operating system software are admitted assets to the extent they conform to the requirements of *SSAP No. 4—Assets and Nonadmitted Assets*. The admitted asset is limited to three percent of capital and surplus; adjusted to exclude any EDP equipment and software, net deferred tax assets and net positive goodwill. However, SSAP No. 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, Equipment and Leasehold Improvements*.

EDP assets generally are subject to various state specific limitations, such as a minimum amount that can be capitalized as an asset, a maximum depreciable life, and/or limits that may be admitted as a percentage of total admitted assets or capital and surplus. These limitations are put in place to avoid undue concentrations of assets that have less marketability than other admitted assets and rapid technological obsolescence. Because of this, the amount reported by a health entity is generally limited to an amount that is not significantly material to the health entity's financial position. It is also common to find that the health entity reports no EDP assets. In these cases, the health entity often relies upon a parent or an affiliated company to provide EDP services with a resultant charge back through a management or service agreement.

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

Procedures / Data

- Ratio of admitted furniture, equipment and supplies to capital and surplus
- Change in the admitted balance of furniture, equipment and supplies from the prior year
- Ratio of admitted EDP equipment and software to capital and surplus
- Change in admitted EDP equipment and software from the prior year

Additional Review Considerations

- Review Annual Financial Statement – Exhibit 8 for the reporting distribution of furniture, equipment and supplies.
- If there are concerns regarding furniture, equipment and supplies, request and review:
  - Clarification of any unusual responses from its independent auditor.
  - Information regarding depreciation and review for reasonableness. Determine if the depreciation period exceeds three years.
- Regarding EDP equipment:
  - Review disclosures in the Notes to the Audited Financial Report for reasonableness.
  - Perform a review to determine whether the minimum capitalization amount, depreciable life and admissibility are in compliance with statutory limitations.
  - Request a description of the methodology used to compute depreciation.
    - Determine if the period of depreciation exceeds three years.
    - Determine if the insurer non-admitted non-operating software.

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- Review the management or service agreements, if any, which provide for EDP services and evaluate whether the charges appear reasonable for the services provided.
- If the insurer did not report an asset for EDP equipment and operating system software, does a management or service agreement exist that provides for electronic data processing services?

Significant Amount of Special Deposits

~~*Property/Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*7*~~	~~*9*~~	~~*8*~~

~~***EXPLANATION:*** Theis procedures assist analysts in d~~Determine~~ing~~ if the insurer is exposed to greater-than-normal liquidity risk with respect to special deposits.

Special deposits are segregated into two sections: 1) for the benefit of all policyholders; and 2) all other special deposits. Both categories reflect amounts aggregated by state. Deposits for the benefit of all policyholders are held by individual states. The assets composing these deposits are held on the various investment schedules in the financial statement. However, the assets are not held in custody of the insurer, and restrictions are placed on the assets disposal. Special deposit assets may be unavailable to pay policyholder claims. In a situation of a rehabilitation of an insurer~~ng~~ or a troubled insurer, these restrictions on assets may cause concerns, particularly those not held for the benefit of all policyholders.

This procedure also assists analyst~~s~~ 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. Analysts may consider this assessment necessary in either of those cases because, once the insurer has moved into rehabilitation, the cash flow position of the insurer may deteriorate rapidly.

Procedures / Data

- Review Annual Financial Statement – Schedule 3 Part 3 to determine if any concerns exist regarding special deposits.
  - Ratio of book adjusted carrying value of total special deposits to total net admitted assets.
  - Ratio of book adjusted carrying value of all other special deposits (not for the benefit of all policyholders) to total special deposits.
  - Difference between the book adjusted carrying value and fair value of total special deposits.

Additional Review Considerations

- Review the listing of special deposits held by the insurer not for the benefit of all policyholders and there is overall liquidity risk regarding the insurer, consider:
  - The number of states in which the insurer has these types of deposits. The greater the number, the more difficult it could be for the domiciliary state to call on these deposits in a rehabilitation.
  - The amount of concentration in any one particular state.
- Contact the domiciliary state or perform research to determine if any of the states have restrictions on the ability of those deposits to be called by the domiciliary state during a rehabilitation.

Liquidity Strain of Surrender and Withdrawal Activity (Life/A&H)

~~*Property/ Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*N/A*~~	~~*10*~~	~~*N/A*~~

~~***EXPLANATION:*** The procedures assist analysts in D~~Ddetermin~~e~~eing ~~if~~ whether surrenders and withdrawals on life and annuity products are significantly affecting the insurer's liquidity position and are trending negatively. In addition, significant levels of guaranteed interest contracts or amounts subject to minimal or no surrender charges can be identified as well.

Liquidity strain of surrenders and withdrawals may be the result of:

- Market decline that results in the need for policyholder cash, resulting in the potential negative impact on availability of liquid assets or a "run on the bank" scenario.
- That liquid assets are insufficient to meet surrender benefits, resulting in insufficient cash from operations.
- Poor asset-liability matching and the potential negative impact

Procedures / Data

- Ratio of surrender benefits and withdrawals on deposit-type contracts to net premiums and deposits on deposit-type contracts
- Ratio of group surrenders to net group premiums in group annuities where group annuity surrenders exceed 20% of total surrenders
- Ratio of surrender benefits and withdrawals on deposit-type contracts to capital and surplus

Additional Review Considerations

- Review Annual Financial Statement, Notes to Financial Statements, Note #32. Determine if the insurer has a material amount of annuity reserves that can be withdrawn with minimal or no charge. (See the Financial Profile Report.)
- Determine which lines of business had significant surrender activity during the year or if there appears to be a negative trend in surrender activity over the past five years.
- Review the insurer's plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy withdrawal features and surrender charges.

Negative (or Negative Trend in) Cash Flow from Operations

~~*Property/Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*8*~~	~~*11*~~	~~*9*~~

The Cash Flow Statement ~~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 (~~a comprehensive overview of an insurer's cash inflows~~)~~ and ~~applications of cash (~~outflows~~)~~. ~~Cash Flow~~It is organized ~~to readily identify the net cash flow from~~into three primary areas: operations, ~~separately from the net cash flow from~~ investing~~ments~~, and financing. By examining these components, analysts can gain valuable insights into the insurer's liquidity and overall financial health. ~~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, analysts should analyze the liquidity of the balance sheet in its entirety 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.~~

~~***EXPLANATION:*** Thi~~s~~e procedures assist analysts in i~~Identify~~ing~~ situations where the insurer's operations are generating negative cash flow. ~~By analyzing the components of net cash from operations, analysts 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~~ Negative cash flow in this area can signal underlying financial weaknesses, such as increased claims activity, inefficient expense management, changes in premiums collected ~~as a result of changes in~~due to revised business strategy or reinsurance agreements, ~~unearned premiums, or agents' balances, or~~ among other ~~issues~~ factors that can drive negative cash flow from operations~~require additional investigation~~. Negative trends in cash flow from operations may create liquidity needs that may result in the sale of investments at a loss. ~~Shifts in cash outflows may be impacted by the timing of claims payments, 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 analysts to review net cash from investments, or financing and miscellaneous sources to identify any potential impact(s) to cash and short-term investments.~~ Negative cash flow from operations should be evaluated closely for persistent negative trends. Additionally, analysts may scrutinize the insurer's reliance on investment income to offset negative cash from operations. While this practice is not inherently problematic, excessive reliance can indicate potential vulnerabilities to market fluctuations. ~~by reviewing the five-year trend within the Financial Profile Report.~~ For life insurers, analysts should also closely evaluate significant net transfers to or from separate accounts, as ~~(#11c) since~~ this could provide insights regarding potential financial problems.

The Cash Flow Statement also provides valuable information about how the insurer finances negative cash from operations. This can involve borrowing funds, issuing surplus notes, or receiving capital support from the parent company. Conversely, positive cash flow from operations is a positive indicator, suggesting the insurer's ability to generate sufficient revenue and manage claims and expenses effectively. Analysts may explore how this positive cash flow is allocated, whether it is reinvested in the business or returned to stockholders through dividends. A high reliance by affiliated companies on dividends paid by the insurer may represent an ongoing liquidity need.

Procedures / Data

- For Property/Casualty:
  - Ratio of net cash from operations to policyholders surplus

- For Life/A&H:
  - Ratio of net cash from operations to to capital and surplus
  - Ratio of other cash provided (applied) to capital and surplus
  - Ratio of net transfers to or from separate accounts to capital and surplus

- For Health:
  - Ratio of net cash from operations to capital and surplus
  - Ratio of prior year net cash from operations to capital and surplus
  - Ratio of net cash from operations to premium income
  - Ratio of other cash provided (applied) to capital and surplus
  - Ratio of benefits and loss related payments to premiums collected net of reinsurance

- FOR HEALTH ENTITIES, PROCEDURE [#9G] 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 other cash flow metrics, such as net cash from operations to capital and surplus, net cash from operations to net premium income, and change in other cash provided (applied) from the prior year. 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.
  - Average number of days of unpaid claims

Additional Review Considerations

- Review the cash flow from operations to determine the underlying cause of the negative cash flow.
- Review the trend in net cash from operations for the past five years and note any unusual fluctuations or negative trends between years.
- Describe any material commitments for capital expenditures as of the end of the reporting period indicating the purpose, anticipated source of funds, changes between equity and debt, and any off-balance sheet financing agreements.
- Compare cash flow from operations with the industry and peer group (Peer Financial Report) in order to identify significant deviations.
- Life/A&H: Review the trend in transfer to/from separate accounts for unusual fluctation, such as significant reliance on cash provided from separate accounts and significant trends in providing cash to separate accounts.
- Health: Review the sources, including the Management's Discussion and Analysis and the Asset Adequacy Analysis from the Statement of Actuarial Opinion (if required) to determine if concerns exist relating to cash flow and liquidity or asset adequacy.
  - *FOR HEALTH ENTITIES:* 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 worksheet for more discussion on asset adequacy analysis.
- Health: Review changes in the average number of days of unpaid claims in past years for unusual fluctuations or negative trends between years.

Related Party Exposure in the Investment Portfolio

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
9	*12*	*10*

Explanation: This procedure assists analysts in dDetermineing related party exposure in the investment portfolio and assessing any related liquidity risk.

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

Related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the reporting entity or its

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policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny.

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

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

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

Procedures

- Review the Annual Financial Statement investment schedules, as disclosed in the column "Investments Involving Related Parties" and utilizing iSite+ tools, determine if the insurer has material related party exposures in its investment portfolio. This disclosure is included in Schedule B, Schedule BA, Schedule D, Schedule DA, Schedule DB, Schedule DL, and Schedule E, Part 2.
  - Consider exposure by asset class and in aggregate, and by the role of the related party in the investment as designed by the "Investments Involving Related Parties" disclosure.
- If concerns exist regarding a material related party exposure in the investment portfolio, assess the credit quality of those investments involving related parties by reviewing designations, assessing historical default experience, etc.

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

Invested Asset Exposure to Climate Change, Transition and Asset Devaluation Risk

Property/Casualty #	Life/A&H/Fraternal #	Health #
10	13	11

The procedure assists analysts in iIdentifying and assessing the potential exposure of the insurer's investment portfolio to the impact of material climate change and/or energy transition risks and asset devaluation risk. The insurer's investment portfolio is subject to prospective devaluation of the assets/changes in the asset return associated with its holdings of climate-affected assets. Transition risks refer to stresses on certain investment holdings arising from the shifts in policy, consumer and business sentiment, or technologies associated with the changes necessary to limit climate change. A few examples of investment holdings and sectors generally subject to greater levels of transition risk include, oil/gas, transportation, heavy manufacturing, and agriculture. In assessing an insurer's exposure to these risks, the analyst is encouraged to review information disclosed by the insurer in its responses to the NAIC's Climate Risk Disclosure Survey, U.S. Securities and Exchange Commission (SEC) filings, and/or the Own Risk and Solvency Assessment (ORSA) Summary Report filings. In addition, the analyst is encouraged to review the results of basic scenario analysis conducted by the NAIC using insurers' Annual Statement filings (U.S. Insurance Industry Climate Affected Investment Analysis) to identify potential concentrations in exposure.

Procedures

- Review information provided in the insurer's response to the NAIC's Climate Risk and Disclosure Survey (if available) on its exposure to material climate change/energy transition risk and related mitigation activity in this area.
- Review relevant information provided in the Own Risk and Solvency Assessment (ORSA) Summary Report, and/or U.S. Securities and Exchange Commission (SEC) 10-K or 10-Q filings (if available) that discusses the insurer's exposure to material climate change/energy transition risk and related mitigation activity in this area.

- Review information provided in the NAIC's U.S. Insurance Industry Climate Affected Investment Analysis to identify potential concentrations in insurer exposure.

~~ADDITIONAL REVIEW CONSIDERATIONS~~Additional Review Considerations

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

Significant Assessments Against Policy Benefits (Fraternal Only)

~~***PROCEDURE #12***~~ ~~This procedure assists analysts in d~~Determine~~ing~~ if the fraternal society has implemented assessments (i.e., liens) against policyholder benefits, which are generally used to increase surplus. If concerns exist, information should be gathered and assessed as to the nature and duration of the liens, and the use of the funds derived from the liens.

Procedures / Data:

- For fraternal societies, did the society report outstanding assessments in the form of liens against policy benefits that have increased surplus?
- Assess the materiality of outstanding assessments. Review the ratio of total liens as a percentage of total current year surplus
- Were new assessments imposed in the current year? Review any information the department has on the nature and duration of the liens. [Annual Financial Statement, General Interrogatories – Part 2 – #35.2]

ADDITIONAL ~~ANALYSIS AND FOLLOW-UP~~ PROCEDURES APPLICABLE TO LIQUIDITY RISK

~~INVESTMENT STRATEGY~~ Investment Policies and Strategy

~~directs analysts to~~ To assess the insurer's investment strategy, consider requesting and reviewing a copy of their ~~insurer's~~ formal adopted investment plan. ~~This should be e~~Evaluate~~d~~ ~~to determine if~~ the plan ~~appears to result in investments that are appropriate for~~to determine if it aligns with the insurer's ~~, based on the types of~~ business, ~~written and its~~ liquidity, and cash flow needs. ~~and to determine~~Additionally, verify whether the insurer ~~appears to be~~is adhering to ~~its~~ the plan's guidelines for the following:~~.~~

~~For example, the insurer's plan for investing in noninvestment-grade bonds should be reviewed for guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location.~~

- *Investment Qualitfy and Diversification:* Evaluate the quality of investments, diversification standards (issuer, industry, duration, liquidity, geographic location), and exposure to climate-related risks.
- *Performance:* Compare expected and actual investment returns.
- *Investment Growth:* Analyze planned increases in investment types, sectors, and markets.

- *Asset-Liability Analysis:* Assess whether the investment plan aligns with the insurer's liability structure. This may involve reviewing asset adequacy analysis and discussing the insurer's plans with management.

Upon review of the investment plan, compare the plan to actual results to help determine if the insurer and its investment manager(s) appear to be adhering to the investment policies and guidelines in the investment plan.

Examination Findings

C~~direct the analsyt to c~~onsider ~~a~~ reviewing ~~of~~ the recent examination report, S~~s~~ummary R~~r~~eview M~~m~~emorandum (SRM) and communication with the examination staff to identify if any findings regarding liquidity risks ~~issues were discovered during the examination.~~associated with:

- Asset liability matching and cash flow stress testing
- Investment returns
- Climate change, transition, and asset devaluation
- Effective management of the insurer's liquidity position
- Other-than-temporary impairment OTTI
- Investment valuation issues
- Adherence to investment policies and strategies
- Investment management, and use of and monitoring of external investment managers
- Determine if liquidity concerns identified during the last exam have been addressed.

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

NAIC Capital Markets Bureau Analytical Assistance

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

Third-Party Investment Advisors

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

Key information provided on a Form ADV includes:

a. Regulatory agencies and states in which the adviser/broker is registered.
b. Information about the advisory business including size of operations and types of customers (Item 5).

c. Information about whether the company provides custodial services (Item 9).
d. Information about disciplinary action and/or criminal records (Item 11).
e. A report of the independent public accountant verifying compliance if the investment advisor also acts as a custodian.

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

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

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

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

If the insurer uses an external asset manager and if investments on Schedule BA Assets are invested in funds that are affiliated with the asset manager or are managed by that asset manager, analysts should consider several possible issues that may result from this scenario. A possible concern may exist when the asset manager is also managing other funds in addition to managing assets for the insurer and then invests the insurer's assets in those other funds that the asset manager manages. While those funds may be good investments, both in general and for the insurer, there are a few issues that may need to be considered. First, is the potential for a conflict of interest if the asset manager is using the insurer's available funds to provide seed money or fund the manager's other funds. Second, is if any concerns exist regarding the appropriateness of the fund for the insurer's investment portfolio and if the transactions would be considered on an arm's-length basis. Third, is the

understanding that the insurer may be paying overlapping fees as the insurer would pay the asset manager a fee for the investment and then also pay a fee within the fund investment. There may be similar concerns with other complex investments such as structured securities that are originated by the asset manager or one of its affiliates/related parties. The fees associated with these investments could be considered arms-length and appropriate but would require further review and potentially additional support or documentation to make that determination.

- Assess and determine if any concerns exist regarding third party investment advisers and associated contractual arrangements.
  - Review Annual Financial Statement, General Interrogatories – Part 1 – #29.05. Does the insurer utilize third party investment advisors, broker/dealer or individuals acting on behalf of the insurer with access to their investment accounts?

    If "yes", consider the following procedures:
    - Verify that all affiliated and unaffiliated investment advisors the analyst is aware of are disclosed in the interrogatory, whether primary or sub-advisors.
      - Verify that Investment Management Agreements required to be filed with the department have been filed and consider requesting copies of agreements that have not been filed with the department for review.
      - Gain an understanding of the types of investments that are being managed by each of the advisors/sub-advisors disclosed in the interrogatory.
    - Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners. Did the examination identify any issues with regard to investment advisers and associated contractual arrangements that require follow-up analysis or communication with the insurer? If yes, document the follow-up work performed.
    - Compare Annual Financial Statement, General Interrogatories – Part 1 – #29.05 for the current year to the prior year to determine if there have been any changes in advisors. If "yes":
      - Consider obtaining an explanation for the change from the insurer.
      - Consider obtaining a copy of the new investment advisor agreement and review it for appropriate provisions.
- Using the information reported in Annual Financial Statement, General Interrogatories, Part 1 – #29.05, obtain and review SEC Form ADV (if available), to determine if the investment advisor is in good standing with the SEC. If not in good standing, contact the insurer to request an explanation.
- If agreements with third party investment advisers are affiliated, have the appropriate Form D – Prior Notice of Transactions been filed and approved by the department? Were any concerns noted or follow-up monitoring recommended?
  - See additional guidance in V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for reviewing affiliated investment manager agreements.
- Request information from the insurer regarding the background and expertise in any complex or non-traditional assets (such as structured securities, mortgage loans, investment funds) of its investment advisors (in-house and/or contractual) and its analytical system capabilities. Determine whether the advisors and systems are adequate to allow the insurer to continuously monitor its investments.
- If the insurer uses an external asset manager, consider if there are any investments that may represent a potential for conflict. Examples of this are (1) if there are Investments Report on Schedule BA that are funds

that are affiliated/related with the asset manager or are managed by that asset manager, (2) Structured Securities in which the asset manager or an affiliate/related party had a role in originating, or (3) direct investments in the asset manager or any of its affiliates/related parties. If the external asset manager qualifies as a related party, utilize guidance provided in the "Related Party Exposure in the Investment Portfolio" section above to assist in this review. Consider the following issues:

- Have any potential conflicts of interest been reviewed and formally approved by the Board or Investment Committee.
- If the investment is appropriate for the insurer's portfolio and is arm's-length.
- If the insurer is paying overlapping fees.

Inquire of the Insurer

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

- General Investment Inquiries
  - If management has adequately reviewed the investment portfolio and understand the yields, underlying collateral, cash flows and investment volatility.
  - Any additional concentration by collateral type.
  - Management's process for valuing securities to assist the analyst in assessing if the securities are valued appropriately.
  - Management's intended use of certain riskier investments and purpose within the insurer's portfolio.
  - If management has an appropriate level of knowledge and expertise with the type of securities being purchased/held.
  - If the insurer has controls implemented to mitigate the risks associated with this investment type.
  - Sources of liquidity, such as letters of credit (LOCs).
  - Information/explanation of guarantees or other commitments to PSA.
  - Securities lending program (nature, size, reinvestment policies, etc.).
  - Separate accounts plan descriptions and/or policy forms as they relate to its securities lending program (Life/A&H).
- Investment Diversification
  - Planned asset mix and diversification strategies.
- Mortgages
  - Handling of foreclosed mortgage loans.
- BA Assets
  - Information regarding the liquidity of non-traditional investments to ensure that limitations in this area are understood.
  - Current Audited Financial Statements and other documents (partnership agreements, etc.) necessary to support the value of the insurer's investment in partnerships and joint ventures.
  - Information necessary to support the value of significant other invested assets other than partnerships and joint ventures.
  - Current details on cash flows and returns for the different types of investments, especially hedge funds and private equity funds.
- RMBS, CMBS and LBaSS

- 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.
- Projected prepayment speeds on its RMBS portfolio and compare with historical prepayments, as well as the prepayment assumption at the time of purchase.

~~OWN RISK AND SOLVENCY ASSESSMENT~~Own Risk and Solvency Assessment (ORSA)

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

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

- Determine whether the ORSA Summary Report analysis conducted by the lead state indicate any liquidity risks that require further monitoring or follow-up.
- Determine whether the ORSA Summary Report analysis conducted by the lead state indicate any mitigating strategies for existing or prospective liquidity risks.
- For relevant business types, determine whether the ORSA Summary Report analysis conducted by the lead state indicate any liquidity risks regarding catastrophic exposure and related mitigating strategies.

~~HOLDING COMPANY ANALYSIS~~ Holding Company Analysis

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

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

Actuarial Filings, Including Asset Liability Matching (Life/A&H and Health)

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

~~Example Prospective Risk Considerations~~

~~The table provides analysts with example risk components for use in the Insurer Profile Summary Branded Risk analysis section and a general description of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the liquidity risk category.~~

~~DISCUSSION OF~~ QUARTERLY ~~PROCEDURES~~LIQUIDITY RISK ASSESSMENT

The ~~Q~~quarterly ~~L~~liquidity ~~R~~risk ~~Repository~~ procedures are designed to identify the following.~~:~~ For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.

Concerns with the liquidity of the insurer's asset portfolio and oInsufficient Overall liquidityLiquidity (or Illiquid Assets are Significant)

Procedures / Data

- Analyze the insurer's liquidity position by reviewing the following metrics and data elements:
  - P/C: ratio of adjusted liabilities to liquid assets and the change from prior year
  - Life/A&H:
    - Ratio of capital and surplus plus AVR to total assets (excluding separate accounts)
    - Change in liquid assets from prior quarter-to-date or prior year-end
  - Health:
    - Ratio of liquid assets (excluding non-investment grade bonds) and receivables to current liabilities
    - Change in liquid assets from prior year-end
    - Ratio of working capital to total assets

Additional Procedures

- Review the liquidity ratio (P/C), liquidity (Life/A&H), and the ratio of total liabilities to liquid assets (Health) within the Financial Profile Report, and document any unusual fluctuations over the last five years.
- If concerns are identified regarding overall liquidity of the asset portfolio, identify and assess other sources of liquidity available to the insurer. (Or, request information from the insurer if necessary. See Additional Analysis and Follow-Up Procedures below).
- Assess the impact of market conditions through consideration of industry and economic events (i.e., news, industry analytics). Is the analyst aware of any market conditions that may threaten the liquidity of insurers' investment portfolios (e.g., market dislocation or other events that could affect liquidity of assets classes such as structured securities, structured notes, Schedule BA assets and non-investment grade bonds).

Concerns with the level of investment in Exposure to Other Invested Assets (Schedule BA) invested assets

Determine whether there are concerns due to the level of investment in Schedule BA Assets.

Procedures / Data

- Ratio of Schedule BA Assets owned to policyholders surplus (P/C) to net admitted assets (Life/A&H) and to capital and surplus (Health)
- Increase in Schedule BA Assets from the prior year-end, where the ratio of Schedule BA Assets to surplus is material

Liquidity of Reinvested Collateral within the Securities Lending Program (P/C and Life/A&H)

Determine if concerns exist regarding the materiality of securities lending activity and the nature of the reinvested collateral.

Procedures / Data

- Ratio of securities lending collateral reinvested to total assets
- Aggregate total collateral received

Additional Procedures

- Review the Quarterly Financial Statement General interrogatories, Part 1, #16 and Notes to the Financial Statements, Note #5 (if reported) to gain an understanding of the scope of the securities lending program and to understand how the cash collateral is reinvested.

~~Concerns with level of~~ Exposure to A~~a~~ffiliated I~~i~~nvestments

Determine whether investments in affiliates are significant.

Procedures / Data

- Ratio of affiliated investments to policyholder surplus (P/C) and to capital and surplus (Life/A&H and Health)
- Change in total affiliated investments from the prior year
- Change in any category of affiliated investments from the prior year

Additional Procedures

- Review the results of the Holding Company Analysis completed by the lead state to determine if any concerns exist regarding affiliated entities.
- Review Quarterly Financial Statement, Notes to the Financial Statements, #10 and #14, if reported, to identify if the insurer is subject to any guarantees or other commitments to parent, subsidiaries, or affiliates (PSA). If the guarantee or commitment is material to the insurer, assess the nature of the agreement and the financial strength of the PSA.

Exposure to Other Less Liquid Receivables (Health)

Review and assess furniture, equipment, supplies, and EDP equipment.

Procedures / Data

- Ratio of admitted furniture, equipment and supplies to capital and surplus
- Change in the admitted balance of furniture, equipment and supplies from the prior year
- Ratio of admitted EDP equipment and software to capital and surplus
- Change in admitted EDP equipment and software from the prior year

~~Concerns with~~ Negative (or Negative Trend in) C~~c~~ash F~~f~~low from O~~o~~perations

Review cash flow from operations and determine if any concerns exist.

Procedures / Data

- Property/Casualty:
  - Ratio of net cash from operations to policyholders surplus (P/C) and the change from prior year-to-date

- Life/A&H:
  - Ratio of net cash from operations to capital and surplus and the change from prior year-to-date
  - Ratio of net cash from operations to premium income
  - Ratio of other cash provided (applied) to capital and surplus
  - Ratio of other cash provided (applied) to net cash from operations
  - Change in other cash provided (applied)
  - Ratio of net transfers to or from separate accounts to capital and surplus and the change from the prior quarter-to-date

- Health:
  - Ratio of net cash from operations to capital and surplus and the change from prior year-to-date
  - Ratio of net cash from operations to premium income
  - Ratio of benefits and loss related payments to premiums collected net of reinsurance

Additional Review Considerations

- Review the cash flow from operations to determine the underlying cause of the negative cash flow.
- Review the trend in net cash from operations for the past five years and note any unusual fluctuations or negative trends between years.

~~Concerns with securities lending transactions~~

~~Concerns with furniture, equipment and supplies, and EDP equipment~~

~~Concerns with~~ Liquidity Strain of S~~s~~urrender and W~~w~~ithdrawal A~~a~~ctivity (Life/A&H)

Determine whether concerns exist regarding the insurer's surrender and withdrawal activity.

Procedures / Data

- Ratio of surrender benefits to net premiums
- Ratio of surrender benefits to capital and surplus
- Change in the ratio of surrender benefits to capital and surplus ratio

Additional Procedures

- Review Quarterly Financial Statement, Notes to Financial Statements, Note #32, if reported, to determine if the insurer has a material amount of annuity reserves withdrawable with minimal or no charge.
- Review the Quarterly Financial Profile Report to determine if there appears to be a negative trend in surrender activity over the past five quarters.
- If concerns exist, review the insurer's plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy withdrawal features and surrender charges.

~~For additional guidance on individual procedure steps, please see the corresponding annual procedures discussed above.~~**Significant Assessments Against Policy Benefits (Fraternal Societies Only)**

Assess the materiality of a Fraternal Society's liens on policyholder benefits.

- For fraternal societies, did the society report outstanding assessments in the form of liens against policy benefits that have increased surplus? [General Interrogatories – Part 2 – #6.1]
- Review the ratio of total liens as a percentage of total current year surplus to assess the materiality of outstanding assessments.
- Determine if new assessments were imposed in the current year. Review any information the department has on the nature and duration of the liens [Quarterly Financial Statement, General Interrogatories – Part 2 – #6.2]

~~Market Risk Assessment~~

Market Risk: 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.

The ~~objective of~~ Market Risk Assessment ~~analysis~~ is focused primarily on exposure to market risk of investments and reinsurance receivables. ~~The following discussion of annual procedures provides suggested data, benchmarks and procedures the analyst can consider in his/her review.~~ In analyzing market risk, the analyst may analyze specific types of investments and receivables held by insurers. An analyst's risk-focused assessment of market risk takes into consideration the following areas (but not be limited to):

- Diversification of assets subject to market risk
- Valuation of assets
- Economic/market impacts on asset value (e.g., real estate, structured notes, etc.)
- Use of derivatives
- Investment turnover
- Capital gains and losses on investments
- Investment Income

~~Overview of Investments~~Derivatives

Refer to IV. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations for general information and a primer on derivatives.

~~Discussion of Annual Procedures~~General Guidance

~~Using the Repository~~

~~The~~ To assess market risk ~~repository is a~~ consider the ~~list of possible quantitative and qualitative~~ procedures, including specific data elements, metrics, and benchmarks in this chapter~~and procedures from which the analyst may select to use in his/her review of market risk~~. The following is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which there is no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

The placement of procedures, metrics, and data within market risk is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting financial determinations of the analysis. For example, key insurance operations or lines of business may have related risks addressed in different risk categories. Therefore, analysts may need to review other risks in conjunction with market risk.

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

Analysts are not expected to ~~respond~~ document every ~~to all~~ procedure~~s~~, data or benchmark result~~s~~. ~~listed in the repository.~~ Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document ~~completion~~ the applicable details within ~~of~~ the analysis. Results of market risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. ~~The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be~~

analyzed by the state insurance department based on the nature and scope of the risk.

In using procedures in the repository, the aAnalysts should review the resultscomplete their market risk assessment in conjunction with:

- A review of -the Supervisory Plan and Insurer Profile Summary and the prior period analysis.
- Communication and/or coordination with other internal departments. are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures in the repository.
- The analyst should also consider tThe 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 placement of the following data and procedures in the market risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, the analyst may need to review other repositories in conjunction with market risk.

Analysis Documentation: Results of market risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.

Quantitative and Qualitative Data and ProceduresAnnual Market Risk Assessment

Investment Portfolio Diversification

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
1	*1*	*1*

EXPLANATION: **Significant Investment Concentration by Asset Class**

The procedure assists the analyst in dDetermineing whether the insurer's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by asset type, duation or issuer.

The ratios of the vVarious types of investments to total net admitted assets (excluding separate accounts for Life/A&H) are a measure of the diversity of the insurer's investment portfolio by type of investment. The results of these ratios may also provide some indication of the insurer's liquidity. In addition, the ratio of the investment in any one issuer to total net admitted assets (excluding separate accounts for Life/A&H) is a measure of the diversity of the insurer's investment portfolio by issuer.

For foreign securites, market risk may include material exposures that could result in credit losses if those investments are affected by negative changes in geopolitical or foreign economic environments.

For mortgage loans, market risk may include the risk that the insurer is not properly identifying, handling and recording foreclosed mortgage loans.

Procedures/Data

- Consider evaluating the following assets classes in comparison to total admitted assets[i] to determine the level of concentration *(See also Credit Risk Assessment for diversification of other asset classes):*

[i] For ratios in this asset concentration procedure, net admitted assets excludes separate accounts for Life/A&H.

- Residential mortgaged-backed securities (RMBS, commercial mortgage-backed securities (CMBS), or other loan-backed and structured securities (LBaSS).
- Foreign bonds.
- Common stocks.
- Mortgage loans.
- Real Estate (before encumbrances), including home office real estate.
- Total derivatives (notional value).
- Investment in affiliates.
- Any one single investment in foreign bonds, common sock, real estate and derivatives (excluding afiliated investments) *(Note that single investments in asset-backed securities are considered in the Credit Risk Assessment).*

~~A~~Additional ~~r~~Review ~~c~~Considerations

- Review the ~~P~~percentage ~~D~~distribution of ~~A~~assets ~~in the Financial Profile Report~~ for significant shifts in the mix of investments owned during the past five years.
- ~~The analyst should c~~Compare the insurer's distribution of cash and invested assets to industry averages and peer averages on iSite+ to determine significant deviations from the industry averages. The comparison should focus on an appropriate peer group based on insurer type and asset size.
- If the insurer's investments include a significant amount of foreign bonds, review the Annual Supplemental Investment Risks Interrogatories (#4 through #11). Consider the insurer's potential foreign currency exposure from holding bonds denominated in a foreign currency.
- Review of the Annual Supplemental Investment Risks Interrogatories to identify any unusual items or areas and determine whether the insurer's investment portfolio is adequately diversified ~~with the appropriate level of liquidity to meet cash flow requirements~~ to avoid significant aggregate market risk.
- Review of the Legal Risk ~~Repository~~ Assessment to determine whether the insurer's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws.
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.
- Inquire of the insurer its planned asset mix, and diversification strategies.

~~**Valuation of Securities**~~

~~***Property/Casualty #***~~	~~***Life/A&H/Fraternal #***~~	~~***Health #***~~
~~***2***~~	~~***2***~~	~~***2***~~

~~***EXPLANATION:***~~

Valuation of Securities Not in Accordance with Standards, or Economic Impact on Portfolio

~~The procedure assists the analyst in d~~Determin~~e~~ing whether the securities owned by the insurer have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office (SVO) and Statutory Accounting Principles.

According to NAIC requirements, all securities purchased that are not filing exempt (FE) per the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) should be submitted to the SVO for valuation within 120 days of the purchase. In accordance with the NAIC *Annual Statement Instructions*, if the SVO provides an NAIC designation or price, that designation or price should be utilized. Insurers are required to complete the general interrogatory on compliance filing requirements of the P&P Manual and list exceptions as a component of the Annual Financial Statement. This interrogatory should indicate the following: 1) all prices or NAIC designations for the securities owned by the insurer that appear in the Valuation of Securities (VOS) product have been obtained directly from the SVO; 2) all securities previously valued by the insurer and identified with a "Z" suffix (which indicates that the security is not FE, does not appear in the SVO VOS product

or has not been reviewed and approved in writing by the SVO) have either been submitted to the SVO for a valuation or disposed of; and 3) all necessary information on securities which have previously been designated NR (not rated due to lack of current information) by the SVO has been submitted to the SVO for a valuation or that the securities have been disposed.

Risks associated with Valuation of securities may include:

- The securities reported on the balance sheet may not exist or may not be free of encumbrances.
- The insurer's investments reported on the balance sheet are incorrectly valued.
- The insurer's bonds, stocks and short-term investments that are considered hard-to-value, high-risk and/or subject to significant price variation are incorrectly valued.
- Portfolio value that is affected by volatility driven by economic changes/conditions.

Procedures

- Determine if the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office have been followed. Document any exceptions noted. [Annual Financial Statement, General Interrogatories, Part 1, #32.1 and #32.2]

Additional Review Considerations

- Assess the impact of market conditions:
  - Through consideration of industry and economic events (i.e., news and industry analytics), determine if there are any market condiitons that may threaten the value of the insurers' investment portfolios.
  - Determine if the insurer is aware of any market conditions that could threaten the value of its investment portfolio through coorespondence with the insurer.
- Determine if the insurer has complied with the requirement to submit securities that are not filing exempt to the Securities Valuation Office (SVO) for a valuation (i.e., there are securities which were acquired prior to the current year with a "Z" suffix after the NAIC designation and/or there is a significant number of securities which were acquired during the current year with a "Z" suffix after the NAIC designation) [Annual Financial Statement, Schedule D – Part 1 and Schedule D – Part 2].
  - If securities with a "Z" suffix after the designation do not qualify as filing exempt, compare the price or designation actually received from the SVO to that included in the Annual Financial Statement for significant increases. [Annual Financial Statement, Schedule D – Part 1 or Schedule D – Part 2]
  - Consider requesting verification from the insurer that the securities are FE or have been submitted to, and subsequently valued by, the SVO and compare the price or designation subsequently received from the SVO to that included in the Annual Financial Statement for significant securities.
- Determine if all bonds with an NAIC designation of 3, 4, 5, 6 (non-investment grade bonds) have been valued at the lesser of book/adjusted carrying value or fair value and all other bonds have been valued at book/adjusted carrying value. [Annual Financial Statement, Schedule D – Part 10]
  - Review 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).

- Determine if sinking fund preferred stocks have been valued at their cost and all other stocks have been valued at their fair value. [Annual Financial Statement, Schedule D – Part 2]
- For each of the securities listed in Annual Financial Statement, Schedule D – Part 1, Schedule D – Part 2 and Schedule DA – Part 1, compare the CUSIP number, NAIC designation, and fair value included in the Annual Financial Statement to information on the NAIC Valuation of Securities (VOS) master file using Jumpstart Reports for investment analysis. Contact the insurer to follow up on any exceptions noted.

- Determine if any unusual valuation methods were noted on the Annual Financial Statement Summary Investment Schedule.
  ~~Review the Jumpstart Reports investment analysis tool (available on iSite+) to compare the CUSIP number, NAIC designation, and fair value for each of the securities listed in Annual Financial Statement, Schedule D – Part 1, Schedule D – Part 2, and Schedule DA – Part 1 to information on the SVO master file.~~

- ~~Review Annual Financial Statement, Schedule D, Part 1 and Schedule D, Part 2, to determine whether it appears that the insurer is complying with the requirement to submit privately held 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.~~

- ~~Review 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.~~

- ~~If concerns exist, for those securities listed in Annual Financial Statement, Schedule D – Part 1 or Schedule D – Part 2, with a "Z" suffix after the NAIC designation, the analyst might request verification from the insurer that the securities are FE or have been submitted to, and subsequently valued by, the SVO and compare the price or designation subsequently received from the SVO to that included in the Annual Financial Statement for significant securities.~~

~~Value of Bond & Sinking Fund Preferred Stock~~

~~Property/Casualty #~~	~~Life/A&H/Fraternal #~~	~~Health #~~
~~3~~	~~3~~	~~3~~

~~EXPLANATION:~~

Valuation of Bond & Sinking Fund Preferred Stock Significantly Greater than Fair Value

~~The procedure assists the analyst in d~~Determin~~ing~~e whether the statement value of bonds and sinking fund preferred stocks is significantly greater than fair value. Annual Financial Statement, General Interrogatories, Part 1, #31 shows the aggregate statement value and the aggregate fair value of 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 (Life and Fraternal only) and the results of its cash flow testing.

Procedures/Data

- Determine whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value.
  - Compare the aggregate excess of the statement value over the fair value of bonds and preferred stocks to the statement value of bonds and preferred stocks owned [Annual Financial Statement, General Interrogatories, Part 1, #30]
  - Compare the aggregate excess of the statement value over the fair value of bonds and preferred stocks owned to surplus (P/C), or to capital and surplus plus asset valuation reserve (AVR) (for Life/A&H), or to capital and surplus (Health) .

Additional Review Considerations

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- Review available information from actuarial reporting on asset/liability matching (ALM) and cash flow testing to determine if there are any concerns regarding:
  - The impact of interest rate changes (or prolonged low interest rate environment, if applicable) on long duration bonds and the potential for prospective liquidity risk to result in market risk.
  - aAsset/liability matching based on the asset composition, based on the duration and maturity profile of the bond portfolio.
  - For this procedure, the analyst may choose to seek the assistance of an in-house actuary.
- Review Annual Financial Statement, Schedule D – Part 1 and Schedule D – Part 2 or request additional information from the insurer to determine which individual securities have a book/adjusted carrying value significantly in excess of their fair value. The analyst should be aware that the value for those securities with an "AV" (amortized value) designation in the rate used to obtain the value column in Schedule D does not represent a true fair value for the securities. For those securities:
  - Verify the NAIC designation assigned and, if not filing exempt, determine whether it has been updated recently by the SVO.
  - If filing exempt, determine the current rating by a Credit Rating Provider (CRP) (e.g., Moody's Investors Service, Standard & Poor's, A.M. Best or Fitch Ratings).
  - Determine whether there has been an other-than-temporary impairment recognized.

ADDITIONAL REVIEW CONSIDERATIONS

Review the Statement of Actuarial Opinion and other actuarial filings along with a review of Annual Financial Statement, Schedule D Part 1A to understand the duration and maturity profile of the bond portfolio to determine if there are any concerns regarding asset/liability matching based on the asset composition. For this procedure, the analyst may choose to seek the assistance of an in-house actuary.

Review the Annual Financial Statement, Schedule D – Part 1 and Schedule D – Part 2 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 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, 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, consider whether the investment should be written down to its fair value to properly reflect the value of the investment.
- If the insurer has experienced negative cash flows or has other liquidity problems, consider requesting information from the insurer regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

Exposure to Structured Notes

Property/Casualty #	***Life/A&H/Fraternal #***	***Health #***
4	***4***	***4***

EXPLANATION: **Structured Notes Cash Flow Volatility, Collateral Concentration Risk, or Default Risk**

The procedure assists the analyst in dDetermineing whether concerns exist due to the level of structured notes held by the insurer and the impact of the volatility of structured notes and the underlying asset on which its cash flows are based (e.g., the risks on structured notes are different from risks of typical corporate bonds). Material investment in structured notes that may have collateral type concentration may result in concentration risk (i.e., lack of diversity) to the insurer's portfolio. (e.g., structures can be complicated and cash flows hard to predict.

Cash flows can be linked to a variety of factors or indices, including those that are not capital markets related.) Structured notes may be subordinated in the overall transaction, representing exposure to non-payment in event of default.

If the amount is material as compared to the 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.

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. Structured notes that are classified as mortgage-referenced securities are valued in accordance with *Statement of Statutory Accounting Principles (SSAP) 43R—Loan-Backed and Structured Securities* while all other structured notes are valued in accordance with *SSAP 86—Derivatives*. Some examples of mortgage-referenced securities include secutiries 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 FE, and the Structured Securities Group (SSG) assigns their NAIC designation based upon modeling assumptions.

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

Procedures/Data
- Ratio of investment in structred notes to surplus.

Additional Review Considerations
- Review the Annual Financial Statement, Schedule D – Part 1 to identify the types of structured notes and the yield reported.

ADDITIONAL REVIEW CONSIDERATIONS
- If an insurer has a material amount of structured notes, 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.
- 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.
- Assess if the notes are valued appropriately so as to ensure the insurer is not undercapitalized.
- Refer to any recent examination findings.
- 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.
  - If management has adequately reviewed the structured note portfolio and understands the underlying yields, cash flows and volatility
  - 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
  - Management's process for valuing the structured notes so as to assist analysts in assessing if the notes are valued appropriately
  - Management's intended use of these structured notes and purpose within the insurer's portfolio
  - If management has an appropriate level of expertise with this type of security
  - If the insurer has controls implemented to mitigate the risks associated with this investment type
  - What the insurer's expectations are for liquidity in the secondary market
  - Ensure that the insurer understands the difference between these instruments and more traditional corporate bonds (i.e., that there is significant risk that is separate from the issuer's ability to pay)

Value of Common Stock

Property/Casualty #	Life/A&H/Fraternal #	Health #
5	5	5

Valuation and Volatility of Common Stock

EXPLANATION: The procedure assists the analyst in deDetermineing whether the fair value of common stock is significantly greater than or less than the actual cost. The analyst should rReview the Annual Financial Statement, Schedule D – Part 2 – Section 2, to compare the aggregate fair value position to the aggregate actual cost of common stock. The analyst should aAlso review individual stock issues to determine if the fair value is significantly above or below actual cost. If the fair value of a stock issue is significantly below cost (unrealized loss), the insurer may incur a loss upon disposition. If the fair value of an individual stock issue is significantly greater than actual cost (unrealized gain), the insurer may be reflecting an unrealized gain that will not be realized at disposition.

Procedures/Data

- Determine if the fair value of common stock is significantly greater than or less than the cost [Annual Financial Statement, Schedule D – Part 2 – Section 2].
  - Determine if the aggregate fair value of common stocks is below the actual cost and if the difference is greater than 10% of surplus (P/C) or capital and surplus (Life/A&H, Health).
  - Determine if the aggregate actual cost of common stocks is below the fair value and if the difference is greater than 10% of surplus (P/C) or capital and surplus (Life/A&H, Health).
  - Determine the fair value to actual cost, when an investment in one issue of common stock is greater than 5% of invested assets.

Additional rReview cConsiderations

- 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.

- If concerns about sector concentration of common stocks, review Annual Financial Statement, Schedule D – Part 2 – Section 2 and consider requesting the NAIC Capital Markets Bureau to perform an analysis of the portfolio focusing on sector risk.
- Review Annual Financial Statement, Schedule D – Part 2 – Section 2, or request additional information from the insurer to determine which individual common stocks have a cost significantly in excess of their fair value. For those securities:
  - If the stock is listed on a market or an exchange (designated by the symbol "L" or "U") - such as the New York Stock Exchange, American Stock Exchange, NASDAQ National Market System, or a foreign exchange - verify the price and total market value.
  - Determine whether the stock is listed on a national exchange and verify the price per stock and the total fair value listed in the statement. If the NAIC designation of the stock is "A" (unit price of the share of privately held common stock is determined analytically by the SVO), review the date that the price per share was last analyzed by the SVO.
  - Consider whether the common stock has had an other-than-temporary decline in its value.
- Requesting the Audited Financial Statement and other documents from the insurer necessary to support the value of the common stock.
- Request information from the insurer regarding investment strategies and short-term cash flow needs to determine whether common stock with a cost significantly in excess of its fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

~~**Exposure to Real Estate**~~

~~*Property/Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*6*~~	~~*6*~~	~~*6*~~

Exposure to Real Estate (or Real Estate Backed Assets)

~~***EXPLANATION:*** The procedure assists the analyst in d~~Determineing whether concerns exist due to the value of investment in real estate. ~~The analyst~~There may ~~have~~ be concerns regarding the fair value of the real estate, whether it is the underlying investment or the collateral for a mortgage loan. Real estate in certain parts of the country has experienced significant declines in fair values from time to time. High exposure to mortgage loans, real estate and non-agency mortgage-backed assets could result in credit losses in the event of a housing and/or commercial real estate market downturn. These investments are less liquid than many other types of investments. Investments in real estate have some similarities to investments in common stock and mortgages since they involve credit risk and the risk of default.

Determine whether there are concerns due to the level or quality of investment in real estate.

Procedures/Data

- Ratio of real estate to surplus (P/C), or to capital and surplus plus asset valuation reserve (AVR) (Life/A&H), or capital and surplus (Health) .
- Increase in total real estate over the prior year, where the ratio of total real estate to surplus (P/C), or to capital and surplus plus asset valuation reserve (AVR) (Life/A&H), or capital and surplus (Health) is material
- Determine if the insurer owns any securities of a real estate holding company or otherwise hold real estate indirectly [Annual Financial Statements, General Interrogatories, Part 1, #12.1].

Additional Review Considerations

- If there are concerns regarding real estate owned, review the Annual Financial Statement, Schedule A – Part 1 to determine whether updated appraisals should be obtained for any of the properties owned, based on the location of the property, the book/adjusted carrying value and reported fair value of the property, and the year of the last appraisal.
  - Consider benchmarking against the National Council of Real Estate Investment Fiduciaries (NCREIF) index number, keeping in mind that the NCREIF is a national benchmark for all property types.
- In addition, for those properties with book/adjusted carrying values in excess of fair value; ~~the analyst might~~ consider whether the asset should be written down. [Annual Financial Statement, Schedule A – Part 1]
- For instances where a property has a book/adjusted carrying value in excess of its cost, request information from the insurer regarding any increases in book/adjusted carrying value during the year. [Annual Financial Statement, Schedule A – Part 1]
- Review Schedule A – Part 1 to identify if real estate owned is concentrated in one or a few geographical areas. Utilize postal code and property type information along with the city and state location information in Schedule A and Schedule B to identify geographic concentrations and to identify differences in volatility based on the property type and geographic location.
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.

~~**Value of Other Invested Assets (Schedule BA)**~~

~~*Property/Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*7*~~	~~*7*~~	~~*7*~~

Valuation of Schedule BA Assets, or Adequacy of Collateral of BA Assets

~~***EXPLANATION:*** The procedure assists the analyst in d~~Determin~~ing~~e whether concerns exist due to the level of investment in other invested assets (Schedule BA). Volatility of underlying assets (example: certain hedge funds) may result in underlying assets that are not adequate. ~~Consider requesting information from the insurer to support any increases by adjustment in book/adjusted carrying value during the year.~~

Procedures/Data

- Determine the ratio of Schedule BA assets to surplus (P/C), or to capital and surplus plus asset valuation reserve (AVR) (Life/A&H), or capital and surplus (Health).
- Determine the increase in Schedule BA assets from the prior year when the ratio of Schedule BA assets to surplus (P/C), or to capital and surplus plus asset valuation reserve (AVR) (Life/A&H), or capital and surplus (Health) is material

Additional ~~r~~Review ~~c~~Considerations

- Review Annual Financial Statement, Schedule BA – Part 1 to determine the amount and types of other invested assets owned and identify if the insurer's exposure to certain classes of Schedule BA assets are significant (e.g., hedge funds and private equity funds).
- Request current audited financial statements and other documents (e.g., partnership agreements, etc.) necessary to support the book/adjusted carrying value of the insurer's investment in partnerships and joint ventures and information to support the book/adjusted carrying value of significant other invested assets (e.g., other than partnerships and joint ventures).
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.
- Review Schedule BA to determine if a significant amount of BA assets have NAIC ratings of 3, 4, 5 or 6 or have a "Z" designation.
- Inquire of the insurer:
  - Request information necessary to determine the fair value of collateral to the amount loaned to ensure the loan is adequately collateralized
  - Information to support significant increases by adjustment in book/adjusted carrying value during the year
  - Current Audited Financial Statements and other documents (partnership agreements, etc.) necessary to support the value of the insurer's investment in partnerships and joint ventures
  - Information necessary to support the value of significant other invested assets other than partnerships and joint ventures
  - Current details on cash flows and returns for the different types of investments, especially hedge funds and private equity funds

~~**Value of Collateral Loans**~~

~~*Property/Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*N/A*~~	~~*8*~~	~~*N/A*~~

Exposure to and Valuation of Collateral Loans (Life/A&H/Fraternal Only)

~~***EXPLANATION:*** The procedure assists the analyst in d~~Determin~~ing~~e whether concerns exist due to the level of investment in collateral loans. ~~The analyst should r~~Review Annual Financial Statement, Schedule BA, Part 1 and Schedule DA – Part 1. In most states, collateral loans are required to be secured or collateralized by assets which have a value in excess of the amount of the loan and which are considered admitted assets for an insurer.

Procedures ~~Additional review considerations~~

- Determine whether there are concerns regarding investment in collateral loans.
  - Compare the value of the collateral to the amount loaned thereon to determine whether the loan is adequately collateralized [Annual Financial Statements, Five-Year Historical Data].
  - In those instances where the underlying collateral is comprised of securities, verify the rate used to obtain the fair value of the securities held as collateral for the loans by reference to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*.
- ~~Compare the fair value of the collateral to the amount loaned to determine whether the loan is adequately collateralized.~~
- ~~In those instances where the underlying collateral is comprised of securities, 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*.~~

~~**Valuation of Affiliated Investments**~~

~~***Property/Casualty #***~~	~~***Life/A&H/Fraternal #***~~	~~***Health #***~~
~~***8***~~	~~***9***~~	~~***8***~~

Exposure to and Valuation of Affiliated Investments; Financial Solvency Risk of PSA

~~***EXPLANATION:*** The procedure assists the analyst in d~~Determin~~e~~ing whether investments in parents, subsidiaries, affiliates (PSA) 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~~substantially overvalued investments ~~may~~ can be ~~substantially overvalued~~detected. ~~In particular, the analyst should r~~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 b~~Be alert to the level of investments in the affiliate ~~but also~~and the level of accrued interest relating to investments in the affiliate. Note also that if a PSA becomes insolvent, it may result in a significant drop in value, which could lead to other risks including liquidity issues.

Procedures/Data

- Total of all investments in affiliates to surplus (P/C), or capital and surplus (Life/A&H, Health) [Annual Financial Statement, Five-Year Historical Data].
- Change in total of all investments in affiliates from the prior year-end.
- Change in any category of affiliated investments from the prior year-end.

Additional Review Considerations

- Review the results of the Holding Company analysis completed by the lead state and note any concerns regarding exposure to (see diversification procedure above) or valuation of affiliated investments.
- If investments in common stocks of PSAs involve publicly traded securities, determine if the investment is valued on a basis other than market valuation.
- If investments in PSA do not involve publicly traded securities, determine if the investment is valued on a basis other than the Statutory Equity or GAAP Equity methods.
- Review the components of investment income reflected on the Annual Financial Statement, Exhibit of Net Investment Income and the Exhibit of Capital Gains (Losses).
  - Calculate the return on investment for current and prior years.
  - Review the components of investment income and determine whether the source is cash or merely an increase in accrued interest income.
  - If a substantial portion of investment income relates to an increase in the accrual, determine whether such revenue recognition is legitimate and reasonable.

- Determine whether accrued interest on investments in affiliates have grown to a significant level.
- Review details of affiliated investments as reported in Annual Financial Statement, Schedule A, Schedule B, Schedule BA and Schedule D, and compare with prior years. Review the trend in the value of affiliated investments to identify any negative trends that may continue in future.
- If concerns exist regarding an affiliate investment(s), consider the following (note that some of this information may be available in the Holding Company analysis completed by the lead state):
  - Obtain an understanding of the primary business activity of the affiliate and determine that such an investment complies with regulatory requirements.
  - Obtain and review the Audited Financial Statement, Annual Financial Statement, and Statement of Actuarial Opinion of the affiliate, if available.
  - Determine the current ratings of the affiliate from the credit rating agencies, if available.
  - Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.
  - Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate. Also review iSite+ data on the reinsurer (i.e., financial statements, Regulatory Information Retrieval System [RIRS] and Global Receivership Information Database [GRID]).
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.

Exposure to Derivative Investments

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
9, 10	*10, 11*	*9, 10*

Exposure to Derivative Investments, or Hedge Effectiveness of Derivatives Portfolio

EXPLANATION: The procedures assists the analyst in dDetermineing whether concerns exist due to the value of investment in derivative instruments. A derivative instrument is a financial market instrument which has a price, performance, value, or cash flow based primarily on the actual or expected price, performance, value, or cash flow of one or more underlying interests. Derivative instruments (which consist of options, caps, floors, collars, swaps, forwards, swaptions and futures) are used by some insurers to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to its assets, liabilities, or anticipated future cash flows. A market risk may include that insurer's derivatives strategy may not meet hedge effectiveness for mitigating risk. If an insurer invests in 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.

Procedures/Data

- Determine whether there are concerns due to the use of deravitive instruments.
  - Determine if the insurer is engaged in derivative activity [Annual Financial Statement, Notes to Financial Statements, Note #1 and Note #8; General Interrogatories, Part 1, #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]
- If Yes,
  - Determine whether derivative holdings at year-end are significant. Review the ratio of total **book/adjusted carrying value** at year-end to surplus (P/C) or to capital and surplus plus AVR (Life/A&H), or capital and surplus (Health). [Annual Financial Statement, Schedule DB, Part A, Part B and Part C, Section 1]

Total **book/adjusted carrying value** and percentage of surplus (P/C) or to capital and surplus plus AVR (Life/A&H), or capital and surplus (Health) for:

- Hedging effective
- Hedging other
- Replication
- Income generation
- Other
- Total derivative transactions

- Determine whether derivative holdings at year-end are significant. Review the ratio of total **fair value** at year-end to surplus (P/C) or to capital and surplus plus AVR (Life/A&H). [Annual Financial Statement, Schedule DB, Part A, Part B and Part C, Section 1]
  Total **fair value** and percentage of surplus (P/C) or to capital and surplus plus AVR (Life/A&H) for:
  - Hedging effective
  - Hedging other
  - Replication
  - Income generation
  - Other
  - Total derivative transactions
- Ratio of total off balance sheet exposure to surplus (P/C) or to capital and surplus plus AVR (Life/A&H) [Annual Financial Statement, Schedule DB – Part D]

- If questions or concerns are noted (Life/A&H):
  - Is the initial cost (original value) of call and put options, warrants, caps, floors, collars, swaps, swaptions and forwards acquired or opened during the year greater than 150% of the initial cost (original value) of derivatives owned or open at prior year-end? [Annual Financial Statement, Schedule DB – Part A – Section 1]
  - Is the current year statement value of futures contracts greater than 150% of the book adjusted carrying value at prior year-end? [Annual Financial Statement – Schedule DB – Part B – Verification]

Additional rReview cConsiderations

- Review Annual Financial Statement, Notes to Financial Statement, Note #5 for any information regarding possible collateral calls and assess the materiality exposure to the insurer if the collateral calls were to come due.
- Review the Annual Financial Statement, Schedule DB and for significant derivative instruments that are open at year-end, request the following information from the insurer:
  - A description of the methodology used to verify the continued effectiveness of the hedge provided.
  - A description of the methodology to determine the fair value.
  - A description of the determination of the book/adjusted carrying value.
- Consider having the insurer's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.
- Inquire of the insurer:
  - The analyst should ask forRequest a derivatives use plan and may also consider obtaining a comprehensive description of the insurer's hedge program in order to obtain an understanding of the insurer's use of derivative instruments to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to the insurer's assets, liabilities, or expected cash flows. Analysis of hedging programs should include consideration of the company's hedge effectiveness analysis. (See Strategic Risk Repository Assessment for further guidance.)
  - -Information on how the insurer will manage any material collateral calls if they come due

- Review the Annual Financial Statement, Schedule DB for significant derivative instruments that are open at year-end, request the following information from the insurer:
    - A description of the methodology used to verify the continued effectiveness of the hedge provided
    - A description of the methodology to determine the fair value
    - A description of the determination of the book/adjusted carrying value
  - Consider having the insurer's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.

Negative Results Generated from Exposure to Derivatives Market

Derivative market volatility could have a negative impact on derivative returns and generate capital losses. Determine whether there are concerns regarding ivnestment income and captial gains(losses) on the investment in derivatives.

Procedures/Data

- Ratio of gross derivative investment income to net investment income. [Annual Financial Statement, Exhibit of Net Investment Income, Line 7]
- Ratio of realized capital loss attributed to derivatives to surplus (P/C), or to capital and surplus plus AVR (Life/A&H), or capital and surplus (Health). [Annual Financial Statement, Exhibit of Capital Gains (Losses), Line 7]
- Aggregate net losses on derivatives to surplus (P/C), or to capital and surplus plus AVR (Life/A&H), or capital and surplus (Health). [Annual Financial Statement, Schedule DB – Part A – Section 2, columns 22, 23, and 24, and Schedule DB – Part B – Section 2, columns 16, 17, and 18. If material to surplus, review and document amount and percent of surplus for the following:
    - Recognized Gains/Losses of derivatives
    - Derivatives used to adjust basis of hedging items
    - Deferred gains or losses on derivatives

~~Investment Portfolio Turnover~~

~~*Property/Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*11*~~	~~*12*~~	~~*11*~~

High Investment Portfolio Turnover

~~***EXPLANATION:***~~ ~~The procedure assists the analyst in d~~Determin~~e~~~~ing~~ whether concerns exist due to the level of investment turnover of long-term bonds, preferred stocks, or common stocks during the year.. ~~The analyst can i~~Identify significant turnover by reviewing Annual Financial Statement, Schedule D – Part 4 and Schedule D – Part 5. The turnover ratio represents the degree of trading activity in long-term bonds, preferred and common stock investments that has occurred during the year. Investment turnover is an indication of whether a buy-and-hold or sell based on short-term fluctuation strategy is utilized. High turnover ratios may be an indication of unusual activity in the management of the investment portfolio. High turnover in the portfolio may be driven by economic/market conditions, resulting in the need to make changes to the portfolio. High turnover in the portfolio may indicate a change in investment strategy. A high turnover of investments generally leads to greater transaction costs, operating expenses and the acceleration of realized capital gains and should be justified by more active management that may or may not be appropriate given the liabilities recorded. Sales result from securities reaching a price objective, anticipated changes in interest rates, changes in credit

worthiness of issuers or general financial or market developments. High turnover ratios may raise questions that investments are being sold at a loss, possibly creating high capital losses.

Procedures/Data

- Long-term bond turnover ratio.
- Stock turnover ratio.
- Total long-term bond and stock turnover ratio.

Additional rReview Cconsiderations

- Review the Annual Financial Statement, Schedule D – Part 3, Schedule D – Part 4 and Schedule D – Part 5 to determine the amount and types of securities purchased and sold during the current year. This information can also assist the analyst in determining the types of securities sold and acquired, the length of time each security was held and the quality of the security.
- Review Annual Financial Statement, Schedule D – Part 3 to determine the quality of bonds acquired, noting any "Z" rated (not rated by the SVO) securities. Also note any NAIC designations of 3, 4, 5, or 6 (non-investment grade bonds).
- Review Annual Financial Statement, Schedule D – Part 3 to determine the quality of preferred and common stocks acquired. Evaluate any "U" (unlisted) or "A" (analytically determined) rated stocks.
- Review realized capital gains from the sale of securities to determine any reliance on these gains to increase surplus, as opposed to unrealized gains and losses.
- Consider having a specialist (i.e., NAIC's Capital Markets Bureau (CMB)) review the insurer's investment program.
- Review the Statement of Actuarial Opinion to determine whether any concerns regarding investment turnover are noted.
- In light of the level of portfolio turnover identified, inquire of the insurer regarding any changes in investment strategy or philosophy, or changes in investment managers. Assess the impact of any strategic changes on the insurer's prospective exposure to market risk.

Realized and Unrealized Capital Gains and Losses

Property/Casualty #	***Life/A&H/Fraternal #***	***Health #***
12	***13***	***12***

Realized and Unrealized Capital Gains and Losses

EXPLANATION: The procedure directs the analyst to rReview the Annual Financial Statement, Notes to the Financial Statements, Exhibit of Capital Gains (Losses) and Investment Schedules to determine the amount of other-than-temporary impairments (OTTI) that have been taken in the current period and to determine if OTTI appear to be in compliance with statutory accounting guidelines.

Procedures/Data

- Ratio of net unrealized capital gains/(losses) to prior year-end surplus.
- Ratio of net realized capital gains to net income, where the absolute value of net realized capital gains or losses is material surplus.

Additional Review Considerations

- Review Annual Financial Statement, Notes to Financial Statements, the Exhibit of Capital Gains (Losses) and Investment Schedules to assess the amount of OTTI have been taken in the current period for reasonableness.
- If concerns exist that OTTI are not properly written down, request information on the insurer's investment policy for recording OTTI to determine if it aligns with statutory accounting requirements

Investment Income

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
13	*14*	*13*

Negative Market Impact on Investment Income/Returns

Narrowing or Low Interest Rate Spreads [Life/A&H]

Investment Results Actual to Projected Variance

EXPLANATION: The procedure directs the analyst to rReview investment yields, interest rate spreads and trends in investment returns. . The analyst should use the available information to dDetermine if the investment returns appear adequate to meet the business plans of the insurer. Economic conditions, such as a low interest rate environment or change in investment markets, may result in a reduced returns on investments compared to expectations. Additionally, the insurer's actual investment portfolio and/or portfolio performance may vary significantly from projections if the insurer is not adhering to the strategy in place (i.e., higher actual credit, market or liquidity risk compared to the plan).

Procedures/Data

- Investment yield ratio
- Adequacy of investment income ratio (IRIS Ratio #4 – Life/A&H only)
- Interest Margin (Life/A&H only). Determine if Investment spread results for life and annuity business is narrowing or worsening.

Additional Review Considerations

- Review the detail of investment income in the Annual Financial Statement, Exhibit of Net Investment Income and the detail of realized gains or (losses) in the Exhibit of Capital Gains (Losses) for reasonableness.
- Review the investment yield ratio for unusual fluctuations and trends between years. [iSite+]
- Calculate and review the investment yield ratio by asset class.
- Compare the ratio of investment income to cash and invested assets to the industry average investment yield to determine any significant deviation from the industry average. [iSite+]

- [Life/A&H Only]: If interest margin (spreads) are negative and issues are identified, consider using available information from the actuarial filings and the Annual Financial Statement and, if necessary, contacting the insurer (see below), to assist in the following:
  - Gaining an understanding of the liquidity requirements and the adequacy of ALM for the insurer's mix of business, including interest rate guarantees on products.
  - Gaining an understanding of the investment portfolio and strategy underlying the investment income returns, specifically understanding what factors are driving the investment yields year-over-year (YOY).
  - Review actual investment performance against projections from the insurer.
  - Gaining an understanding of trends and whether investment returns or guaranteed rates are driving the spread results.
  - Reviewing the Actuarial Memorandum and Regulatory Asset Adequacy Issues Summary (RAAIS) stress testing results (e.g., for prolonged low interest rate) and booking of additional ALM reserves.

- Consider talking to the Company's appointed actuary to understand his or her perspective on the ALM testing and his or her comfort level.

- Gaining an understanding of prospective strategic plans to manage this risk for prolonged low interest rate, including any changes in investment strategy, impacts of other factors including market volatility, changes in guaranteed rates on policies, and additional reserving.
- If the negative margin result cannot be explained by other transactions that skew the ratio, gain an understanding of what actions the company is taking or should take to resolve or mitigate the risk.

~~**Investments Involving Related Parties**~~

~~***Property/Casualty #***~~	~~***Life/A&H/Fraternal #***~~	~~***Health #***~~
~~***13***~~	~~***15***~~	~~***12***~~

Related Party Exposure in the Investment Portfolio

~~This procedure assists analysts in d~~Determin~~e~~ing related party exposure in the investment portfolio and assessing any related credit [market, liquidity, operational] risk.

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

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

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

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

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.
2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.
3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other

similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.
5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.
6. The investment does not involve a related party.

Procedures

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

      Consider exposure by asset class and in aggregate, and by the role of the related party in the investment as designed by the "Investments Involving Related Parties" disclosure.
- If concerns exist regarding a material related party exposure in the investment portfolio, assess the credit quality of those investments involving related parties by reviewing designations, assessing historical default experience, etc.
- If concerns exist regarding a material related party exposure in investment management or advisory services, consider the following:
    - Review the procedures in the "Additional Procedures" section below regarding Third Party Investment Advisors and consider their application to related party advisors in that role.
    - In addition to the additional analysis procedures regarding third party investment advisors, consider the following:
        - Review the insurer's investment policy guidelines and determine whether the related party investments follow the guidelines and are in compliance with regulatory requirements.
        - Review whether the fee structure for asset management is fair, reasonable, and appropriately recognized as investment expenses.
        - If the related party asset manager also originates/securitizes investments held by the insurer, consider requesting additional information from the insurer to determine the following:
            - Whether the asset manager has adequate experience and knowledge in originating and managing the types of investments.
            - Whether the asset manager follows appropriate underwriting practices and applicable regulatory requirements in originating investments.
            - Whether the fee structures embedded in securities (if applicable) are fair, reasonable, and appropriately account for potential duplication of fees or conflicts of interest.
- Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding market risks associated with investment concentration and exposure to riskier asset classes.

Invested Asset Exposure to Climate Change Risk

Property/Casualty #	Life/A&H/Fraternal #	Health #
15	16	14

Invested Asset Exposure to Climate Change, Transition and Asset Devaluation Risk

The procedure assists analysts in iIdentifying and assessing the potential exposure of the insurer's investment portfolio to the impact of material climate change and/or energy transition risks. The insurer's investment portfolio may be subject to prospective devaluation of the assets/changes in the asset return associated with its holdings of climate-affected assets. Transition risks refer to stresses on certain investment holdings arising from the shifts in policy, consumer and business sentiment, or technologies associated with the changes necessary to limit climate change. A few examples of investment holdings and sectors generally subject to greater levels of transition risk include oil/gas, transportation, heavy manufacturing, and agriculture. In assessing an insurer's exposure to these risks, the analyst is encouraged to review information disclosed by the insurer in its responses to the NAIC's Climate Risk Disclosure Survey, U.S. Securities and Exchange Commission (SEC) filings, and/or the Own Risk and Solvency Assessment (ORSA) Summary Report filings. In addition, the analyst is encouraged to review the results of basic scenario analysis conducted by the NAIC using insurers' Annual Statement filings (U.S. Insurance Industry Climate Affected Investment Analysis) to identify potential concentrations in exposure.

Procedures

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

ADDITIONAL REVIEW CONSIDERATIONSAdditional Review Considerations

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

Additional Analysis and Follow-Up Procedures

Investment StrategyINVESTMENT STRATEGY directs the analyst to consider

Consider requesting and reviewing a copy of the insurer's formal adopted investment plan to determine if it is appropriately structured to support its ongoing business plan. If an insurer's investment strategy is not structured to support the business plan, it could indicate the strategy enjoys higher credit, market and liquidity

risks than are appropriate for the liabilities of the insurer and may lead to financial concerns in the future. This should be evaluated to determine if the plan appears to result in investments that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs and to determine whether the insurer appears to be adhering to its plan. For example, the insurer's plan for investing in noninvestment-grade bonds should be reviewed for guidelines regarding the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location. -Experience in execution of an investment strategy can also be a concern with more volatile and complex markets. The use of external investment managers can raise a host of other issues.(see additional guidance below)

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

Examination Findings ~~direct the analsyt to c~~

Consider -a review of the most recent examination report, summary review memorandum and communication with the examination staff to identify if any market risk issues were discovered during the examination such as:~~n.~~

- Asset liability matching
- Adherence to investment policies and strategies
- Investment management, and use of and monitoring of external investment managers

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

NAIC Capital Markets Bureau Analytical Assistance ~~directs the analyst to c~~

Consider requesting the NAIC's CMB to assist with analytical review of the insurer's investment portfolio or investment management agreement~~ analysis~~. The CMB has different levels of analysis that can be arranged to assist the state.

Third-Party ~~INVESTMENT~~ Investment Advisors ~~assists the analyst in d~~

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

Key information provided on a Form ADV includes:

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

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

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

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

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

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

~~The analyst should c~~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 d~~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.) and see V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for additional guidance on reviewing affiliated investment management agreements.

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

If the insurer uses an external asset manager and if investments on Schedule BA assets are invested in funds that are affiliated with the asset manager or are managed by that asset manager, the analyst should consider several possible issues that may result from this scenario. A possible concern may exist when the asset manager is also managing other funds in addition to managing assets for the insurer and then invests the insurer's assets in those other funds that the asset manager manages. While those funds may be good investments, both in general and for the insurer, there are a few issues that may need to be considered. First is the potential for a conflict of interest if the asset manager is using the insurer's available funds to provide seed money or fund the manager's other funds. Second is if any concerns exist regarding the appropriateness of the fund for the insurer's investment portfolio and if the transactions would be considered on an arm's-length basis. Third is the understanding that the insurer may be paying ~~double~~overlapping fees as the insurer would pay the asset

manager a fee for the investment and then also pay a fee within the fund investment. There may be similar concerns with other complex investments such as structured securities that are originated by the asset manager or one of its affiliates/related parties. The fees associated with these investments could be considered arms-length and appropriate but would require further review and potentially additional support or documentation to make that determination.

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

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

If "yes," consider the following procedures:

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

- If any potential conflicts of interest have been reviewed and formally approved by the Board or Investment Committee.;
- If the investment is appropriate for the insurer's portfolio and is arm's-length.
- If the insurer is paying overlapping fees.

Inquire of the Insurer directs the analyst to consider

If concerns exist, consider requesting additional information from the insurer if market risk concerns exist in a specific area. Note that the list provided includes examples of types of information or explanations to be obtained that may assist in the analysis of marekt risk for specific topics where concerns have been identified.

General Investment Inquiries

- If management has adequately reviewed the investment portfolio and understands the yields, underlying collateral, cash flows and investment volatility
- Any additional concentration by collateral type
- Management's process for valuing securities so as to assist analysts in assessing if the securities are valued appropriately
- Management's intended use of certain riskier investments and purpose within the insurer's portfolio
- If management has an appropriate level of knowledge and expertise with the type of securities being purchased/held
- If the insurer has controls implemented to mitigate the risks associated with this investment type
- Sources of liquidity, such as letters of credit (LOCs)
- Investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements

RMBS, CMBS and LBaSS

- 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
- Projected prepayment speeds on its RMBS portfolio and compare with historical prepayments, as well as the prepayment assumption at the time of purchase

OWN RISK AND SOLVENCY ASSESSMENTOwn Risk and Solvency Assessment (ORSA) directs the analyst to o
Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing risks faced by the insurer.

- Did the ORSA Summary Report analysis conducted by the lead state indicate any market risks that require further monitoring or follow-up?
- Did the ORSA Summary Report analysis conducted by the lead state indicate any mitigating strategies for existing or prospective market risks?

HOLDING COMPANY ANALYSISHolding Company Analysis directs the analyst to o
Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

- Did the Holding Company analysis conducted by the lead state indicate any market risks impacting the insurer that require further monitoring or follow-up?
- Did the Holding Company analysis conducted by the lead state indicate any mitigating strategies for existing or prospective market risks impacting the insurer?

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Actuarial Filings, Including Asset Liability Matching (Life/A&H, Health)

Did the review of the Statement of Actuarial Opinion or other actuarial filings indicate any concerns regarding:

- The adequacy of asset/liability matching and the sufficiency of assets to meet the business obligations of the insurer
- Exposure to certain asset classes
- Investment turnover
- Interest rate spreads

~~Example Prospective Risk Considerations~~

~~The table provides the analyst with example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general discription of the risk components. Note that the risks listed are only examples and do not represent a complete list of all risks available for the market risk category.~~

~~DISCUSSION OF~~ QUARTERLY MARKET RISK ASSESSMENT~~PROCEDURES~~

The ~~Q~~quarterly ~~M~~market ~~R~~risk ~~Repository~~ procedures are designed to identify the following.

~~:~~Significant Investment Concentration by Asset Class

Determine ~~W~~whether the insurer's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue. See also Credit Risk Assessment for diversification of other asset classes.

Procedures/Data

- Common stocks owned as a percent of total net admitted assets[ii].
- Mortgage loans owned as a percent of total net admitted assets.
- Real estate (before encumbrances), including home office real estate owned as a percent of total net admitted assets.
- Investments in affiliates owned as a percent of total net admitted assets.

Additional Procedures

- Review iSite+ for significant shifts in the mix of investments owned over the last five years.

Increased Exposure to Volatility and Valuation Risk by Asset Class

Determine if ~~C~~concerns exist due to the change in certain asset classes from the prior year-end.

Procedures/Data

- Increase in real estate from the prior year-end, where the ratio of total real estate to surplus (P/C), or cash and invested assets (Life/A&H), or capital and surplus (Health) is material.
- Increase in mortgage loans from the prior year-end, where the ratio of total mortgage loans estate to surplus (P/C), or cash and invested assets (Life/A&H), or capital and surplus (Health) is material.
- Increase in affiliated investments from the prior year-end, where the ratio affiliated investments estate to surplus (P/C), or cash and invested assets (Life/A&H), or capital and surplus (Health) is material.
- Increase in BA assets from the prior year-end, where the ratio of BA assets estate to surplus (P/C), or cash and invested assets (Life/A&H), or capital and surplus (Health) is material.

[ii] For ratios in this asset concentration procedure, net admitted assets excludes separate accounts for Life/A&H, and Health.

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Valuation of Securities

Determine if Cconcerns exist with the valuation of securities.

Procedures/Data

- Determine if the insurer has followed the filing requirements of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* [Quarterly Financial Statement, General Interrogatories, Part 1, #18.1 and #18.2].

Additional Procedures

- Assess the impact of market conditions.
  - Through consideration of industry and economic events (i.e., news and industry analytics), determine if there are any market conditions that may threaten the value of insurers' investment portfolios.
  - Through correspondence with the insurer, determine if there are any market conditions that could threaten the value of its investment portfolio.

Valuation of Affiliated Investments

Determine if Cconcerns with the level of exposure to investments in affiliates and valuation of the investments.

Procedures/Data

- Total of all investments in affiliates to surplus (P/C), or capital and surplus (Life/A&H, Health) [Quarterly Financial Statement, General Interrogatories Part 1, #14].
- Change in total of all investments in affiliates from the prior year-end.
- Change in any category of affiliated investments from the prior year-end.

Additional Procedures

- Review the results of the Holding Company analysis completed by the lead state. Note any concerns regarding exposure to (see diversification procedure above) or valuation of affiliated investments.
- If investments in common stocks of parents, subsidiaries, and affiliates (PSA) involve publicly traded securities, determine if the investment is valued on a basis other than market valuation.
- If investments in common stocks of PSA do not involve publicly traded securities, determine if the investment is valued on a basis other than the statutory equity or generally accepted accounting principles (GAAP) equity methods.
- If concerns exist regarding an affiliate investment(s) and/or material changes have occurred since the prior period analysis, consider the following (note that some of this information may be available in the Holding Company analysis completed by the lead state):
  - Obtain an understanding of the primary business activity of the affiliate and determine that such an investment complies with regulatory requirements.
  - Obtain and review the Audited Financial Statement, Annual Financial Statement and Statement of Actuarial Opinion of the affiliate, if available.
  - Determine the current ratings of the affiliate from the major rating agencies, if available.
  - Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.
  - Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate. Also, review iSite+ data on the reinsurer (i.e., financial statements, Regulatory Information Retrieval System [RIRS] and Global Receivership Information Database [GRID]).

Exposure to Derivative Investments

Determine if there are cConcerns due to the use of derivative instruments.

Procedures/Data

- Determine whether derivative holdings are significant. Review the ratio of total **book/adjusted carrying value** to surplus [Quarterly Financial Statement, Schedule DB, Part A and Part B, Section 1].

  Total **book/adjusted carrying value** and percentage of surplus (P/C), or capital and surplus plus AVR (Life/A&H), or capital and surplus (Health) for:

  - Hedging effective
  - Hedging other
  - Replication
  - Income generation
  - Other
  - Total derivative transactions
- Determine whether derivative holdings at are significant. Review the ratio of total **fair value** at quarter-end to surplus (P/C), or capital and surplus plus AVR (Life/A&H) [Quarterly Financial Statement Schedule DB, Part A and Part B, Section 1].

  Total **fair value** and percentage of surplus for:

  - Hedging effective
  - Hedging other
  - Replication
  - Income generation
  - Other
  - Total derivative transactions
- Increase in derivative investments over the prior year-end where the ratio of potential exposure on futures contracts and options, caps, floors, collars, swaps and forwards to surplus (P/C), or capital and surplus plus AVR (Life/A&H) is material. [Quarterly Financial Statement, Schedule DB, Part A and Part B, Section 1].

Additional Procedures

- Review detail provided in Quarterly Financial Statement, Schedule DB columns for Description of Item(s) Hedged, Used for Income Generation, or Replicated and Type(s) of Risk(s) to determine if the insurer's detailed use of derivatives appears to be consistent with the overall strategy that the reporting entity has described elsewhere. Where the detail reported in Schedule DB differs from other information provided by the insurer, request further clarifying information from the reporting entity.
- Review detail provided in Quarterly Financial Statement, Schedule DB columns for Hedge Effectiveness at Inception and at Quarter-End. Note anything unusual or any variances from the insurer's current hedging program description.

Realized and Unrealized Capital Gains and Losses

Assess if Cconcerns exisit with realized and unrealized capital gains (losses), including other-than-temporary impariments (OTTI).

Procedures/Data

- Ratio of net unrealized capital gains/(losses) to prior year-end surplus (P/C), or capital and surplus (Life/A&H, Health).
- Ratio of net realized capital gains to net income, where the absolute value of net realized capital gains or losses material to surplus (P/C), or capital and surplus (Life/A&H, Health).

Additional Procedures

- Review the iSite+ for significant changes or trends in capital gains (losses) by quarter over the last five years.

Negative Market Impact on Investment Income/Returns

Determine if concerns exist regarding the Aadequacy of net investment income.

Procedures/Data

- Ratio of investment income to cash and invested assets (rolling year).

Additional Procedures

- Review iSite+ for significant changes or trends in investment income by quarter over the last five years.

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

~~Operational Risk Assessment~~

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

The ~~objective of~~ Operational Risk Assessment ~~analysis~~ is ~~to~~ focused on risks inherent in the company's daily operations. As such, although operational risk encompasses overall profitability, other risks in this area may not be identified through traditional financial statement review. Therefore, analysts may require additional investigation and information requests to understand and assess the potential impact of these risks. For example, analysts may need additional information to assess the insurer's exposure to cybersecurity risks. In addition, information presented in the Enterprise Risk Report (Form F) and Own Risk and Solvency Assessment (ORSA) Summary Report (if available), which are reviewed and risks documented by the lead state, may assist analysts in identifying and assessing the insurer's exposure to operational risks.

~~The following discussion of procedures provides suggested data, benchmarks and procedures analysts can consider in his/her review.~~ Analysts' risk-focused assessment of operational risk should take into consideration the following areas (but not be limited to):

- Statement of income and operating performance
- Corporate governance practices
- Changes in officers and directors
- Investment operations (purchases and sales)
- Use of investment advisors
- Changes in corporate structure
- Related party transactions
- Use of managing general agents (MGAs) and third-party administrators (TPAs)
- Separate accounts (Life only)
- Risk transfer arrangements other than reinsurance (Health only)
- Provider liabilities (Health only)

~~Discussion of Annual Procedures~~~~General Guidance~~GENERAL GUIDANCE

~~**Using the Repository**~~

To assess ~~Tthe~~ operational risk, ~~repository is a list of possible quantitative and qualitative~~consider the procedures, ~~including specific~~ data elements, metrics~~,~~ and benchmarks in this chapter.~~and procedures from which analysts may select to use in their review of operational risk.~~
The following is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

The placement of procedures, metrics and data within operational risk is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting financial determinations of the analysis. For example, key insurance operations or lines of business may have related risks addressed in different risk categories. Therefore, analysts may need to review other risks in conjunction with operational risk.

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

Analysts are not expected to ~~respond to all~~document every procedure~~s~~, data or benchmark result~~s listed in the repository~~. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document ~~completion of~~~~of~~ the applicable details within the analysis. Results of operational risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.
~~The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.~~

Results of operational risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. ~~In using procedures in the repository, a~~

Analysts should ~~review the results in~~ complete their operational risk assessment in conjunction with:

- A review of the Supervisory Plan and Insurer Profile Summary and the prior period analysis.
- Communication and/or coordination with other internal departments. ~~are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures in the repository.~~
-
- ~~Analysts should also consider t~~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 placement of the following data and procedures in the operational risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with operational risk.

Analysis Documentation: Results of operational risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.

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

ANNUAL OPERATIONAL RISK ASSESSMENTQuantitative and Qualitative Data and Procedures

Operating Performance

Property/Casualty #	***Life/A&H/Fraternal #***	***Health #***
1	*1*	*1*

PROPERTY/CASUALTY (P/C)

Trend of Poor (or Declining) -Operating Performance For P/C Insurers

EXPLANATION: The procedure assists analysts in determining Determine whether concerns exist regarding the insurer's Statement of Income or operating performance.

In evaluating the insurer's operating performance, analysts should review analyze the combined ratio to measureas a key indicator of underwriting profitability. Identify and assess potential concerns such as elevated losses, decreased premiums, or increased underwriting expenses. Delve into the underlying causes of these issues to gain deeper insights. High commission and expense ratios may indicate a high expense structure that may make it difficult for the insurer to attract new business, compete with other insurers and fulfill its strategic plan.

While the combined ratio solely focuses on underwriting performance, in conjunction with the the two-year overall operating ratio (Insurance Regulatory Information System (IRIS) ratio #5) and return on surplus offer a broader perspective on overall profitability. The two-year operating ratio reflects the insurer's financial performance relative to underwriting and investment activities over a two-year period. Conversely, Another measure of the insurer's operating performance is the return on surplus , which considersmeasurers net income and unrealized gains (losses) as a percentage of two-year average surplus.

In addition to analyzing the current year results, analysts are encouraged to review data andshould also examine trends in these metrics over the past five years. Continued trends in expense ratio, combined ratio and overall profitability may indicate ongoing solvency risks.provided and presented in the Annual Financial Profile Report

~~over a five-year period to identify trends and areas of concern. Finally~~ Additionally, ~~analysts are encouraged to compare results in certain areas~~benchmarking certain metrics against industry averages ~~to identify~~can highlight outliers and potential areas of concern.

Procedures/Data

- Analyze the current year's performance, changes from the prior year and trends over past five years in the following metrics to assess the insurer's operating performance:
  - Combined ratio
  - Loss ratio (direct, assumed, gross, ceded, and net)
  - Expense ratio
  - Commissions and brokerage ratios
  - Change in individual income and expense line items (i.e., net premium earned, incurred losses and loss adjustment expenses, expenses and commissions)
  - Net income
  - Return on surplus ratio
  - Two-year operating ratio (IRIS #5)
  - Ratio of other income to net income, when the absolute value of other income is material to surplus

Additional Review Considerations~~:~~

- Compare the entity's actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
- Compare the metrics and data above for operating performance to industry averages to determine any significant deviations.
- Review the components of other income in the Annual Financial Statement, Statement of Income, including write-ins for miscellaneous income, for reasonableness.
- Describe any known trends that have had or that the insurer reasonably expects will have a material favorable or unfavorable impact on net revenues or net income. If the insurer knows of events that will cause a material change in the relationship between benefits, losses, and expenses, the change in the relationship should be disclosed.
- Review the Annual Statement Blank, Insurance Expense Exhibit (IEE), to identify any expense allocation concerns or unusual operating results by line of business. The (IEE) is a supplemental P/C schedule filed by April 1. The IEE includes an interrogatories section and three major parts. Part I shows, for each expense line item included in the Annual Financial Statement, the allocation to five expense groups: 1) loss adjustment expense; 2) acquisition, field supervision, and collection expenses; 3) general expenses; 4) taxes, licenses and fees; and 5) investment expenses. Part II shows major categories of expenses and the allocation to each line of business. Part III is similar to Part II except that premiums are reflected on a direct basis. While the IEE is not a primary source of information for solvency analysis, it does provide meaningful information for evaluating an insurer's operations and overall profitability. In addition, the IEE may be used in the rate-making process or for evaluating an insurer's performance by line of business.
  - Investigate unusual items, especially situations where expenses were allocated to lines of business using methods not defined in the Annual Statement Instructions. The Annual Statement Instructions are

included in the Supplements section and additional guidance in this regard is included in the *Financial Condition Examiners Handbook*.

- Review IEE, Part 1:
  - Investigate significant fluctuations in expenses by expense groups between years
  - Compare expenses by expense group for the insurer with the industry averages
- Review the IEE , Part II and Part III:
  - Investigate significant fluctuations in expenses by lines of business between years
  - Compare expenses by line of business with industry averages
  - Determine whether the totals agree with financial statement line items included in the Annual Financial Statement
- Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses. ~~This procedure can assist analysst in understanding the cause of poor operating performance and assess whether it is likely to continue going forward.~~
- Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations. ~~This procedure can assist analysts in evaluating the insurer's plans and mitigation strategies for addressing the poor operating performance.~~
- In conjunction with review of reinsurance program(s) (within Strategic Risk), consider the impact of reinsurance program(s) on the insurer's operating performance. This could include assessing whether there are any risk limiting features or insufficient ceding commission rates that could be a significant additional drain on operating earnings when insurers utilize reinsurance for RBC or premium leverage considerations.

Poor (Or Declining) Operating Performance for Life/-A~~ccident~~ &H~~ealth/Fraternal~~ Insurers

~~***EXPLANATION:*** The procedure assists analysts in d~~Determining whether concerns exist regarding the insurer's Summary of Operations or operating performance.

One of the most common measures of overall profitability and operating performance for an A&H insurer is the IRIS ratio of net income to total income (including realized capital gains and losses). Six principal factors affect the insurer's net gain, as reflected in this ratio: 1) mortality and morbidity experience; 2) adequacy of investment income; 3) commissions and expenses; 4) reinsurance transactions; 5) the relationship of statutory reserve requirements to prevailing interest and mortality rates; and 6) realized capital gains and losses. This ratio is an indicator of the insurer's overall profitability and operating performance without consideration of realized gains and losses. Another important measure of the insurer's operating performance is the return on capital and surplus, which considers net income as a percentage of capital and surplus. All of these metrics are intended to assist analysts in determining whether the operating performance and profitability of the insurer may represent a current or prospective operating risk to be evaluated and assessed.

Additional steps ~~analysts~~ may include reviewing the summary of the individual income and expense items for the past five years for unusual fluctuations or trends between years. In addition, analysts might compare the ratio of return on capital and surplus to industry average results to determine any significant deviation from the industry average. By reviewing the Analysis of Operations by Lines of Business in the Annual Financial Statement, analysts could determine which lines of business had significant surrender activity during the year, which lines of business were profitable, and which lines of business generated a loss, and whether commissions and expenses on any lines of business appear excessive, based on the volume of premiums and deposit-type funds. If the ratio

of commissions and expenses to premiums appears high or if the ratio of investment yield appears unusual, analysts should consider: 1) reviewing these ratio results for the past five years for unusual fluctuations or trends between years; and 2) comparing the ratio results to industry averages to determine any significant deviations from the industry averages. If write-ins for miscellaneous income or deductions are significant, analysts should consider reviewing the individual components of these amounts for reasonableness.

Procedures/Data

Determine whether concerns exist regarding the insurer's income statement or operating performance.

- Review the net income/(loss) and related ratios:
  - Net Loss in the current year, or in two or more of the past three years.
  - Change in net income/(loss) if the value of net income is material to capital and surplus.
  - Ratio of net income to total income (including realized capital gains and losses) (IRIS Ratio 3).
  - Ratio of net gain from operations (before realized capital gains and losses) to total income.
- Ratio of return on capital and surplus.
- Ratio of commissions and administrative expenses to gross premiums for non-life insurers, and five-year trend.
- Accident and health (A&H) loss ratio, and 5-year trend.
- Ratio of aggregate write-ins for miscellaneous income to net income when aggregate write-ins for miscellaneous income is material to capital and surplus.
- Ratio of aggregate write-ins for deductions to net income when aggregate write-ins for deductions are material to capital and surplus.
- Change in material individual income and expense categories, and five-year trend.
- Compare the following measures of operating performance to the industry average to determine any significant deviations:
  - Return on capital and surplus ratio
  - Commissions and administrative expenses to premiums ratio
- Review the lines of business information from the Analysis of Operations by Lines of Business and determine:
  - Income/(Loss) by lines of business in the current year, or negative trend in profitability over the past five years.
  - Whether commissions and expenses on any lines of business appear excessive based on the volume of premiums.

Additional Review Considerations:

- Compare the entity's actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
- Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on the net revenues or net income, or a material impact on the relationship between benefits, losses, and expenses.
- Review the components of the aggregate write-ins for miscellaneous income and aggregate write-ins for deductions for reasonableness.
- If concerns exist regarding operating performance, consider the following procedures:

- Review Exhibit 2 – General Expenses to identify concerns or unusual items to identify any expense allocation concerns or unusual operating results by line of business to assist in identifying areas for follow-up and investigation with the insurer.
- Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses.
- Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations.

- ~~Review Exhibit 2 to identify concerns or unusual items to identify any expense allocation concerns or unusual operating results by line of business. This procedure may assist analysts in identifying areas for follow-up and investigation with the insurer.~~
- Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses. This procedure can assist analysts in further understanding the cause of poor operating performance and assess whether it is likely to continue going forward.
- Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations. This procedure can assist analysts in evaluating the insurer's plans and mitigation strategies for addressing the poor operating performance.
- If the insurer writes Medicare Part D business, obtain and review supporting documents if concerns are identified related to the operating performance of Medicare Part D business. Supporting documents may include information on contracted benefits, premium and cost sharing with the CMS, and support for reserve, utilization and benefit cost assumptions projected in the development of the contract.

Poor (or Declining) Operating Performance for Health Insurers

~~***EXPLANATION:*** The procedure assists analysts in d~~Determin~~ing~~e whether concerns exist regarding the insurer's Statement of Revenue and Expenses or operating performance.

Each of the ratios provided in this procedure is designed to provide analysts with an overall assessment of the health entity's profitability. The profit margins in the health insurance industry have traditionally been fairly low. As a result, the threshold for this ratio is established at less than 0% or greater than 10%. A profit margin ratio less than 0% indicates the health entity has experienced a net loss and operating problems may exist. With continued losses, the health entity's capital cushion to support the business is likely to be diminished. Conversely, a profit margin greater than 10% is unusual in the health insurance industry and should be investigated.

Another ratio that provides an assessment of a health entity's profitability is the combined ratio. The threshold for the combined ratio is set at greater than 100%. A health entity with a combined ratio of 100% should have investment income for profit. The combined ratio consists of the medical loss and the administrative expense ratios. The administrative expense ratio includes administrative expenses as well as claims adjustment expenses. Claims adjustment expenses are the costs incurred relating to reported and unreported claims and are considered to be administrative in nature. The threshold for the medical loss ratio is set at greater than 85% and the administrative expense ratio is set at greater than 15%. These thresholds are based upon a typical relationship between the combined, medical loss, and administrative expense ratios. Some health entities may have a higher medical loss ratio but a lower administrative expense ratio. Some view this relationship as positive

because more benefits are provided to the consumer. Other health entities may have a lower medical loss ratio and a higher administrative expense ratio. In some cases, this relationship may be positive because sometimes this is indicative of a health entity with lower operating leverage. Also, the medical loss ratio measures the direct cost of business as related to premiums earned and should have a consistent trend, while the administrative expense ratio which measures indirect expenses as related to premiums earned should decrease as the company becomes more efficient over a period of time. Typically, premium increases are driven by claim cost trends that exceed general inflation, which drives administrative costs. On the other hand, in situations where general inflation is less than medical cost trends, administrative cost ratios may actually increase since administrative trends will be higher than premium trends. As previously mentioned, analysts should also be familiar with the health entity's primary lines of business in order to evaluate their operating performance. This includes lines with business risk (ASO/ASC) but no underwriting risk, which report fees as a reduction of expenses, instead of as premium.

In addition to providing information on the current year's operating performance, this procedure also provides information on changes from the prior year. As previously mentioned an increase in a health entity's medical loss ratio may indicate a loss of control in the health entity's underwriting or pricing processes. An increase in the administrative expense ratio may indicate escalating costs or an expense structure that no longer supports the health entity's premium volume. Changes may also be the result of a change in the health entity's business mix. As previously mentioned, a health entity's entrance into new lines of business or sales regions might result in financial problems if the health entity does not have expertise in these new lines of business or regions. All of these items should be further investigated to further assess the risk to the health entity.

All of these metrics are intended to assist analysts in determining whether the operating performance and profitability of the insurer may represent a current or prospective operating risk to be evaluated and assessed. In addition, analysts are encouraged to review data and metrics provided and presented in the Annual Financial Profile Report over a five-year period to identify trends and areas of concern. Analysts are also encouraged to compare results in certain areas against industry averages to identify outliers and areas of concern. Finally, ~~analysts can also~~ review the Analysis of Operations by Line of Business and the Statement of Revenues and Expenses line item aggregate write-ins to understand results, recognize trends and identify items for follow-up with the insurer.

Procedures/Data

Determine whether concerns exist regarding the insurer's income statement or operating performance.

- Net income (loss)
  - Current year net loss
  - Change in net income when net income is material to surplus
  - Net loss in two or more of the past five years
- Review the components of the Statement of Revenues and Expenses line item aggregate write-ins for other health care related revenues, other income or expenses for reasonableness.
- Profit margin ratio, change from the prior year and, or negative trend over the past five years.
- Return on capital and surplus ratio
- Combined ratio, change from the prior year and, negative trend over the past five years
- Medical loss ratio, change from the prior year and, negative trend over the past five years

- Administrative expense ratio, change from the prior year and, negative trend over the past five years
- Combined ratio for any line of business
- Determine if combined, medical loss, and administrative expense ratios appear reasonable.
- Losses incurred from ASO/ASC plans [Annual Financial Statement, Notes to Financial Statements, Note #18]
- Review the five-year trend with the Annual Financial Profile Report for the following measures of operating performance, and note any unusual fluctuations or trends between years for each ratio:
    - Ratios by line of business
    - Change in material individual income and expense categories
- Review the Analysis of Operations by Line of Business to determine which lines of business generated a loss.
- Compare the following measures of operating performance to the industry average to determine any significant deviations
    - Combined ratio
    - Return on capital and surplus

Additional ~~r~~Review ~~c~~Considerations~~:~~

- Compare the insurer's actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
- Describe any known trends that have had or that the insurer reasonably expects will have a material favorable or unfavorable impact on net revenues or net income or a material impact on the relationship between benefits, losses and expenses.
    - Consider if the insurer is dependent upon investment income.
    - If the insurer knows of events that will cause a material change in the relationship between benefits, losses, and expenses, the change in relationship should be disclosed.
- Review the Supplemental Health Care Exhibit (SHCE) to identify concerns or unusual items for further analysis. This procedure can help analysts determine what specific areas of operations or lines of business may be the source of poor operating performance.
    - Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses. This procedure can assist analysts in understanding the cause of poor operating performance and assess whether it is likely to continue going forward.
    - Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations. This procedure can assist analysts in evaluating the insurer's plans and mitigation strategies for addressing the poor operating performance.
- If the insurer writes Medicare Part D business, obtain and review supporting documents if concerns are identified related to the operating performance of Medicare Part D business. Supporting documents may include information on contracted benefits, premium and cost sharing with the CMS, and support for reserve, utilization and benefit cost assumptions projected in the development of the contract.

Lack of Effective Corporate Governance/Oversight of Operations

~~**Corporate Governance**~~		
~~***Property/Casualty #***~~	~~***Life/A&H/Fraternal #***~~	~~***Health #***~~
~~***2, 3***~~	~~***2, 3***~~	~~***2, 3***~~

~~*PROCEDURE #2* assists analysts in d~~Determin~~e~~ing ~~whether concerns exist regarding the insurer's corporate governance practices.~~ The lack of an effective governance function to oversee operations may make it difficult for the insurer to fulfill its strategic plan and achieve desired outcomes.

Procedures

Determine whether corporate governance practices of the insurer provide effective oversight of operations.

- ~~Analysts are asked to r~~Review the Corporate Governance Annual Disclosure (CGAD) filing (if filed on an insurance entity basis) to identify and assess the governance practices in place at the insurer. If the CGAD is filed on a group basis, ~~the anlayst should~~ rely on the information provided in the GPS or provided by the lead state if material risks are only relevant to specific insurance entities.
  - Identify and follow up on any issues noted that could affect the insurer's ability to adequately oversee operations.
- If your state is the lead state, document information and risks from the CGAD in the Group Profile Summary (GPS) (Refer to the procedures in chapter VI.D. Corporate Governance Disclosure Procedures of the Handbook.)
  - Identify and follow up on any issues noted that could affect the group's ability to adequately oversee operations.
  - If material risk relates only to an insurance entity, contact the domestic state in a timely manner.
- If your state is not the lead state and the CGAD is filed to the lead state, review the corporate governance assessment included in the lead state's GPS and contact the lead state with any questions, concerns or follow-ups. Upon the receipt of any additional information, the non-lead state should document any material concerns regarding corporate governance that could impact the financial condition (e.g., operations, policyholder surplus or capital position) of the domestic insurer.
- ~~In addition, analysts is encouraged to r~~Review the results of the corporate governance assessment conducted during the last on-site examination, other examination documentation or summaries, communication with the examiner-in-charge, or the most recent communication with the insurer, to identify issues or concerns to be considered or addressed.
- If concerns are identified, ~~analysts may elect to~~ request a copy of recent board minutes to determine if the board of directors has taken any significant actions that may result in changes in operations, business structure, or management that may result in a material financial impact on the insurer. ~~to review and/or~~
- Consider reviewing internal resources on file related to the following, and if not on file, request the following information from the insurer:
  - For the board of directors and each committee established by the board of directors request a copy of the charter/policy, the business ethic policy, code of conduct policy, and conflict of interest policy
  - The most recent conflict of interest statement, or its equivalent, for each member of the board of directors and committees established by the board of directors including an explanation of any conflicts reported
  - Financial expertise or statutory accounting principles expertise of the audit committee
  - Reporting structure of the internal audit function
  - Copy of the company's by-laws currently in effect
  - If part of a holding company system, discussion on the level of oversight the parent company maintains over the insurer

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  - Discussion of compliance with corporate governance statutes
  - Discussion of compensation policies, bonus/incentive programs, and management performance and assessment programs
  - Discussion of the board of directors' and management's responsibilities and authority
- cContact the insurer regarding actions taken to address the concerns identified.
- Based on the above procedures, determine if the board of directors and management provide a sufficient level of oversight and support.

Risks of Change in Operations/Turnover in Key Board or Sr. Management Positions

Evaluate the effects of changes in officers or directors on the operations of the insurer. A significant change in operations resulting from turnover or changes in key board of directors and/or senior management positions may increase operational risk and should be evaluated for their potential impact on the current and prospective solvency of the insurer.

Procedures

- Review any changes in officers, directors or trustees and any concerns noted during a review of biographical affidavits to assess suitability. Determine if:
  - new directors and officers have the required knowledge, experience and training to perform their duties. Document any concerns.
  - new board of directors' members sufficiently independent from management and adequately engaged in performing their duties.
  - there has been significant turnover in management in the current year or a pattern of turnover in the past five years. If so, document the reasons.
  - new directors and officers have ever been officers, directors, trustees, key employees or controlling stockholders of an insurance company that, while they occupied any such position or served in any such capacity with respect to it:
    - Been placed in supervision, conservation, rehabilitation, or liquidation.
    - Been enjoined from, or ordered to cease and desist from, violating any securities or insurance law regulation.
    - Suffered the suspension or revocation of their certificate of authority or license to do business in any state.
    - If so, request and review the insurer's policies and procedures regarding performance of background checks on new management.
- If a significant amount of turnover and/or changes in key positions are identified, gain an understanding and evaluate the impact of such changes on the insurer's operations.
- Request updated business plans, hold in-person meetings, conduct conference calls, and take other steps to understand and address significant changes.
- Determine if there have been significant operational or business changes that have resulted in significant changes in staffing levels, consolidations of operations with affiliates, outsourcing of key functions, or placing blocks of business into run-off (closed) blocks.
- Review and evaluate the insurer's human capital and succession planning processes and controls.

- Evaluate the insurer's management and personnel to identify directors, executives, or key employees that may be approaching retirement and discuss the steps taken by the company to plan for succession for any individuals identified.
- Determine whether the insurer is overly reliant on any one individual to produce its business or manage its operations and discuss succession plans for any individuals identified.
- Describe the insurer's processes to identify, appoint, train, evaluate, and compensate directors, executives, and key members of personnel.

- ***PROCEDURE #3*** assists analysts in determining whether there are significant changes in staffing or key positions at the insurer that could result in operational risk. Analyst are encouraged to review biographical affidavits of new officers and directors of the insurer to identify and assess risks relating to their suitability. In addition, the procedure encourages meeting with the insurer to discuss significant turnover in key positions and its potential to result in operational risk. Finally, the procedure encourages consideration of whether any other changes in operations or business practices have the potential to result in operational risk. Changes in officers/directors/management brought on by a generational change in ownership/control of the insurer or insurance group could be a source of operational risk as it may be indicative of changes in corporate culture and philosophy. Examples of items to be considered include changes in staffing levels, consolidation of operations with affiliates, outsourcing of functions or placing lines of business into runoff. Any of these actions have the potential to result in operational risk and should be evaluated for their potential impact on the current and prospective solvency of the insurer.

PROCEDURE #3D is intended to assist analysts in evaluating the insurer's human capital and succession planning. Human capital can be defined as the collective skills, knowledge, or other intangible assets of employees and directors that can be used to create economic value for an organization. Insurer's face a number of wide-ranging threats to the quality of their human capital including aging directors/executives, over-reliance on key individuals in an increasingly competitive employment market and the lack of a workforce possessing insurance knowledge and skills. Insurers may be able to mitigate their risk in this area by implementing effective succession planning, recognizing and rewarding outstanding performance, and developing effective training, coaching and performance evaluation processes.

Investment Operations

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
4, 5	*4, 5*	*4, 5*

Investment OperationsLack of Control over Purchases, Sales, and Control of Investment Operations

PROCEDURE #4 assists analysts in dDetermineing whether concerns exist related to investment operations, including purchases and sales of securities and control of assets. Assets not under the full control of the insurer may not be available to fulfill policyholder obligations. Assets that are not under the insurer's control might not meet the state's requirements to be considered net admitted assets.

Procedures/Data

- Ratio of payable for securities to total invested assets.
- Ratio of receivable for securities to total invested assets.

- Review Annual Financial Statement, General Interrogatories, Part 1, #16 to determine if the purchase or sale of any investments have not been approved by the board of directors or a subordinate comettee thereof.
- Review the Annual Financial Statement, General Interrogatories, Part 1, #25.01 and #25.02 to determine:
  - if any stocks, bonds and other securities owned, over which the insurer has exclusive control, not in the actual possession of the insurer, other than securities lending programs.
  - the reason the securities are not in the entity's possession and who holds the securities in order to evaluate whether they qualify as net admitted assets of the entity under the state insurance laws or whether there are concerns regarding the entity's ability to have access to the securities when needed.
- -Review Annual Financial Statement, General Interrogatories, Part 1, #26.1 and #26.21 to determine:
  - if any stocks, bonds or other assets owned by the insurer not exclusively under the control of the insurer.
  - why the assets are not under the entity's exclusive control (e.g., loaned to others, subject to repurchase or reverse purchase agreements, pledged as collateral, placed under option agreements). ~~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 Interrogatories, Part 1, #16 indicates whether this has been done. The Annual Financial Statement, General Interrogatories, Part 1, #24.01 and #24.02 indicate 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. The Annual Financial Statement, General Interrogatories, Part 1, #25.1 and #25.2 indicate 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.~~
- Review Annual Financial Statement, General Interrogatories, Part 1, #21.1 and #21.21 to determine
  - if any assets were reported subject to a contractual obligation to transfer to another party without the liability for such obligation being reported.
  - the purpose and the amount.
  - ~~Is the ratio of payable for securities to total invested assets greater than 10%?~~
  - ~~Is the ratio of receivable for securities to total invested assets greater than 10%?~~

Additional Review Considerations

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

Questionable Investment Activities

Analysts should also consider if the insurer's investment performance or risks in its investment portfolio may be masked due to questionable investment activities (e.g., wash sales, window dressing, etc.).

Procedures

- Review the Annual Financial Statement, Schedule D – Part 3 and Schedule D – Part 5, to determine:
  - if significant amounts of bonds or stocks purchased near the beginning or the end of the year.

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- types of securities purchased and the vendors used for those purchases.
- Review the Annual Financial Statement, Schedule D – Part 4 and Schedule D – Part 5, to determine:
  - if significant amounts of bonds or stocks disposed of near the beginning or the end of the year.
  - types of securities sold and the purchasers of those securities.
- Review Annual Financial Statement, Schedule D – Part 5 to determine
  - if significant amounts of bonds or stocks acquired near the beginning of the year and disposed of near the end of the year
  - types of securities purchased, the vendors used for those purchases and the purchasers of those securities.
- Based on the results of the two previous questions, determine whether the insurer might have engaged in "window dressing" of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end).

Concerns with Third-Party Investment Advisors ~~Additional steps may be performed if there are concerns regarding investment approval or control and possession. If there are concerns regarding investment approval, analysts 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, analysts should consider reviewing the Annual Financial Statement, General Interrogatories, Part 1, #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, analysts 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 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 analysts in d~~Determine~~ing~~ whether any concerns exist regarding third-party investment advisors, ~~and~~ associated contractual arrangements, and related party exposure in the investment portfolio. Heavy reliance on unqualified investment advisors or lack of effective oversight may lead to excessive risk taking and increases in fraud and investment reporting risks.

As investments and investment strategies grow in complexity, insurers may consider the use of unaffiliated third-party investment advisers to manage their investment strategy. Investment advisers may operate independently or as part of an investment company. Investment advisers and companies are subject to regulation by the U.S. Securities and Exchange Commission (SEC) and/or by the states in which they operate, generally based on the size of their business. In certain situations insurers may use a broker-dealer for

investment advice. Broker dealers are subject to regulation by the Financial Industry Regulatory Authority (FINRA). Regardless, most broker dealers and investment advisers will register with the SEC and annually update a Form ADV-Uniform Application for Investment Adviser Registration and Report Form by Exempt Reporting Advisers which provides extensive information about the nature of the organization's operations. To locate these forms, analysts can go to *www.adviserinfo.sec.gov* and perform a search based on the company name.

Key Information provided on a Form ADV includes:

a. Regulatory agencies and states in which the adviser/broker is registered
b. Information about the advisory business including size of operation and types of customers (Item 5)
c. Information about whether the company provides custodial services (Item 9)
d. Information about disciplinary action and/or criminal records (Item 11)
e. A report of the independent public accountant verifying compliance if the investment advisor also acts as custodian

It is important to note that the information provided on Form ADV is self-reported and is subject to limited regulatory oversight. However, the information may be valuable to analysts in assessing the suitability and capability of investment advisers providing advisory services to insurers. Note that Tthe SEC does not officially use the term "good standing"; however, for this analysis, the term is used to mean a firm that is registered as an investment adviser with the SEC and does not report disciplinary actions or criminal records in Item 11 of the form ADV.

Procedures

- Review the Annual Financial Statement, General Interrogatories, Part 1, #29.05 to determine if -the insurer utilizes third party investment advisors, broker-dealers or individuals acting on behalf of the insurer with access to its investment accounts.
- If yes, consider the following procedures:
  - Verify that all affiliated and unaffiliated investment advisors the analyst is aware of are disclosed in the interrogatory, whether primary or sub-advisors.
    - Verify that Investment Management Agreements required to be filed with the department have been filed and consider requesting copies of agreements that have not been filed with the department for review.
    - Gain an understanding of the types of investments that are being managed by each of the advisors/sub-advisors disclosed in the interrogatory.
  - Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners. Determine if the examination identified any issues with regard to investment advisors and associated contractual arrangements that require follow-up analysis or communication with the insurer. If yes, document the follow-up performed.
    - Note: The examiner may have performed steps to determine the following: 1) whether the investment adviser is suitable for the role (including whether he/she registered and in good standing with the SEC and/or state securities regulators); 2) whether the investment advisory agreements contain appropriate provisions; 3) whether the adviser is acting in accordance with the agreement; and 4) whether management/board oversight of the investment adviser is sufficient for the relationships in place.

- Compare Annual Financial Statement, General Interrogatories, Part 1, #29.05 for the current year to the prior year to determine if there have been any changes in advisors that may prospectively impact the insurer's investment strategy and overall management of the investment portfolio. If yes, consider obtaining:
  - An explanation for the change from the insurer
  - A copy of the new investment advisor agreement and review it for appropriate provisions, to gain an understanding of the provisions including the adviser's authority, specific reference to compliance with the insurer's investment strategy and/or policy statements, as well as state investment laws; conflicts of interest; fiduciary responsibilities; fees; and the insurer's review of the adviser's performance. (Refer to the *Financial Condition Examiners Handbook* for further guidance.)
- Using the information reported in Annual Financial Statement, General Interrogatories, Part 1, #29.05, obtain and review SEC Form ADV (if available), to determine if the investment advisor is in good standing with the SEC. If not, contact the insurer to request an explanation.
  - See additional guidance in V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for reviewing affiliated investment manager agreements.
- If agreements with third party investment advisors are affiliated, has the appropriate form D-Prior Notice of Transaction been filed and approved by the department? Were any concerns noted or follow-up monitoring recommended?
- Request information from the insurer regarding the background and expertise in any complex or non-traditional assets (such as structured securities, mortgage loans, investment funds) of its investment advisors (in-house and/or contractual) and its analytical systems capabilities. Determine whether the advisors and systems are adequate to allow the entity to continuously monitor its investments.
- If the insurer uses an external asset manager, consider if there are any investments that may represent a potential for conflict. Examples of this are (1) if there are Investments Report on Schedule BA that are funds that are affiliated/related with the asset manager or are managed by that asset manager, (2) Structured Securities in which the asset manager or an affiliate/related party had a role in originating, or (3) direct investments in the asset manager or any of its affiliates/related parties. If the external asset manager qualifies as a related party, utilize guidance provided in the "Related Party Exposure in the Investment Portfolio" section above to assist in this review. Consider the following issues:
  - Have any potential conflicts of interest been reviewed and formally approved by the Board or Investment Committee.
  - If the investment is appropriate for the insurer's portfolio and is arm's-length.
  - If the insurer is paying overlapping fees.

~~Analysts should consider any significant risks identified in the most recent risk-focused examination and whether any follow-up procedures were recommended by the examiner. The examiner may have performed steps to determine the following: 1) whether the investment adviser is suitable for the role (including whether he/she registered and in good standing with the SEC and/or state securities regulators); 2) whether the investment advisory agreements contain appropriate provisions; 3) whether the adviser is acting in accordance with the agreement; and 4) whether management/board oversight of the investment adviser is sufficient for the relationships in place.~~

~~Analysts should determine if changes have occurred in the insurer's use of investment advisers that may prospectively impact the insurer's investment strategy and overall management of the investment portfolio. If changes have occurred, analysts may consider asking the insurer for an explanation for the change in investment advisers and obtain a copy of the new adviser agreement to gain an understanding of the provisions including the adviser's authority, specific reference to compliance with the insurer's investment strategy and/or policy~~

statements, as well as state investment laws; conflicts of interest; fiduciary responsibilities; fees; and the insurer's review of the adviser's performance. (Refer to the *Financial Condition Examiners Handbook* for further guidance.)

Analysts 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.

Investments Involving Related Parties

Property/Casualty #	*Life/A&H/Fraternal #*	*Health #*
5	*5*	*5*

Related Party Exposure in Investment Portfolio

This procedure assists analysts in dDetermineing related party exposure in the investment portfolio and assessing any related market risk.

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

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

Procedures

- The anlayst should uReview the Annual Financial Statement investment schedules B, BA, D, DA, DB, DL, and E (Part 2), as disclosed in the column "Investments Involving Related Parties" and Utilize the tools available in iSite+ to identify if the insurer has a material exposure to investments involving related parties, either on an asset category basis or in aggregate, and by the related party designation noted below. All investments involving related parties must include disclosure to ensure full transparency which is located in the column previously noted. It designates investments by the following roles:
    1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.
    2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.
    3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.
5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.
6. ~~1.~~6. The investment does not involve a related party.

- If a material exposure exists, further assessment of the [credit, market, liquidity] risk may be warranted to assess the credit quality of those investments by reviewing designations, assessing historical default experience, etc. ~~For example, what is the NAIC designation of investments involving related parties? Analysts may a~~Also consider the extent to which related parties are involved in securitizing or originating business for the insurer, and what differences may exist in how investments involving related parties are valued. If the role of the related party is that of a third-party advisor, factors to consider may include for example, the expertise of the related party advisor, any potential conflicts of interest, and if related parties are originating investments only for the insurer or also to the public, the latter being subject to SEC requirements. ~~The analyst may consider utilizing suggested procedures in the "Additional Procedures" section of the repository on third-party advisors, if applicable.~~
- Review the insurer's investment policy guidelines and determine whether the related party investments follow the guidelines and are in compliance with regulatory requirements.
- Review whether the fee structure for asset management is fair, reasonable, and appropriately recognized as investment expenses.
- If the related party assets manager also originates/securitizes investments held by the insurer, consider requesting additional information from the insurer to determine the following:
  - Whether the assets manager has adequate experienceand knowledge in originating and manging the types of investments;
  - Whether the assets manager follows appropriate underwriting practices and applicable regulatory requirements in originating investments; and
  - Whether the fee structures embedded in securities (if applicable) are fair, reasonable, and appropriately account for potential dulpication of fees or conflicts of interest.

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

1. ~~Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.~~
2. ~~Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.~~
3. ~~Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.~~

~~4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.~~

~~5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.~~

~~6. The investment does not involve a related party.~~

~~**Exposure to Transactions with Affiliates**~~

~~***Property/Casualty #***~~	~~***Life/A&H/Fraternal #***~~	~~***Health #***~~
~~***6, 7, 8***~~	~~***6, 7, 8***~~	~~***6, 7, 8***~~

Changes in Corporate Structure

~~***PROCEDURE #6*** assists analysts in d~~Determin~~ing~~e whether any concerns exist regarding changes in the insurer's corporate structure.

Significant changes in corporate structure may materially impact the entity's future financial condition and generally require prior regulatory approval. ~~Analysts should closely a~~Analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure in which the insurer operates, ~~analysts may be able to foresee~~ future problems ~~and take appropriate action~~may be avoided. For example, a common corporate structure ~~analysts may encounter~~ involves a holding company whose only significant asset is the stock of the insurance entity. The holding company may have financed the acquisition of the insurer through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the insurer. This type of corporate structure warrants close attention ~~by analysts~~ to ensure that dividends are valid and in compliance with your state's applicable dividend restrictions, and that any other payments by the insurer to the holding company are legitimate, rather than dividends in disguise. Analysts should also be alert to a corporate structure that includes affiliated brokers or intermediaries that may be recording unusual or significant levels of commissions and fees. When a corporate structure is involved that includes multiple tiers of affiliates where significant levels of surplus are comprised of investments in affiliates, ~~analysts should~~ focus on the level of surplus that exists on a consolidated basis.

Additional steps may be performed if the insurer's corporate structure elevates concerns about transactions with affiliates. The primary objective is to understand the financial position of the parent company. By understanding the financial commitments of the parent, analysts will be able to better understand the parent's motivation for entering into transactions with the insurer or other affiliates. Financial statements of affiliates may reveal unauthorized transactions in progress.

The following procedures for the review of corporate structure and transactions with affiliates should consider any analysis already completed or anticipated to be completed with regard to the Holding Company Analysis performed by the lead state, review of the Form B – Registration Statement and any review of Form D – Material Transactions to avoid duplication of analysis.

Procedures

- Review the Annual Financial Statement, Schedule Y – Part 1 and additional information provided in Form B, for the current and prior year to determine:
  - if there any significant changes to the corporate structure during the year (e.g., acquisitions, divestitures, mergers).
    - If the answer is yes, and the change involved ownership of the insurer or a transaction with an affiliate, determine if the insurer failed -to receive proper regulatory approval.
  - if there are any indications that the corporate structure may include a holding company whose primary asset is the stock of an insurance company.
  - if the insurer has an agency or brokerage subsidiary.

Risks Associated with Significant and Complex Services and Transactions with Affiliates

~~**Affiliated Transactions—Economic-ased and In Compliance**~~***PROCEDURE #7*** ~~assists analysst in d~~Determineing ~~whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.~~

Several types of transactions with affiliates are reported in the Annual Financial Statement, Schedule Y – Part 2, and explanatory comments are provided in the Annual Financial Statement, Notes to Financial Statements, #10. In addition, information is made available in Note #13, as well as in holding company filings (Form B and Form D) that are received from insurance holding company systems throughout the year. ~~Analysts should r~~Refer to all of these sources of information in order to develop an understanding and assessment of the underlying transactions with affiliates.

Risks of Affiliated Transactions—Economic-Based and In Compliance

The primary objective in this area is to understand the substance of the transactions and to determine whether the transactions are economic-based and in compliance with regulatory guidelines. Review the extent of transactions with officers and directors to ensure that the transactions are at arm's length and are not detrimental to the financial condition of the insurer. Significant services and transactions with affiliates can alter financial performance and increase risks related to cost sharing, contingent liabilities, unauthorized dividends, etc.

Risk of Unauthorized Dividends, or Risks Related to Capital Contributions

The following briefly describes the key concerns ~~to analysts~~ for several of the major transactions with affiliates. For shareholder dividends, the major concern relates to whether the level of dividends is within the regulatory guidelines and whether the dividends should be considered extraordinary, and therefore requires prior regulatory approval.

For capital contributions from the insurer to another affiliate, analysts should determine that such contributions do not substantially impact the financial condition of the insurer.

For non-cash capital contributions to the insurer, analysts should determine that the infusion is recorded at fair value so as to not arbitrarily inflate surplus. In the case of purchases, sales or exchanges of loans, securities, real estate, mortgage loans, or other investments, the concern to analysts is primarily one of valuation. These types of transfers should be at arm's length and recorded at fair value.

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~~Analysts should a~~Also, be alert to possible abuses regarding the transfer of assets between property/casualty and life/health affiliates merely to impact the RBC calculation of the affiliates. For management agreements and service contracts, the main concerns ~~to analysts~~ 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. ~~Analysts should u~~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 analysts~~ to determine whether an arm's length transaction exists is to contact one of the vendors and request a proposal or fee estimate for a similar service.

In understanding and evaluating these transactions, ~~analysts should~~ identify any discrepancies in reporting across the various information sources. In addition, ~~analysts should~~ verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.

Procedures/Data

- Review the ratio of management fees paid to affiliates to total expenses incurred. (P/C Annual Financial Statement, Underwriting and Investment Income Exhibit, Part 3), (L/A&H Annual Financial Statement, Exhibit 2 General Expenses, Footnote (a)), or (Health Annual Financial Statement, Underwriting and Investment Exhibit, Part 3).
- Review the Annual Financial Statement, Schedule Y – Part 2, Notes to Financial Statement – Note #10 and Note #13, and additional information provided in Form B and D:
  - Determine whether any unusual items were noted, such as significant new transactions with affiliates or modified intercompany agreements from the prior year or significant increases in transaction amounts.
  - Determine whether the insurer has forwarded to any affiliate funds greater than 15% of the insurer's surplus.
  - Determine whether affiliated undertakings resulting in a contingent liability to the insurer involve financial exposure greater than 25% of surplus.
  - Review the description of management agreements and service contracts. Determine if an allocation basis involved other than one designed to estimate actual cost.
- Review the Annual Financial Statement, Schedule Y – Part 2 and the Notes to Financial Statements – Note #10 to identify any discrepancies in reporting between the two disclosures.
- Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved (e.g., Dividends – Note #13 and Structured Settlements – Note #27).
- Did capital contributions from the insurer to another affiliate substantially impact the financial condition of the insurer?
  - Were non-cash capital contributions into the insurer not recorded at fair value?
  - Were purchases, sales, or exchanges of loans, securities, real-estate, mortgage loans, or other investments, not at arms-length or not recorded at fair value?
  - Did any transfer of assets between insurance affiliates impact the risk-based capital calculation?
- **Risk Retention Groups:** Summarize the insurer's level of reliance on captive managers, TPAs, or MGAs to run its business operations (e.g., underwriting, claims, records, and reporting).

- If significant reliance exists, describe the services provided, and additional relationships, whether the expense ratio is in line with indstry standards, and whether those parties service other insurers.

Additional Review Considerations
Take additional steps if concerns regarding the economic substance of an affliated transaction are identified. Such steps include independent appraisals, comparisons to third-party services/bids, detailed review of contracts, review of the financial condition of the affiliate, reviewing collection, etc. In addition, the analyst should consider recommending procedures for the next examination (targeted or full-scope) to verify information reported on transactions with affiliates and to further evaluate the fairness and reasonableness of charges. In so doing, consider additional guidance regarding criteria to be considered in determining whether an agreement with affiliates merits review during an onsite examination at section V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide (Form D - Prior Notice of a Transaction).

- If there is a concern related to the fair value of a transaction with affiliates:
  - Obtain and review an appraisal of the asset transferred.
  - Consider consulting an independent appraiser.
- If the concern involves a management agreement or service contract:
  - Obtain and review the supporting contract and compare against Form D filing previously submitted to the department (if applicable).
  - Determine whether the amounts involved are reasonable approximations of actual costs.
  - Determine whether the actual amounts paid are in agreement with the supporting contact.
  - For any arrangement based on a cost-plus formula or percent of premiums formula, request justification from the insurer for amounts in excess of the actual costs of providing the service.
  - For those services being performed by/for an affiliate and that are also provided by unrelated third-party vendors (e.g., data processing, actuarial, investment management), contact such vendors or review vendor pricing schedules in order to determine the reasonableness of the intercompany transfer pricing level.
  - Evaluate whether any portion of such fees in substance dividends should be evaluated in the contact of dividend regulations.
  - Determine if agreements received appropriate regulatory approval in conformity with regulatory requirements.
  - Consider whether additional examination procedures should be recommended to verify/validate information regarding transactions and services with affiliates or to further consider whether the expense allocations continue to be fair and reasonable.
  - See additional guidance regarding criteria to be considered in determining whether an agreement with affiliates merits review during an onsite examination at section V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide (Form D - Prior Notice of a Transaction).

Risk of Affiliated Transactions—Not Legitimate or Not Properly Accounted For
Determine whether other transactions with affiliates are legitimate and properly accounted for.

Exposure to Collectability Risk

Closely monitor other transactions with affiliates to ensure that the insurer is not exposed to significant collectability risk. For example, if the insurer is included in a consolidated federal income tax return and a significant asset for federal income tax recoverable is recorded on the financial statements of the insurer, Closely review the financial statements of the parent to determine the parent's ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectability risk to the insurer. When the amounts of structured settlements are significant, analysts should review and understand the financial statements of the life insurance affiliate.

~~***PROCEDURE #8*** assists analysts in d~~Determin~~e~~ing whether other transactions with affiliates are legitimate and properly accounted for.~~

~~Analysts' The primary objective in this area is to understand the substance of the transactions and to determine whether the transactions are economic based. Analysts should rReview 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. Analysts should cClosely monitor other transactions with affiliates to ensure that the insurer is not exposed to significant collectability risk. For example, if the insurer is included in a consolidated federal income tax return and a significant asset for federal income tax recoverable is recorded on the financial statements of the insurer, analysts should cClosely review the financial statements of the parent to determine the parent's ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectability risk to the insurer. When the amounts of structured settlements are significant, analysts should review and understand the financial statements of the life insurance affiliate.~~

Procedures/Data

- Review the following ratios to determine the level of affiliated transactions:
  - Affiliated receivables to policyholder surplus.
  - Affiliated payables to policyholder surplus.
  - Federal income tax recoverables to policyholder surplus (P&C) or to capital and surplus (Life/A&H, and Health).
  - Health: Non-current balances [Health Annual Financial Statement, Exhibit 6]
  - Health: Ratio of payments made to affiliated providers to total payments
- Determine if any foreign entity controls 10% or more of the insurer, either directly or indirectly, through a holding company system. [Annual Financial Statement, General Interrogatories, Part 1, #7.1 and #7.2.].
  - If so, determine if the insurer properly disclosed the investment in Schedule Y, Part 1.
- Review the Annual Financial Statement, General Interrogatories, Part 1, #20.1 and #20.2 to assess the exposure to loans to directors, officers, and other stakeholders:
  - Ratio of total amount loaned to directors, other officers, or stockholders to net income.
  - Ratio of total amount of loans outstanding at the end of the year to directors, other officers, or stockholders to policyholder surplus.
- Determine if the insurer has failed to establish a conflict-of-interest disclosure policy [Annual Financial Statement, General Interrogatories, Part 1, #18].
  - If so, is there any evidence that activities of directors, officers or shareholders were in violation of state statutes?

Additional Review Considerations

- Review Annual Financial Statement, Schedule E – Part 1:
  - Determine if any open depositories a parent, subsidiary, or affiliate.
  - Based upon a review of the holding company financial statements (as filed with the Annual Holding Company Registration Statement Form B), determine if any holding company lenders reported that also appear as open depositories of the insurer.
  - If holding company lenders also appear as open depositories of the insurer, verify this is properly disclosed on Schedule Y – Part 1
  - Determine if there is any evidence that activities directors, officers and shareholders were in violation of state statutes
- Review the Annual Financial Statement, Notes to Financial Statements, Note #9:
  - If the insurer is included in a consolidation federal income tax return, note any concerns relating to how taxes are allocated to the insurer.
  - Review the tax-sharing agreement and verify whether the terms are being followed.
  - Obtain and review the financial statements of the parent of affiliate and evaluate any collectability to the insurer.
  - Verify whether the amount recoverable from the prior year-end has been collected/recovered.
  - If federal income tax recoverables are greater material to surplus, and if there are federal income tax recoverables due from an affiliate.
  - If the concern relates to federal tax recoverables from a parent or affiliate:
    - Obtain and review the financial statements of the parent or affiliate, and evaluate any collectability risk to the insurer
    - Review the tax-sharing agreement, and verify that terms of the tax-sharing agreement are being followed
    - Verify that the amount recoverable from the prior year-end has been paid
- Review the Annual Financial Statement, Notes to Financial Statements, Note #27:
  - Determine if the insurer has acquired structured settlements from an affiliated life insurance company.
  - If so, determine if the amount of loss reserved eliminated by annuities greater material to surplus.
  - Determine the current rating of the affiliates from the major rating agencies, if available.
  - Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.
  - Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.
  - Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.
- Review the Annual Financial Statement, General Interrogatories, Part 2, #5. In case of reciprocal exchange:
  - Check for any unusual items noted regarding compensation of the attorney-in-fact.
  - If there is an approved agreement on file with the insurance department, review the Articles of Agreement.

If unusual items were noted, determine if the insurer properly disclosed the investment on the Annual Financial Statement, Schedule Y – Part 2.

- If not properly disclosed in Schedule Y – Part 2, determine if any evidence exists that activities of directors, other officers, or shareholders were in violation of state statutes.

- Are there any financial guarantees in place, in any form between the insurer and any member of the holding company system?
- Review the Annual Financial Statement, Schedule SIS to determine if there are any unusual items noted regarding transactions with, or compensation to directors and officers.
- Assemble a list of all affiliated and other related parties and summarize the financial impact of each transaction. Identify any other unusual transactions and investigate for reasonableness.

Health Only:

- If concern exists regarding downstream risk with affiliated provider intermediaries:
    - Obtain and review the Audited Financial Report and Annual Financial Statement of the affiliate, if available.
    - Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups, if available.
    - Obtain and review the actuarial opinion of the affiliate, if available.
    - Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.
- Review the Annual Financial Statement, Exhibit 5.
    - Are there any balances over 90 days, which are admitted?
    - Does the exhibit otherwise suggest that the insurer may have collectability issues with its affiliates?
    - Are any of the receivable balances from an affiliate which the insurer also reports a payable balance on Exhibit 6 and could therefore net the balances on the face of the balance sheet if the requirements of SSAP 64 were met?
    - Is the analyst aware of any receivable balances from an affiliate which has experienced some financial problems?
    - Are there any affiliated receivable balances from medical providers or intermediaries included on Exhibit 5?
- Review the Annual Financial Statement, Exhibit 6. Are any of the balances unusually large for the description or are any of the descriptions unusual?
- Review the Annual Financial Statement, Exhibit 7 – Part 1. Has there been any indication that the amount charged by the affiliated provider is non-economic or non-arms-length?

MGAs and TPAs

Property/Casualty #	***Life/A&H/Fraternal #***	***Health #***
9	***9***	***9***

Significant Reliance on MGAs and TPAs

Concerns with MGAs and TPAs

PROCEDURE #9 assists analysts in dDetermineing whether concerns exist due to a significant amount of the insurer's direct premiums being written through MGAs and TPAs.

While the amount of direct premiums written by MGAs and TPAs is not necessarily an indication of a problem or concern, this procedure provides an indication to analysts 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.

~~Analysts may p~~Perform additional steps if there are concerns regarding the insurer's use of MGAs and TPAs. ~~Analysts should c~~Consider reviewing the information in the Annual Financial Statement, Notes to Financial Statements, Note #19 to determine which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the insurer), the types and amount of direct premium written by each, and the types of authority granted to each by the insurer.

For the more significant MGAs and TPAs, ~~analysts 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, ~~analysts might~~ consider determining whether the MGA or TPA is affiliated with the reinsurer. In addition, ~~analysts should~~ consider reviewing the reinsurance agreements to determine whether the terms are reasonable. For the more significant MGAs and TPAs, ~~analysts 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, ~~analysts 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, ~~analysts 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. ~~Analysts should a~~Also consider requesting from the insurer copies of financial statements for the significant MGAs and TPAs and documentation supporting the insurer's periodic (at least semi-annual) review of the underwriting and claims processing systems. If there are concerns regarding the business placed with the insurer by an MGA or TPA, analysts should consider determining if other insurers are utilizing the same MGA or TPA and comparing the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates).

Procedures/Data
Determine whether concerns exist due to a significant amount of the insurer's direct premiums being written through managing general agents (MGAs) and third-party administrators (TPAs).

- Determine if any agent, general agent, broker, sales representative, non-affiliated sales/service organization, or any combination thereof under common control (other than salaried employees of the insurer) received credit or commissions for or control a substantial part of either the sale of new business or renewals. [Annual Financial Statement, General Interrogatories, Part 1, #4.1 and #4.2].
- Determine if the aggregate amount of direct premiums written through MGAs and TPAs to total direct premiums written were material. [Annual Financial Statements, Note #19].
- Health: Ratio of Aggregate direct premiums written through MGAs and TPAs to 11Xand surplus.

- Health: Ratio of direct medical expense payments made to intermediaries to total medical expense payments.

Additional Review Considerations

- Review the Annual Financial Statement, Notes to Financial Statements, Note #19 (which lists all individual MGAs and TPAs whose direct writings are greater than 5% of surplus), determine the following:
  - Which MGAs and TPAs are being utilized and whether any are affiliated with the insurer.
  - The types and amount of direct business written by MGAs and TPAs.
  - The types of authority granted to the MGAs and TPAs by the insurer.
- Determine whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid certificates of authority. In some states, an insurer may utilize an MGA who is not licensed if biographical questionnaires have been submitted for each individual owning more than 10% of the MGA. If this provision is applicable and the MGA is not licensed, verify that the required biographical questionnaires have been submitted.

For the more significant MGAs and TPAs, if further concerns exist request the following information from the insurer to evaluate:

- P&C: The comparability of the incurred loss and LAE ratios on the business written by the MGA and TPA with that written directly by the insurer (for the lines of business in which significant, but not all, direct business is written through the MGA/TPA).
- Whether the business produced by the MGA and TPA is ceded to a particular reinsurer and, if so, whether that reinsurance was arranged by the MGA or TPA. If the MGA or TPA arranged for the reinsurance, determine whether the MGA or TPA is affiliated with the reinsurer, and consider reviewing the reinsurance agreements to determine whether the terms are reasonable.
- Commission rates and any other amounts paid to the MGA and TPA. Review the information for reasonableness and compare the commission rates to those paid by the insurer to other agents.
- Whether the contracts between the insurer and MGA include minimum required provisions per Section 4 of the NAIC *Managing General Agents Act* (#225) and/or the applicable sections of the insurance code.
- Whether the contracts between the insurer and TPA include minimum required provisions per Sections 2,4,6,7 and 8 of the NAIC *Registration and Regulation of Third-Party Administrators* (#1090) and/or the applicable sections of the insurance code.
- The most recent independent CPA audit or annual report of the MGA or TPA (or IPA for Health Entities).
- For P&C: If the MGA establishes loss reserves, the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA.
- Documentation supporting the insurer's periodic (at least semi-annual) on-site review of the MGA's underwriting and claims processing operations.
- Documentation supporting the insurer's periodic (at least semi-annual) review of the underwriting and claims processing operations of the TPA (or IPA for Health Entities). (Model #225 requires at least one of the semi-annual reviews to be an on-site audit of the operations of the TPA.)
- For Health Entities, consider requesting from the insurer:
  - A listing of significant TPAs and IPAs that pre-authorize, or process claims for the insurer, by line of health business (e.g., pharmacy, vision, mental health) and/or provider types (Hospitals, Physicians).

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  - Whether the TPAs and IPAs utilized by the insurer are properly licensed to process, preauthorize or otherwise administrator claims.
  - Contracts between the insurer and the TPA or IPA to determine whether the contracts include minimum provisions.
- For Health Entities, review analyst notes or exam reports for the other companies using the same intermediaries if there is reason to believe problems exist with those entities.
- For Health Entities, if, with respect to business produced by the TPA or IPA, the TPA or IPA provides the insurer with claim reserve and/or claim adjustment expense reserve estimates that are incorporated into the insurer's financial statement, an opinion from an actuary employed or retained by the TPA or IPA attesting to the adequacy of such reserves.
- For Health Entities, if the TPA or IPA provides paid claims data that is used by the insurer in establishing claim reserves, determine whether the insurer or the actuary providing the insurer's claim reserve certification tested data provided by the TPA or IPA.

If there are concerns regarding the business placed with the insurer by an MGA or TPA, consider determining if other insurers are utilizing the same MGA or TPA and perform the following:

- Compare the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether the contracts are similar (e.g., contain the same commission rates).
- Compare the insurer's loss and LAE ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer may be receiving a disproportionate amount of "bad" business from the MGA or TPA.

~~Separate Accounts~~

~~***Property & Casualty #***~~	~~***Life/A&H/Fraternal #***~~	~~***Health #***~~
~~***N/A***~~	~~***10***~~	~~***N/A***~~

~~Concerns with~~ Risks With Management of Separate Accounts (Life/A&H)

~~***PROCEURE #10***~~ ~~assists analysts in d~~Determin~~ing~~e whether concerns exist regarding the appropriateness of business being placed within separate accounts or regarding transactions between the general account and the separate account. Challenges in properly managing and reporting separate account business and transactions with the general account may mask true financial performance and/or understate liabilities due to the separate account.

Criteria for qualifying for separate account classification under GAAP are outlined in *Statement of Statutory Accounting Principles (*SSAP*) No. 56—Separate Accounts*. A separate account product must meet four conditions as defined in Separate Accounts Annual Financial Statement, General Interrogatories, #8.2 in order to receive separate account classification: 1) legal recognition; 2) legal insulation; 3) investment directive; and 4) investment performance. If an insurer reports any products that do not meet these criteria, analysts should review the conditions listed in Separate Accounts Annual Financial Statement, General Interrogatories, #8.3 and further review the details of the separate account disclosures, as this is an indication the insurer includes products in its separate account that are not true separate account products.

Some insurers may include non-variable (non-unit linked) products in the separate account. Separate Accounts Annual Financial Statement, General Interrogatories, #8.3 may assist analysts in determining if such products are included. Analysts should gain an understanding of the reasons why non-variable products are included in the separate account. Analysts may need to contact the policy form unit within the insurance department to obtain information about the policy form application and approval to help gain such understanding of the products included in the separate account. Analysts may need to contact the insurer to request additional information about the policies included in the separate account. Considerations may include: What investment guidelines apply to these products? Outside of product guarantees, does the general account have any responsibilities for funding the reserve liabilities?

If the insurer filed a non-insulated separate accounts statement, *Procedure #10.b.* assists analysts in gaining an understanding of the insurer's non-insulated products.

All separate accounts activity reaches the Separate Accounts Annual Financial Statement through the General Account Annual Financial Statement. Premiums are recorded in the general account and then "transferred to" the Separate Accounts Annual Financial Statement through the item Net Transfers to or from Separate Accounts (referred to as "above the line" activity). Once the premiums have been moved to the separate accounts, all direct investment activity and reserve changes are recorded on the Separate Accounts Annual Financial Statement. Seed money is "contributed to or withdrawn from" the Separate Accounts Annual Financial Statement through the item Surplus (contributed to) withdrawn from Separate Accounts during the period (referred to as "below the line" activity).

Additional procedures assist analysts in determining that the accounting for activity between the separate accounts and the general accounts is proper. The primary concern here is to properly classify such activity as to "above the line" (i.e., recorded on the Net Transfers to or (from) Separate Accounts line on the general account) or "below the line" activity (i.e., recorded on the Change in Surplus in Separate Accounts Statement on the general account). An additional area analysts should investigate in this regard is the level of investment management fees charged to the separate accounts. The SEC has set maximums for the level of such fees. Common industry practice is for this fee to range between 125 and 140 basis points on separate accounts assets.

Procedures/Data

Determine whether concerns exist regarding the appropriateness of business being placed within separate accounts or regarding transactions between the general account and the separate account.

- Determine if the insurer reported any separate account products that do not meet separate account GAAP classification? If so, review in detail the products and conditions listed. [Separate Accounts Financial Statement, General Interrogatory #8.3]
- Determine if the insurer filed a non-insulated separate accounts statement. Identify and document any concerns regarding the inclusion of non-insulated products in the separate account.
- Portion of capital and surplus funds of the insurer covered by assets in the Separate Accounts Financial Statement greater than capital and surplus
- Portion of capital and surplus not distributable from the separate accounts to the general account for use by the general account. [Annual Financial Statement, General Interrogatories, Part 2, #3.3]

- Compare the amounts recorded on page 4, line 20 of the Separate Accounts Financial Statement, contributed surplus, to Page 4, line 46 of the General Account Financial Statement, surplus (contributed to) withdrawn from separate accounts during period and verify the amounts reconcile.
- Determine if other changes in surplus in the Separate Accounts Financial Statement are greater than capital and surplus.

Additional Review Considerations

- Determine if any non-variable (non-unit linked) products were reported in the Separate Account. If so:
  - Review the specific product information to determine and understand the reasons for including non-variable products in the separate accounts.
  - Identify and document any concerns regarding the non-variable products' inclusion in the separate accounts.
- Request additional information from the insurer of any unusual or non-variable (non-unit linked) products included in the separate accounts.
- Review the Annual Financial Statement, Notes to Financial Statements, Note #35 – Separate Accounts.
  - Determine if the amounts transferred between the general account and separate accounts statement(s) reconcile.
  - Determine if any recording adjustments are noted.
  - Determine if the net amount of all reconciling items is material to statutory net income.
- Assess and determine if any additional concerns exist regarding separate accounts reporting.
- Review the Separate Accounts Annual Financial Statement and the General Account Annual Financial Statement and:
  - Verify that the separate accounts gain from operations is properly recorded in the capital and surplus section of the General Account Summary of Operations.
  - Verify that all other premium and benefits activity is properly recorded on the net transfers to or (from) separate accounts line of the General Account Summary of Operations.
  - Review the Separate Accounts Summary of Operations and surplus account in order to identify potential misclassifications as to "above the line" and "below the line" classifications.
- Review the level of investment management fees charged to the separate accounts to determine that they are in the generally accepted range of 125 to 140 basis points on separate accounts assets.
- Review the insurer's response to Annual Financial Statement, General Interrogatories, Part 2, #3.3. Assess if any concerns exist regarding the portion of capital and surplus funds of the insurer covered by assets in the Separate Accounts Financial Statements that are not currently distributable from the separate accounts to the general account for use by the general account.

~~Risk Transfer Arrangements Other Than Reinsurance~~

~~*Property/Casualty #*~~	~~*Life/A&H/Fraternal #*~~	~~*Health #*~~
~~*N/A*~~	~~*N/A*~~	~~*10, 11, 12*~~

Risk Transfer Agreements Other Than Reinsurance (Health)

~~***PROCEDURE #10***~~ ~~assists analysts in d~~Determin~~eing~~ whether experience rating arrangements are significant, reasonable and paid on a timely basis.

Concerns with Experience Rated Arrangements

The materiality of experience rated arrangements is determined by comparing the amount due from groups (from write-in for other than invested assets) and the amount due to groups (from reserve for rate credits or experience rating refunds on the Annual Financial Statement, Underwriting and Investment Exhibit, Part 2D, Line 4) to total hospital and medical benefits paid. If experience rating arrangements are significant, analysts should determine whether amounts are reasonable and settled on a timely basis by comparing to prior year balances and inquiring of the company, if necessary.

Procedures/Data

- Determine if experience rating arrangements are significant, reasonable, and settled on a timely basis.
  - Compare reserve for rate credits or experience rating refunds to total hospital and medical expenses. Determine if the insurer reported reserve for rate credits or experienced rating refunds to be collected from the prior year. If not settled on a timely manner, inquire with the insurer for any balances outstanding. [Annual Financial Statement, Underwriting and Investment Exhibit – Part 2D, Line 4]
  - Compare amounts due from experience rating arrangements from the write-in for other than invested assets to total hospital and medical expenses. Determine if the insurer reported amounts due from experience rating arrangements.
  - Determine whether the insurer has reported appropriate reserves. Determine if a premium stabilization reserve been included in the reserve for rate credits or experience rating refunds. [Annual Financial Statement, Underwriting and Investment Exhibit – Part 2D, Line 4]

Concerns with Capitation Agreements and Payments

~~***PROCEDURE #11***~~ ~~assists analysts in d~~Determin~~e~~ ~~ing~~ whether capitation payments with providers are material and whether risks exist with providers' or intermediaries' ability to meet capitation agreement obligations. The significance of capitation payments is determined by comparing their total to hospital and medical benefits paid. Also, the percent of capitation being paid to intermediaries or "other providers" is reviewed to determine if there is a disproportionate amount being paid to these entities and the proportion of bonuses and withhold payments is reviewed for appropriateness. If capitation payments are material, analysts are asked to review whether provider agreements have been filed with the department and if the arrangements are properly reflected in RBC reporting. If an intermediary (TPA or Individual Practice Associations (IPA)) is involved in capitation payments, analysts are encouraged to request audited financial statements for the intermediary (to verify financial position) and to consider obtaining and reviewing an actuarial opinion on the reserves established for claims incurred and outstanding on business produced by the intermediary.

Determine if capitation payments with providers are material and if so, whether risks exist with providers' or intermediaries' ability to meet capitation agreement obligations.

Procedures/Data

- Compare total capitation payments to intermediaries to total hospital and medical expenses [Annual Financial Statement, Exhibit 7 – Part 1]
- Health care receivables to capital and surplus.
- Percentage of members covered by capitated arrangements based on capitation payments to total payments.

Additional Review Considerations

- Determine if the insurer has completed Annual Financial Statement, Exhibit 7 – Part 1.
- Determine if the insurer has capitation agreements with providers.
  - Determine if there are copies of provider agreements with domiciliary jurisdiction.
  - If the insurer has capitation arrangements with providers, ensure the appropriate information has been entered in the RBC filing (worksheet XR017).
- Determine if capitation to groups or intermediaries reported in Annual Financial Statement, Exhibit 7 is actually disbursed or withheld by the insurer for future payment of claims as they are submitted.
- Determine if the insurer pays or processes claims for the participating providers of a capitated intermediary.
- Request the most recent independent audited report of the intermediary (TPA or IPA). If not available, request the most recent annual report.
- Obtain the opinion of an actuary attesting to the adequacy of claim reserves and claim adjustment expenses established for claims incurred and outstanding on business produced by the intermediaries, if available.
- Review analyst notes or exam reports for the other companies using the same intermediaries if there is reason to believe problems exist with those entities.

Concerns with Special Payment Arrangments

PROCEDURE #12 assists analysts in dDetermineing whether special payment arrangements (i.e., bonuses and withholds) with providers are material, reasonable and reported correctly. The significance of special payment arrangements is determined by comparing their total to hospital and medical benefits paid. Also, the percent of bonus/withhold to intermediaries or "other providers" is reviewed to determine if there is a disproportionate amount being paid to these entities and/or if the level paid is appropriate.

12a and 12b assist analysts in dDetermineing if the health entity's use of bonus and withhold arrangements are significant. Since health entities use these arrangements to different degrees, it is important to determine the significance of their use by the health entity under review. These procedures determine if the amount of bonus and withhold liabilities and expenses compared to the total hospital and medical expense is significant.

12d and 12e assist analysts in dDetermineing the significance of the liabilities outstanding for bonuses and withholds. While these procedures focus on materiality, there are very few tests that can be made to verify that provider liabilities are appropriate. Provider contracts often change dramatically from year to year, limiting the value of year-over-year comparisons. These liabilities build up over the contract period and then are paid, decreasing the liability to zero. Contract periods for different providers may cover different periods so that wide fluctuations can be seen from period to period. Therefore, analysts are encouraged to perform other qualitative procedures to evaluate provider liabilities such as reviewing the Statement of Actuarial Opinion, reviewing provisions in provider contracts and obtaining the detailed calculation supporting the liabilities.

12r assists analysts in vVerifying that information that is reported in the financial statement for the health entity is consistent with what is reported in the health entity's RBC filing. Since withholds and bonuses are reported both in the Annual Financial Statement and in the RBC filing, they should not appear in one and not the other. This procedure also assists analysts in determining if a significant amount of the prior year's withholds and

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bonuses available were not paid during that reporting year. Withholds and Bonuses Available represent the total amount that could have been paid in withholds and bonuses. (This information is provided in the RBC filing on page XR016.) The amount paid compared to the amount available provides analysts with a rough indication of how well provider groups were able to meet their contract goals. Further analysis may be necessary in order to determine whether the provider group is able to meet its financial or operational goals in its contracts with the health entity, currently and going forward. Provider groups not being able to meet their financial and operational goals and thus not earning all of their withholds in one year can result in higher claims costs than anticipated and/or less favorable contracts in the next contracting cycle.

Additional procedures may be performed if there are concerns regarding the amount of prior year withholds and if bonuses available not paid were significant. If the level of these arrangements is significant, it is important to determine if any actual risk is being transferred. Potentially, these arrangements could be used to create the appearance of capitated risk transfer when in fact the bonus and withholds result in no actual risk transfer. Since these arrangements reduce RBC, capital requirements could be understated. Some health entities have many types of contracts with providers, but it is possible to request that a health entity provide the primary contracts with its largest contracting providers.

It is also important to determine if these arrangements are concentrated within a few providers. If there is a concentration, any financial weakness of the providers could result in them not being able to fulfill their part of the risk transfer contract. Standards published by the Actuarial Standards Board of the American Academy of Actuaries (Actuarial Standard of Practice 16) requires that the actuarial opinion disclose the actuary's knowledge of the health entity's capitated risk contracts indicating if the actuary evaluated the financial position of the contracting providers. The actuarial opinion should be reviewed to determine if the capitated risk contracts, as well as the financial strength of the contracting providers were or were not reviewed by the opining actuary. It may be necessary to contact the qualified actuary to discuss his or her review and potential concerns.

It is possible that the contracting provider is actually an affiliate of the health entity. This can be the case where hospitals own HMOs that then contract back to the parent hospital. These arrangements should be understood for potential impact of the financial weakness of any of the participants.

Determine whether the insurer's special payment arrangements (i.e., bonus and withold arrangements) with providers are material, reasonable, and reported correctly.

Procedures/Data

- Compare total bonus/withhold arrangement payments to total hospital and medical benefits.
- Compare pool/withhold arrangement payments to total bonus/withhold accrual.
- Bonus/withhold payments and prior year underwriting losses.
- Liability for accrued medical incentive pool and bonus payments to total hospital and medical expense.
- Liability for amounts withheld from paid claims and capitations to total hospital and medical expense.
- Incentive pool and withhold adjustments expense to total hospital and medical expense.
- Change in bonus/withhold accrual from prior year to current year.

Additional Review Considerations

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- Review the Annual Financial Statement, General Interrogatories, Part 2. Determine if the insurer reported bonus/withhold arrangements with providers.
- Determine if risk transfer arrangements with providers have had a negative impact on utilization. Review the Exhibit of Premiums, Enrollment, and Utilization in the Annual Financial Statement and compare to prior years. Determine if utilization compared to membership increased.
- Determine if the insurer failed to comply with state-specific laws, regulations, or guidelines regarding arrangements for risk transfer other than reinsurance.
- Request a listing of provider groups contracting with the insurer.
- Review the Statement of Actuarial Opinion to determine if capitation arrangements were reviewed.
- Review the Statement of Actuarial Opinion to determine if:
  - The financial strength of contracting provider groups was or was not reviewed or excluded by the opining actuary.
  - Provider insolvencies were considered when determining the reserves and liabilities.
- Evaluate the financial condition of the largest contracting provider groups.
- Contact the qualified actuary who signed the insurer's actuarial opinion to discuss the nature and scope of the review of the provider contracts.
- Review bonus/withhold provisions of the provider contracts.
- Obtain detailed calculation of direct bonus and withhold payments, and accruals and those covering capitated arrangements.
- Request information concerning the specific contract provisions of the primary bonuses and withhold arrangements that the insurer is using.
- Request withheld and bonus liability amounts (included in "Accrued medical incentive pool and bonus payments" from Page 3, Column 3, Line 2) for the top five provider groups.
- Evaluate the appropriateness of withhold distributions or bonus payments made to providers relative to contract provisions and the insurer's underwriting results.
- Determine whether the insurer is compliant with RBC filing requirements and verify that amounts reported for bonuses and withholds in the insurer's Risk-Based Capital (RBC) filing are consistent with what is reported in the Annual Financial Statement filing.
  - Determine if there is an amount entered in accrued medical incentive pool and bonus Payments on Page 3, Column 3, Line 2, even though the RBC filing on worksheet XR017.
  - Column 2, Lines 3 and 4, indicates that no business is subject to withholds or bonuses
  - Determine if there is no amount entered in accrued medical incentive pool and bonus payments on Page 3, Column 3, Line 2, even though the RBC filing on worksheet XR017 Column 2, Lines 3 and 4, indicates that some business is subject to withholds or bonuses.
  - Determine if the prior year withholds and bonuses paid differed by more than 40% from prior year withholds and bonuses available from RBC worksheet XR017 in the RBC filing. (XR018: ABS (Line 18 - Line 19)/(Line 18)).
  - If amounts reported for bonuses and withholds in the insurer's RBC filing appear to be potentially inconsistent with what is reported in the annual statement filing, request that the insurer provide an explanation. If further analysis indicates that there is a disconnect between the two filings, request that the insurer amend whichever filing is incorrect.

Cybersecurity		
Property/Casualty #	Life/A&H/Fraternal #	Health #
10	11	13

Exposure to Cybersecurity Risk
Ineffective Mitigation of Cybersecurity Risk

The procedure assists analysts in dDetermineing whether concerns exist regarding the insurer's exposure to and mitigation of cybersecurity risk.

Cybersecurity is defined as a set of technologies and processes that protect a company's information system as well as information stored on the system. An insurer's exposure to cybersecurity risk may be influenced by its size and complexity, the nature and scope of its activities, and the sensitivity of non-public information used by the insurer or in the insurer's possession, custody or control. These potential cyber risks may directly lead to financial loss and/or reputational risk. As cybersecurity events become more prevalent, there are additional pressures for insurers to enhance their information security program to protect personal and sensitive information. Therefore, the NAIC adopted the *Insurance Data Security Model Law* (#668) in October 2017 to outline requirements for insurers in addressing cybersecurity risks. States are expected to adopt the model in the coming years, which should result in more consistency and authority for state insurance regulators in this area. However, in the meantime, analysts may consider discussing, reviewing and assessing risks in this area on a more frequent basis than the routine examination schedule. As cybersecurity activities and controls are commonly conducted at the group level, efforts may need to be coordinated with the lead state.

Procedures

- Gain an understanding of and evaluate the company's exposure to and mitigation of cybersecurity risk by reviewing recent exam results and findings, company documentation, and other relevant information. Considerations may include whether the company's information security program appropriately identifies, prevents, detects and responds/recovers from cybersecurity events. Concern may be heightened in the event of companies with planned mergers or acquisitions (and the resulting system integration), system updates, and/or significant unresolved findings from financial exam or other third-party security audits. If the analyst's level of concern merits additional analysis, consider performing the following procedures:
  - Obtain and review information on the cybersecurity insurance coverage maintained by the insurer to limit exposure to cybersecurity events.
  - Inquire on recent adjustments made to the company's information security program to address emerging threats and vulnerabilities.
- If material risk warrants further investigation, or more technical analysis, the analyst should consider seeking the expertise of a cybersecurity expert (e.g., internal examination staff or external consultants) to conduct additional risk analysis and/or target examination in this area. If the cybersecurity expert's level of concern merits additional analysis, consider performing the following procedures in the scope of the work to be performed by the expert:

- Obtain and review results of recent vulnerability assessments and/or penetration tests to identify weaknesses in the existing security framework.
- Obtain and review results of external/internal security audits, including those performed by other regulatory agencies–e.g., Office of Management and Budget (OMB) or Federal Reserve (FRB)–and corresponding changes to the company's security techniques (e.g., firewalls or intrusion detections, logical access controls (e.g., user access rights or authentication mechanisms) and disaster recovery processes).

- If the state has passed the NAIC's *Insurance Data Security Model Law* (#668), consider:
  - Obtaining and reviewing any changes to the company's information security program to ensure compliance with the law's provisions, which notably include sections on oversight by board of directors and oversight of third-party service provider arrangements.
  - Ensuring the company has submitted an "Annual Certification to Commissioner of Domiciliary State," which is a new requirement under the Model #668 whereby an insurance company asserts compliance with Section 4 of the model law (i.e., risk assessment, risk management, oversight by board of directors, etc.).
  - Reviewing any recent notifications of a cybersecurity event provided by the company in accordance with Section 6 of Model #668.
    - Gain an understanding of the nature and extent of any cybersecurity event and its expected impact on the company's reputation and financial standing.
    - For each cybersecurity event, determine whether the company took appropriate steps to remediate, including timely reporting to impacted stakeholders, protection of policyholders against identity theft and/or corrective actions to address identified weaknesses in IT security.
- If the state has not passed Model #668, consider obtaining and reviewing information regarding any cybersecurity events the company has detected over the past 12 months.
  - Gain an understanding of the nature and extent of any cybersecurity event and its expected impact on the company's reputation and financial standing.
  - For each cybersecurity event, determine whether the company took appropriate steps to remediate, including timely reporting to impacted stakeholders, protection of policyholders against identity theft and/or corrective actions to address identified weaknesses in IT security.

ADDITIONAL ~~ANALYSIS AND FOLLOW-UP~~ PROCEDURES APPLICABLE TO OPERATIONAL RISK

Examination Findings

~~direct analysts to c~~Consider a review of the recent examination report, summary review memorandum and communication with the examination staff to identify if any operational risk issues were discovered during the examination with any of the following:

- Operating Performance
- Information Technology (IT) Systems
- Cybersecurity
- Fraud
- Internal Controls
- Disaster Recovery

- Transactions and services with affiliates

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

- ~~**OVERALL OPERATING PERFORMANCE** directs analysts to perform additional steps, as necessary, to understand and evaluate issues related to the insurer's operating performance. Such steps include comparing actual results to projections, reviewing details of expenses by comparing to prior years and industry averages, and requesting additional information from the insurer and/or third parties (i.e., federal Centers for Medicare & Medicaid Services—CMS) to evaluate performance.~~

~~**Medicare Part D Operating Performance (Life/Health)** directs analysts to obtain and review supporting documents if concerns are identified related to the operating performance of Medicare Part D business. Supporting documents may include information on contracted benefits, premium and cost sharing with the CMS, and support for reserve, utilization and benefit cost assumptions projected in the development of the contract.~~

~~**CORPORATE GOVERNANCE** directs analysts to use the CGAD and/or request additional information from the insurer (if filed on an insurance enitty basis or your state is the lead state) to review and evaluate relevant policies and processes such as board/committee charters, code of conduct policy, conflict of interest policy, bylaws, compensation policies, etc. If you state is not the lead state rely on information provided in the GPS or provided by the lead state, where the CGAD is filed on a group basis.~~

~~**transactions with affiliates** direct analysts to take additional steps if concerns regarding the economic substance of an affliated transaction are identified. Such steps include independent appraisals, comparisons to third-party services/bids, detailed review of contracts, review of the financial condition of the affiliate, reviewing collection, etc. In addition, the analyst should consider recommending procedures for the next examination (targeted or full-scope) to verify information reported on transactions with affiliates and to further evaluate the fairness and reasonableness of charges. In so doing, the analyst should consider additional guidance regarding criteria to be considered in determining whether an agreement with affiliates merits review during an onsite examination at section V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide (Form D - Prior Notice of a Transaction).~~

~~**MGAs AND TPAs** direct analysts to take additional steps if concerns regarding significant MGAs, TPAs and IPAs are identified. Such steps include comparing the performance of MGA/TPA/IPA business to other business written by the insurer, reviewing the reasonableness of commissions and fees paid, performing detailed contract review, obtaining audited financial statements, etc.~~

~~Risk transfer~~ ~~Transfer~~ ~~other~~ ~~Other~~ ~~than~~ ~~Than~~ ~~reinsuRance~~ ~~Reinsurance~~

~~directs~~ ~~Directs~~ ~~analysts to take additional steps if concerns are identified in this area, including requesting and reviewing provider contracts, requesting and reviewing liability amounts for the top five provider groups, and contacting the appointed actuary regarding the nature and scope of the review of provider contracts during the actuarial review.~~

~~OWN~~ Own ~~RISK~~ Risk ~~AND~~ and ~~SOLVENCY~~ Solvency ~~ASSESSMENT~~ Assessment (ORSA)

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

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

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

HOLDING Holding COMPANY Company ANALYSIS Analysis

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

- Determine if the Holding Company analysis conducted by the lead state indicates any operational risks impacting the insurer that require further monitoring or follow-up.
- Determine if the Holding Company analysis conducted by the lead state indicates any mitigating strategies for existing or prospective operational risks impacting the insurer.

ENTERPRISE RISK MANAGEMENT - PANDEMIC (HEALTH)

directs Directs analysts to conductConsider conducting additional procedures if concerns exist regarding the insurer's preparedness and ability to respond to a pandemic outbreak event. A pandemic is defined as an epidemic of infectious disease that has spread through human populations across a large region. The effects a pandemic may have on an insurer include, but are not limited to, significant increases in claims volume, increased loss costs and liquidity demands. Therefore, it is important to understand the processes and strategies put in place by health insurers to limit the effect of a pandemic on an insurer's operations and ongoing solvency, including the results of stress testing performed to assess and quantify the impact on an insurer. Such procedures may include gaining an understanding of the company's plans and processes for dealing with such an event and evaluating whether they address increased utilization, liquidity needs and impact on workforce.

Example Prospective Risk Considerations

The table provides analysts with example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general discription of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the operational risk category.

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DISCUSSION OF QUARTERLY OPERATIONAL RISK PROCEDURES ASSESSMENT

The Qquarterly Ooperational Rrisk Repository procedures are designed to identify the following:

Concerns with the insurer's Statement of Income or oPoor (or Declining) Operating Pperformance.

Analyze the currant year-to-date performance and trends in the following items to determine whether concerns exist regarding the insurer's operating performance.

Procedures/Data

- Review the Statement of Income and operating performance.
  - Net Loss (current year-to-date, and five-year trend).

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- Change in net income (loss) from prior year-to-date when absolute value of net income (loss) is material to surplus.
- P/C: Profitability Ratios (current quarter, change from prior year-to-date, and five-year trend).
    - Combined ratio and its components.
        - Change in net premiums earned from prior year-to-date.
        - Change in net incurred losses from prior year-to-date.
    - Net loss ratio (direct, assumed, gross, ceded, and net).
    - Pure loss ratio.
    - Pure loss adjustment expense (LAE) ratio.
    - Expense ratio.
    - Dividend ratio.
    - Ratio of other income to net income when the absolute value of other income is material to surplus.
- Life/A&H: Profitability Ratios (current quarter, change from prior year-to-date, and five-year trend)
    - Net income/total revenue (ROR).
    - Annualized net income/total assets (ROA).
    - Annualized net income/capital & surplus (ROE).
    - Ratio of commissions and administrative expenses to premiums and deposits.
    - Ratio of aggregate write-ins for miscellaneous income to net income when aggregate write-ins for miscellaneous income are materials to capital and surplus.
    - Ratio of aggregate write-ins for deductions to net income when aggregate write-ins for deductions are material to capital and surplus.
- Health: Profitability Ratios (current quarter, change from prior year-to-date or year-end, and five-year trend)
    - Profit margin ratio.
    - Combined ratio.
    - Medical loss ratio (MLR).
    - Administrative expense ratio.

Additional Review Considerations

- Review the components of other income in the Quarterly Financial Statement, Statement of Income, including write-ins for miscellaneous income, for reasonableness.
- Describe any known trends that have had or that the insurer reasonably expects will have a material favorable or unfavorable impact on net revenues or net income. If the insurer knows of events that will cause a material change in the relationship between benefits, losses and expenses, the change in the relationship should be disclosed.
- If concerns exist regarding operating performance, consider the following procedures:
    - Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses.
    - Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations.

Risks with Investment Operations

Determine ~~W~~whether all securities owned are under the control of the insurer and in the insurer's possession.

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Procedures/Data

- Determine if any of the assets of the insurer loaned, placed under option agreements, or otherwise made available for use by another person (excluding securities under securities lending agreements)? If so, determine if there any concerns regarding these assets. [Quarterly Financial Statement, General Interrogatories, Part 1, #11.1 and #11.2]

Exposure to Affiliated/Related Party Transactions

Note: The following procedures for the review of Corporate Structure and Affiliated Transactions should consider any analysis already completed or anticipated to be completed with regard to the Holding Company Analysis performed by the lead state, review of the Form B – Registration Statement and any review of Form D – Material Transactions to avoid duplication of analysis.

Procedures/Data

Determine whether the insurer is a member of a holding company group and whether the corporate structure elevates concerns about affiliated transactions.

- Determine if the insurer is part of a holding company system. [Quarterly Financial Statement, General Interrogatories, Part 1, #3.1]
- Determine if there have been substantial changes in the organizational chart since the prior quarter end. [Quarterly Financial Statement, General Interrogatories, Part 1, #3.2]

Additional Review Considerations

- If there have been substantial changes and the change involved ownership of the insurer or a transaction with an affiliate, determine if the insurer received proper regulatory approvals.
- Determine if there any indications that the corporate structure may include a holding company whose primary asset is the stock of the insurance company.
- Determine if the insurer has an agency or brokerage subsidiary.

Procedures/Data

Identify whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.

- Determine if there have been changes to any management agreement, including third-party administrators (TPAs) and managing general agents (MGAs) in terms of the agreement or principals involved. [Quarterly Financial Statement, General Interrogatories, Part 1, #5].

Additional Review Considerations

- Review Quarterly Financial Statement, Schedule A – Part 2 and Part 3 and Schedule BA – Part 2 and Part 3:
    - Determine if any such acquisitions or disposition involve an affiliate or other related party.
    - Determine if the amount of the transaction was material to surplus?

- Determine if there is any reason to believe that the acquisition was recorded on a basis other than fair value.

Concerns with Separate Accounts (Life/A&H)

Determine whether concerns exist regarding the insurer's separate accounts.

Procedures/Data

- Determine whether the insurer maintains Separate Accounts. Review the Quarterly Financial Statement, Balance Sheet asset and liability items relating to separate accounts business. Determine if there balances in either of these categories

If not, do not proceed with the remaining Separate Accounts procedures.

- Change in separate account assets or liabilities from the prior year-end.
- Review the Quarterly Financial Statement, Capital and Surplus Account Statement page.
    - Determine if the line item, "Other changes in surplus in the Separate Accounts Statement," is greater than capital and surplus.
    - Change in line item, "Other changes in surplus in the Separate Accounts Statement," from the prior year, same quarter.
- Review the Quarterly Financial Statement, Summary of Operations page.
    - Change in line item, "Net transfers to or (from) separate accounts," from the prior year, same quarter.
    - Determine if the insurer reported a net loss in the line item, "Separate accounts net gain from operations excluding unrealized gains or losses," whose absolute value material to the general account capital and surplus.

Significant Bonus and Withholding Arrangements (Health)

Determine whether the insurer's use of bonus and withhold arrangements are significant.

Procedures/Data

- Ratio of Liability for accrued medical incentive pool and bonus payments to annualized total hospital and medical expenses.
- Ratio of Incentive pool and withhold adjustments to total hospital and medical expense.

1. ~~Whether the insurer is a member of a holding company group and whether the corporate structure elevates concerns about transactions with affiliates.~~
2. ~~Whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.~~
3. ~~Whether the insurer's use of bonus withhold arrangements are significant.~~
4. ~~Concerns with the insurer's separate accounts.~~

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

~~Pricing and Underwriting Risk Assessment~~

Pricing and Underwriting Risk: Pricing and underwriting practices are inadequate to provide for risks assumed.

The ~~objective of~~ Pricing and Underwriting Risk Assessment ~~analysis~~ is ~~to~~ focused primarily on risks inherent in writing business and premium production. Although pricing and underwriting risk is a component of overall profitability and operations, it is reviewed separately from other operational risks. Analysts may require additional investigation and information requests to understand and assess the potential impact of these risks. For example, analysts may need additional information to assess the insurer's capacity for growth and plans for expansion.

~~The following discussion of procedures provides suggested data, benchmarks and procedures analysts can consider in his/her review.~~ An analyst's risk-focused assessment of pricing and underwriting risk should take into consideration, the following areas (but not be limited to):

- Underwriting performance
- Premium production
- Premium concentration
- Writings leverage
- Financial impact of the federal Affordable Care Act (ACA) (Life/A&H, Health)

~~Discussion of Annual Procedures~~General Guidance

~~Using the Repository~~

To assess~~The~~ pricing and underwriting risk, ~~risk repository is a~~consider the ~~list of possible quantitative and qualitative~~ procedures, including specific data elements, metrics and benchmarks in this chapter~~and procedures from which analysts may select to use in his/her review of pricing and underwriting risk.~~

The placement of the following data and procedures in the pricing and underwriting risk ~~repository~~ is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with pricing and underwriting risk.

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

Analysts are not expected to responddocument every to procedures, data or benchmark results listed in the repository. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document completion the applicable details within of the analysis. Results of pricing and underwriting risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.
The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.
In using procedures in the repository, aAnalysts should review the results complete their pricing and underwriting risk assessment in conjunction with;

- A review of the Supervisory Plan and Insurer Profile Summary and the prior period analysis.
- Communication and/or coordination with other internal departments. are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures in the repository.

- Analysts should also consider tThe 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 placement of the following data and procedures in the pricing and underwriting risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with pricing and underwriting risk.

ANALYSIS DOCUMENTATION: Results of pricing and underwriting risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document. The following is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

Annual Pricing and Underwriting Risk AssessmentQuantitative and Qualitative Data and Procedures – Property & Casualty

Underwriting Performance

Poor Overall Underwriting Performance – P/C

PROCEDURE #1 assists analysts in determining Determine thewhether concerns exist regarding the insurer's underwriting performance –including the impacts of the various components of underwriting performance, including premium revenue, incurred losses, loss adjustment expenses and commissions expenses.

Key ratios and procedures ~~included in~~for assessing underwriting performance are ~~the underwriting expense ratio, net loss ratio and the commissions to direct premium ratio. The procedure includes recommendations to look at Annual Financial Statement, Schedule P and trending on the Financial Profile Report.~~as follows. Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums written may be an indication of an insurer's entrance into new lines of business or sales territories that might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses. Significant increases in incurred loss ratios may indicate premium pricing errors or reserve strengthening due to prior reserve understatements, whereas significant decreases in incurred loss ratios may be indicative of current reserve redundancies.

Procedures/Data

- Consider the following metrics to determine whether concerns exist regarding the insurer's underwriting performance:
  - Change in net premiums earned
  - Change in net incurred losses and loss adjustment expense (LAE)
  - Other underwriting expense ratio
  - Net loss ratio
  - Change in net loss ratio
  - Direct commissions to direct premiums ratio

Additional Review Considerations

- Review the five-year trend with the Financial Profile Report and/or the Management Discussion and Analysis (MD&A), for the following measures of operating performance, and note any unusual fluctuations, events (e.g., catastrophes) or trends between years for each ratio:
  - Loss ratios for direct, assumed and ceded business
  - Incurred loss and LAE by line of business
- Compare, by line of business, the pure net loss ratio to the industry averages in the Financial Profile Report to determine any significant deviations.
- Review each line of business included in the Annual Financial Statement, Schedule P, for trends in accident year loss ratios, on both a gross and net basis, that may indicate a deterioration in underwriting results.
- If concerns exist regarding underwriting results, consider requesting from the insurer the following for review:
  - Additional information from the insurer on the causes of poor underwriting performance.
  - Explanations for unusually high loss and combined ratios.
  - Plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
  - Rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.
  - Descriptions of underwriting practices and policies, including any exposure limits established by the insurer.
  - Descriptions of pricing practices (e.g., frequency of review) and policies.
  - Status of recent and pending rate increase requests.

- Review the write-ins for underwriting deductions in the Annual Financial Statement, Statement of Income and the Financial Profile Report and note any unusual fluctuations or trends.

~~Premium Production, Concentration and Writings Leverage~~

Concerns over Premium Production, Concentration and Writings Leverage – P/C

The following are examples of risks that may be identified related to premium production.

- **Concerns over Changes in Premium Production—**See below.
- **Concentration of Writings**—See below.
- **High Writings Leverage [or Trend]** —A high writings leverage trend may indicate concentrations, overexposure to certain insurance risks and/or a lack of support from ownership/parent. See below.
- **Lack of Underwriting Expertise** —A lack of underwriting expertise may result in underpricing or faulty risk acceptance if the insurer is not experienced in underwriting a new line of business
- **Lack of Sufficient Underwriting Standards** —A lack of sufficient underwriting policies and procedures may results in underpricing, acceptance of unknown/excessive risks, etc.
- **Negative Variance on Projected Premium/Sales to Actual** —Actual premium volume or new sales results vary materially from projections, leading to an inability to fulfill the strategic plan
- **Rapid Expansion/Growth** —Rapid growth or expansion into new geographic areas or new states may result in a higher-than-expected strain on surplus.
- **Declining Premium Volume** —Declines in premium volume may result in insufficient revenue to sustain current operations.

Lack of Clear Underwriting/Marketing Strategy —Failure to define and update the underwriting/marketing strategy of the insurer may lead to inconsistent results, inappropriate risk acceptance, etc.

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~~***PROCEDURE #2*** assists analysts in determining~~Determine whether concerns exist regarding changes in the volume of premiums written or changes in the insurer's mix of business (lines of business and/or geographic location) and changes in writing leverage. Significant increases or decreases in premiums written may indicate a lack of stability in the insurer's operations. In addition, a significant increase in premiums written may be an indication of the insurer's entrance into new lines of business or sales territories, which might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums written might also be an indication that the insurer is engaging in cash flow underwriting. Cash flow underwriting is the practice of writing a significant amount of business in order to invest and earn a greater investment return than the costs associated with potentially underpriced business. Cash flow underwriting can be a serious concern if it is accompanied by a shift in business written from short-tail property lines of business to long-tail liability lines.

Analysts should consider reviewing premiums written by line of business to determine which lines increased or decreased significantly and whether any new lines of business are being written. Analysts should also consider verifying that the insurer is authorized to write all lines of business being written. If new lines of business are being written, or if premiums are being written in new states, analysts should consider determining whether the insurer has expertise in the new lines of business or new sales territories. This would include expertise in distribution, underwriting, claims, and reserving. There is no information in the Annual Financial Statement to assist analysts in making this determination. However, there may be helpful information in the insurer's Management's Discussion and Analysis (MD&A). Otherwise, information may be requested from the insurer.

Within several lines of business and policy types (most notably commercial property), property/casualty insurers may be exposed to losses resulting from acts of terrorism. Following the September 11, 2001, attacks on the New York World Trade Center and the U.S. Pentagon, terrorism coverage became prohibitively expensive, if offered at all. In response, the U.S. Congress passed the ~~Terrorsim~~Terrorism Risk Insurance Act (TRIA) of 2002.

TRIA was initially created as a temporary three-year federal program that required insurers to offer commercial policyholders with terrorism coverage, while allowing the Federal Government to share monetary losses with insurers on commercial property/casualty losses from a terrorist attack. Since then, it has been renewed four times and is due to expire on December 31, 2027. Before this backstop can be accessed, several stipulations and limits are applied, many of which have been adjusted under subsequent extensions of the Act to limit the support available to insurers. Analysts should assess the insurer's exposure to losses related to acts of terrorism and consider any mitigation by TRIA.

The ~~P~~procedure ~~#2 a~~also assist~~s~~ analysts in determining whether the insurer is excessively leveraged due to the volume of premiums written. Surplus can be considered as underwriting capacity, and the ratios of gross and net writings leverage measure the extent to which that capacity is being utilized and the adequacy of the insurer's surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross writings leverage ratio result greater than 900% may indicate that the insurer is excessively leveraged, and special attention should be given to the adequacy of the insurer's reinsurance protection and the quality of the reinsurers. A net writings leverage ratio greater than 300% may also indicate that the insurer is excessively leveraged and lacks sufficient surplus to finance the business currently being written. In evaluating these ratios, analysts should also consider the nature of the insurer's business. For example, an insurer that has historically written primarily short-tail property lines of business might not be considered excessively leveraged even though it has higher ratio results, because the risk of significant underpricing or adverse underwriting results is less than that of an insurer that writes primarily volatile long-tail liability lines of business such as medical professional liability.

Analysts should consider reviewing the net premiums written by line to determine which lines of business are being written. An insurer that writes primarily short-tail property lines may be able to write at higher levels of premiums to surplus than an insurer that writes primarily long-tail liability lines, because the risk of underpricing and significant adverse underwriting results is less with the short-tail property lines of business. Analysts should also consider comparing the ratios of gross and net writings leverage to industry averages to help evaluate the insurer's leverage. If the insurer is a member of an affiliated group of insurers, analysts might want to compute the net and gross writings leverage ratios on a consolidated basis to help evaluate whether the affiliated group of insurers is excessively leveraged. If the net and gross writings leverage ratios results are high, analysts should consider determining whether the insurer has adequate reinsurance protection against large losses and catastrophes and that the reinsurers are of high quality.

Procedures/Data

- Consider the following metrics to assess materiality of exposure to premium production, concentration, and writings leverage:
  - Change in gross premiums written
  - Change in net premiums written
  - Change in direct premiums written (DPW) for any line of business
  - Ratio of DPW for any new lines to total DPW
  - Change in DPW in any one state when DPW is greater than 10% of total DPW in either the current or prior year-end
  - Ratio of DPW in a new state to total DPW
  - Gross premiums written to surplus [IRIS #1]
  - Net premiums written to surplus [IRIS #2]

Additional Review Considerations

- If significant changes in premium volume are identified, consider the following procedures:
  - Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.

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  - Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.
- Review, by line of business, premiums written by year in the Financial Profile Report for shifts in the mix of business between years and to gain an understanding of lines of business written.
- Determine whether the insurer has material exposure to losses resulting from acts of terrorism. If concerns are identified, consider the following procedures:
  - Request additional data/information from the insurer to gain an understanding of its exposure to terrorism risk.
  - If the insurer is subject to ORSA reporting, review information provided on terrorism exposure and risk assessment in the ORSA Summary Report or obtain the lead state's review (if applicable).
  - Gain an understanding of the insurer's mitigation of terrorism risk through TRIA coverage.
  - Assess the reasonableness of the ultimate exposure based on the insurer's business strategy and capital position.
  - Consider the reasonableness of the insurer's plan to limit exposures, such as policy limits, policy exclusions, location of risks, pricing modifications, non-renewal of certain policies, plans for diversification, or other risk mitigation strategies.
- Review the Five-Year Historical Data of the Annual Financial Statement. Determine whether there has been a shift in the mix of gross premiums written or net premiums written from property lines to liability lines within the past five years. If so, evaluate the underwriting/marketing strategy of the insurer and its expertise in writing liability lines of business.
- Review Annual Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.
- Review Annual Financial Statement, Schedule T and the writings section in the Financial Profile Report to evaluate the top states in terms of direct premiums and the percentage of total DPW in those states. Based on the lines of business written, determine whether large concentrations of premiums are written in areas prone to catastrophic events.
- Determine whether the company is diversified in terms of product lines and geographical exposure. If not, request and review information from the insurer regarding:
  - Mitigation strategies to limit exposure concentrations.
  - Explanations for significant shifts in geographic concentrations, lines of business, amounts of premiums written, high leverage positions, etc.
- Review the insurer's underwriting/marketing strategy included in its business plan.
  - If the change in DPW in any one state is greater than 10% of total DPW in either the current or prior year-end, evaluate the insurer's marketing and expansion plans in that state.
  - Determine whether the insurer is planning expansion into new states or premium growth in the future.
  - Determine whether the insurer has applied for or received new licenses in other states.
  - Determine whether the insurer has reported that it has ceased writing new business, a line of business or writing in a certain geographical location.
  - Determine whether the insurer has any closed block operations.
  - Ascertain whether the insurer's marketing strategy and projected premium growth match actual results reported in the current period. If materially different, evaluate the reasons why, or ask the insurer for an explanation.
- Determine whether the insurer has expertise (e.g., distribution network, underwriting, claims, and reserving) in the lines of business written. Consider reviewing the insurer's MD&A, business plan and/or additional information from the insurer to determine the expertise in the lines of business written.
- Review the insurer's gross and net writings leverage positions to assist in evaluating risk exposure. Consider the following specific procedures in this area:
  - Compare the gross writings leverage and net writings leverage ratios to the industry averages and determine any significant variances.

  - If the insurer is a member of a group, compute the gross premiums written to surplus ratio and the net premiums written to surplus ratio on a consolidated basis to determine if the group appears to be excessively leveraged.
  - Obtain an explanation from the insurer for unusual results for P/C IRIS ratios #1 and #2.
- Inquire of the insurer:
  - Marketing strategy, including distribution channels/networks, planned growth or cessation of business, expansion into new states or regions, management of closed block operations, etc.
  - Financial projections for expected premium/sales.

~~Exposure to Catastrophic Events~~

Exposure to Catastrophic Events – P/C

~~**PROCEDURE #3**~~ ~~assists analysts in i~~Identify~~ing~~ and assess~~ing~~ the insurer's current and prospective exposure to catastrophic events as well as the risk management practices of insurers writing a significant percentage of their business in products and geographic areas that are exposed to severe loss events. These types of catastrophic risk exposures have frequently been the cause or contributing factor in insurer insolvencies. Various steps included in this procedure assist in identifying the potential concentrations of exposure through a review of information provided in the annual statement as well as additional information provided within the RBC filing regarding modeled catastrophic risk exposures.

The Catastrophe Risk Charge in RBC (RCAT or PR027) is required to be completed by all insurers filing on the Property/Casualty blank unless they are exempted from filing due to limited exposure to property lines or coverage in catastrophe-prone areas. Insurers that are not exempted from this charge are required to provide modeled loss outputs from an approved catastrophe model for the worst year in 50, 100, 250, and 500, using the insurance company's own insured property exposure information as inputs to the model. Insurers are not required to utilize any prescribed set of modeling assumptions but are expected to use the same exposure data, modeling, and assumptions used in its own internal catastrophe risk management process.

If the analyst identifies potentially significant concentrations or exposures in writings or modeled losses, the analyst should gain an understanding of the risk mitigation practices in place to identify, monitor and mitigate significant exposures. An understanding could be gained through a review of existing information available to the analyst through company responses to the NAIC Climate Risk Disclosure Survey, ORSA Summary Report filings, or public information sources such as SEC 10K or 10Q filings. If these existing information sources are not available or do not provide adequate details of exposures and risk management practices, the analyst is encouraged to reach out to the company to request and review additional information.

In reviewing the insurer's exposure to catastrophic losses, it is important to consider both the current and prospective nature of the exposures. Increases in weather-related catastrophic losses may result from noticeable changes in climate that have been recorded over an extended period, including rising sea levels, changes in temperatures, precipitation, and/or wind patterns. The concern is that climate change or change in weather patterns may increase the severity and frequency of future weather events including, but not limited to: thunderstorms, including severe hail and strong winds; tornadoes; hurricanes; windstorms; floods; heat waves; drought; and wildfires. If the insurer is exposed to significant catastrophic losses that could be the result of climate change, the analyst should take steps to gain an understanding of and evaluate the potential impact on the company's business and underwriting strategy over medium and longer-term time horizons.

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Consider evaluating the following items to determine whether concerns exist regarding the insurer's exposure to catastrophic events.

Procedures

- Review Annual Financial Statement, Schedule T and the writings section in the Financial Profile Report (or the Mix of Business Dashboard) to evaluate the top states in terms of direct premiums and the percentage of total DPW in those states. Based on the lines of business written, determine whether there is a material concentration of premiums written in areas prone to catastrophic events.
- Review information provided by the insurer in the RCAT (PR027) section of its Risk Based Capital filing to identify and assess the insurer's current exposure to catastrophic events at modeled worst year in 50, 100, 250, and 500 levels on both a gross (direct and assumed) and net basis (after reinsurance). Evaluate the potential impact of the company's modeled loss results on its capital and surplus and RBC position.
- Review information provided in the insurer's response to the NAIC's Climate Risk and Disclosure Survey (if available) on its exposure to physical losses impacted by climate change, as well as its related mitigation activity.
  - Determine whether any of the company's responses require further investigation and inquiry.
- Review information provided in the ORSA Summary Report and/or SEC 10K or 10Q filings (if available) regarding the insurer's exposure to physical losses impacted by climate change, as well as its related mitigation activity.
- Utilize the information gathered and/or request additional information as necessary to assess the insurer's exposure to climate/catastrophic risks, as well as processes and strategies in place to limit exposures.
  - Gain an understanding of how the company incorporates catastrophe modeling results into its underwriting processes (e.g., assessment of risk appetite or determination of net retained risk) and the insurer's oversight of the process.
  - Use of modeled results to set underwriting exposure limits and refine underwriting guideline.
  - Gain an understanding of and evaluate the potential impact of climate change on the company's business and underwriting strategy over medium and longer-term time horizons.
  - Determine whether there are any concerns regarding the company's risk management processes in regard to climate change, both currently and prospectively.

Annual Pricing and Underwriting Risk Assessment~~Quantitative and Qualitative Data and Procedures~~ – Life, Accident & Health (A&H)~~, Fraternal~~

~~Underwriting Performance~~

Poor Overall Underwriting Performance – Life/A&H

~~***PROCEDURE #1*** assists analysts in determining~~Review the annual financial statement, summary of operations and determine ~~the~~ whether concerns exist regarding the insurer's underwriting performance including the impacts of ~~the various components of underwriting performance, including~~ net gain from operations before realized capital gains to total revenue, operating loss trends, loss ratio and commissions expenses.

Procedures/Data

- -Consider evaluating the following items to determine whether concerns exist regarding the insurer's underwriting performance:
  - Ratio of net gain from operations (before realized capital gains and losses) to total income.
  - Determine whether there have been operating losses in two or more of the past three years.
  - A&H loss ratio.
  - Direct commissions to direct premium ratio.

Additional Review Considerations

- Review the five-year trend with the Annual Statement Summary of Operations, Annual Financial Profile Report, and Management Discussion and Analysis (MD&A) for the following measures of operating performance, and note any unusual fluctuations, events or trends between years for each:
  - Operating income.
  - A&H loss ratio.
  - Commissions to premiums ratio.
- Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on net revenues or net income, or a material impact on the relationship between benefits, losses, and expenses.
- Review the Annual Financial Statement, Analysis of Operations by Lines of Business and the Financial Profile Report and:
  - Determine which lines of business were profitable for the insurer and which lines of business generated a loss.
  - Determine if any lines of business indicate a negative trend in profitability over the past five years.
  - Determine whether commissions on any lines of business appear excessive based on the volume of premiums.
- If concerns exist regarding underwriting results, consider inquiring of the insurer for the following, for review:
  - Additional information from the insurer on the causes of poor underwriting performance.
  - Plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
  - Rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.
  - Descriptions of underwriting practices and policies.
  - Descriptions of pricing practices (e.g., frequency of review) and policies
- Review the components of the Annual Financial Statement, Summary of Operations line items Aggregate Write-ins for Miscellaneous Income and Aggregate Write-ins for Deductions for reasonableness.

Poor Underwriting Performance on Medicare Part D Coverage – Life/A&H

~~***PROCEDURE #2*** assists analysts in~~ Review the annual financial statement, Medicare Part D Coverage Supplement and ~~evaluating~~determine whether concerns exist regarding ~~-~~the insurer's underwriting performance of the Medicare Part D Prescription Drug coverage. The procedures utilize data in the Annual Financial Statement, Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, analysts should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated when the contract was made. If the insurer is reporting unusual results, analysts should consider if any delays in payments from the federal Centers for Medicare & Medicaid Services (CMS) are affecting results.

Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for a period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If policyholders utilize more benefits than were projected in the contract, the insurer may experience losses because the income from CMS is set for a full year. Analysts should consider obtaining and reviewing information on the contracted benefits, premium, and cost-sharing with CMS. Analysts should also evaluate a comparison of premiums, reserves, expected utilization, and benefit costs to actual experience on each plan.

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Procedures/Data

Consider evaluating the following items to determine whether concerns exist regarding the insurer's Medicare Part D coverage:

- Underwriting loss of either group or individual coverage
- Medical loss ratio of either group or individual coverage
- Expense loss ratio of either group or individual coverage
- Combined ratio of either group or individual coverage

Additional Review Considerations

- Obtain and review information regarding the contracted benefits, premium and cost sharing with the federal Centers for Medicare & Medicaid Services (CMS).
- Review the types of products being written, including any enhanced benefit products.
- Request information on and review the assumptions for reserves, utilization, and benefit costs projected in the development of the contract.
- If concerns exist regarding operating performance, request, review and evaluate information from the insurer regarding its plans to address the issues.

Poor Underwriting Performance on A&H Lines – Life/A&H

~~***PROCEDURE #3*** assists analysts in e~~Evaluat~~e~~~~ing~~ the underwriting performance of the individual A&H lines of business through a review of the Annual Financial Statement, A&H Policy Experience Exhibit (April 1 filing), including a review of the loss ratio by line and consideration of multiyear trend analysis by line.

Procedures/Data

- Ascertain whether the insurer reported an underwriting loss on any line of business as reported on the Analysis of Operations by Line of Business page of the Annual Financial Statement.

Additional Review Considerations

- If underwriting losses were reported on the Analysis of Operations by Lines of Business page, review the A&H Policy Experience Exhibit to further identify specific health lines that may be experiencing losses.
- Compare results with prior years to identify any concerns with multiyear trends in premium, benefit, loss ratios or membership.

Poor Underwriting Performance on Long-Term Care Insurance – Life/A&H

~~***PROCEDURE #4*** assists analysts in e~~Evaluat~~inge~~ the underwriting performance of the long-term care insurance (LTCI) line of business through a review of the Annual Financial Statement, Long-Term Care Experience Reporting Forms (April 1 filing), the Actuarial Guideline-51 reporting, actuarial memorandum or any other related actuarial information filed to the department including trends in premiums, claims and loss ratios. Analysts should consider requesting the assistance of the department actuary to review trends in reserving that may affect underwriting results. (See additional guidance in the Reserving Risk ~~Repository~~ Assessment~~Analyst Reference Guide~~ of this Handbook).

Procedures

- Ascertain whether the insurer reported an underwriting loss on the "Other Health" line of business on the Analysis of Operations by Line of Business page of the Annual Financial Statement, and determine whether the insurer writes long-term care insurance (LTCI).

If "yes," further investigate the underwriting loss by reviewing the Annual Financial Statement, LTC Experience Reporting Forms, A&H Policy Experience Exhibit, and the Actuarial Guideline-51 reporting. Request a department actuary to assist in the review, if available.

- Review the operational results in conjunction with the actuarial review of the LTC Experience Reporting Forms, the Actuarial Guideline-51 reporting, actuarial memorandum, or other related information filed to the department:
  - Identify by policy form or in aggregate trends in premiums, benefits and the LTC loss ratio (benefits divided by premiums).
  - Identify trends in under-reserving that may affect underwriting results. (Refer to the Actuarial Risk Assessment for A&H and Statement of Actuarial Opinion review procedures.)
- Compare results to prior years to identify any concerns with multi-year trends.

~~Premium Production, Concentration and Writings Leverage~~

Concerns over Premium Production, Concentration and Writings Leverage – Life/A&H

The following are examples of risks that may be identified related to premium production.

- **Concerns over Changes in Premium Production—**See below.
- **Concentration of Writings**—See below.
- **Lack of Underwriting Expertise**—A lack of underwriting expertise may result in underpricing or faulty risk acceptance if the insurer is not experienced in underwriting a new line of business
- **Lack of Sufficient Underwriting Standards**—A lack of sufficient underwriting policies and procedures may results in underpricing, acceptance of unknown/excessive risks, etc.
- **Negative Variance on Projected Premium/Sales to Actual**—Actual premium volume or new sales results vary materially from projections, leading to an inability to fulfill the strategic plan
- **Rapid Expansion/Growth**—Rapid growth or expansion into new geographic areas or new states may result in a higher-than-expected strain on surplus.
- **Declining Premium Volume** Declines in premium volume may result in insufficient revenue to sustain current operations.
- **Lack of Clear Underwriting/Marketing Strategy**—Failure to define and update the underwriting/marketing strategy of the insurer may lead to inconsistent results, inappropriate risk acceptance, etc.

~~***PROCEDURE #5***~~ ~~assists analysts in d~~Determin~~ing~~e whether concerns exist regarding changes in the volume of premiums and deposit-type funds or changes in the insurer's mix of business (lines of business written and/or geographic location of premium written). Significant increases or decreases in premiums written may indicate a lack of stability in the insurer's operations. In addition, a significant increase in premiums written may be an indication of the insurer's entrance into new lines of business or sales territories that might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums might also be an indication that the insurer is engaging in cash flow underwriting to increase cash income in order to cover current benefit payments.

Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums may be an indication of an insurer's entrance into new lines of business or sales territories which might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses, particularly if the insurer primarily writes A&H insurance.

Analysts may also perform qualitative procedures if concerns exist regarding changes in the volume of premiums and deposit-type funds or changes in the insurer's mix of business (lines of business written and/or geographic location of the premiums written) include reviewing the insurer's mix of business to determine: 1) which lines of

business are being written; 2) which lines of business have increased or decreased significantly; and 3) whether any new lines of business are being written. Analysts should also consider verifying that the insurer is authorized to write all lines of business being written. If new lines of business are being written or if premiums are being written in new states, analysts should consider determining whether the insurer has expertise in the new lines of business or new sales territories. This would include expertise in distribution, underwriting, claims, and reserving. There is no information in the Annual Financial Statement to assist analysts in making this determination. However, there may be helpful information in the insurer's Management's Discussion and Analysis. Otherwise, information may be requested from the insurer. Analysts should also consider determining if, as a result of changes in the mix of business, the insurer's business is concentrated in specific geographic areas that could result in the insurer being potentially exposed to catastrophic losses.

Procedures/Data

- Ratio of change in net premiums, annuity considerations and deposit-type funds
- Ratio of change in direct and assumed annuities and deposit-type funds for non-health insurers
- Ratio of Change in Product Mix (IRIS Ratio 10).
- Review the Direct Premium Written by State:
    - Identify any significant change in direct premiums written in any one state in which either current or prior year direct premium are material to total direct premium.
    - Identify any premiums being written in any new state where that state's premiums are material to total direct premiums written.

Additional Review Considerations

- Review the Mix of Business in the Annual Financial Profile Reports:
    - Determine which lines of business are being written.
    - Determine whether there has been a significant increase or decrease or shifts in direct premiums written for any line of business.
    - Determine whether any new lines of business are being written.
- If significant changes in premium volume are identified, consider the following procedures:
    - Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.
    - Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.
- Review Annual Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.
- Review information provided in the Annual Financial Statement and supporting schedules (e.g., Schedule T, the writings section in the Financial Profile Report, etc.) to identify potential risk concentrations in terms of product types, guarantees, geographical exposures, etc. If concerns are identified, request and review information from the insurer regarding mitigation strategies to limit exposure concentrations.
- Request and review the insurer's marketing strategy included in its business plan.
    - If the combined ratio of either group or individual coverage is >100%, evaluate the insurer's marketing and expansion plans in that state.
    - Determine whether the insurer is planning expansion into new states or premium growth in the future.
    - Ascertain whether the insurer has applied for or received new licenses in other states.
    - Identify whether the insurer has reported that it has ceased writing new business, a line of business or writing in certain locations.
    - Determine whether the insurer has closed block operations.
    - Distribution channels/networks, planned growth or cessation of business, expansion into new states or regions, management of closed block operations, etc.
    - Financial projections for expected premium/sales.

- o Determine whether the insurer's marketing strategy and projected premium growth match actual results reported in the current period. If there appears to be a material difference, evaluate the reasons why or ask the insurer for an explanation.
- Determine whether the insurer has expertise (distribution network, underwriting, claims and reserving) in the lines of business written. Consider reviewing the insurer's Management's Discussion and Analysis and/or seeking additional information from the insurer to determine the insurer's expertise in the lines of business written.

High A&H Writings Leverage [or Trend] – Life/A&H

~~***PROCEDURE #6*** assists analysts in d~~Determine~~ing~~ whether the insurer ~~is~~may be excessively leveraged due to its volume of A&H business written. A high writings leverage trend may indicate concentrations, overexposure to certain insurance risks and/or a lack of support from ownership/parent.
Capital and surplus can be considered as underwriting capacity, and the ratios of gross (direct plus assumed reinsurance) A&H premiums to capital and surplus and net (gross less reinsurance ceded) A&H premiums to capital and surplus measure the extent to which that capacity is being utilized and the adequacy of the insurer's capital and surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross A&H premium to capital and surplus ratio greater than 500% may indicate that the insurer is excessively leveraged, and special attention should be given to the adequacy of the insurer's reinsurance protection and the quality of the reinsurers. A net A&H premium to capital and surplus ratio greater than 300% may also indicate that the insurer is excessively leveraged and lacks sufficient capital and surplus to finance the A&H business currently being written. In evaluating these leverage ratios, analysts should also consider the nature of the insurer's business. For example, an insurer that has written primarily A&H business for many years and has proven that it can manage the business profitably is probably not as risky as an insurer which has just begun writing A&H business, even if both insurers have the same leverage ratio results.

Analysts may also consider performing qualitative procedures if there are concerns regarding whether the insurer may be excessively leveraged due to its volume of A&H business including comparing the ratios of gross A&H premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to help evaluate the insurer's leverage. Analysts might also want to review Annual Financial Statement, Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written, determine whether the A&H lines of business have historically been profitable for the insurer, and determine whether A&H loss reserve adequacy has been maintained. As noted previously, an insurer that has historically written primarily A&H business might not be considered excessively leveraged, even though it has higher leverage ratio results, because the risk of significant underpricing or adverse underwriting results is less than for an insurer that has just begun writing A&H business.

~~***HEALTH:*** 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, analysts should still assess the level of business written by the health entity by comparing premium and risk revenue to capital and surplus. This comparison should include premium and risk revenue recorded by the health entity in its income statement since both sources of revenue represent exposure to the health entity. This type of comparison is generally considered a measure of a health entity's operating leverage and is important in determining the potential losses to the health entity. The higher the writings ratio, the more likely the health entity will record a material loss when morbidity spikes. For example, if a health entity is writing at a 5 to 1 ratio and reports a combined ratio of 105% (assuming no investment income and no federal income taxes) the health entity would report a 25% decrease in capital and surplus based upon the net loss alone. Therefore, for every $5 in writings at a loss of 5%, surplus would be impacted 5 times greater and incur a 25% loss. If a health entity is writing at a 10 to 1 ratio and reports a combined ratio of 105% (assuming no investment income and no federal income taxes) the health entity would report a 50% decrease in capital and surplus. Therefore, for every $10 in writings at a loss of 5%, surplus would be impacted 10 times greater and incur a 50% loss.~~

Procedures/Data

- Ratio of A&H business to net premiums and annuity considerations
- If the ratio of A&H business to net premiums and annuity considerations is material, review
  - Ratio of gross A&H premiums to capital and surplus
  - Ratio of net A&H premiums to capital and surplus

Additional Review Considerations

- Compare the ratios of gross A&H premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to determine any significant deviations from the industry averages.
- In the Annual Financial Statement, review Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written.
- In the Annual Financial Statement, review Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written.
- Review the A&H loss percentage ratio (Annual Financial Profile Reports) for unusual fluctuations or trends between years.

Financial Impact of Affordable Care Act – Life/A&H

Determine whether there are concerns regarding the impact by line of business to the insurer's overall operating results and financial solvency. The strain from writing business subject to ACA requirements may result in significant assessments, high claims experience, rebate obligations or risk sharing payments that have the potential to affect the insurer's solvency position. *See Health section of the Pricing/Underwriting chapter for more guidance on ACA solvency challenges.*

Procedures/Data

- Review the preliminary medical loss ratio (MLR) by line of business (either the national Preliminary MLR or the state-level MLR). If any of the following benchmarks are met, assess the financial solvency of the plan and the impact of the plan on the overall financial solvency of the insurer.
  - Individual comprehensive.

- Small group employer comprehensive
- Large group employer comprehensive
- Individual mini-med
- Small group employer mini-med
- Large group employer mini-med
- Small group expatriate plans
- Large group expatriate plans
- Student health plans

- Analyze the underwriting gain/(loss) result by line of business and determine whether any line of business on the Supplemental Health Care Exhibit (SHCE) reported an underwriting loss.
  - Individual comprehensive.
  - Small group employer comprehensive
  - Large group employer comprehensive
  - Individual mini-med
  - Small group employer mini-med
  - Large group employer mini-med
  - Small group expatriate plans
  - Large group expatriate plans
  - Student health plans

Additional Review Considerations

- If any line of business in reported an underwriting loss, determine the reasons for the loss and assess the impact of each line of business to the overall operating results of the insurer.
- Compare the results of your analysis of the Preliminary MLR to your analysis of the existing MLR calculations [refer to Financial Profile Report or Operations Risk Assessment] and assess the impact to the overall solvency of the insurer.
- During the review of the health care business pursuant to the Public Health Service Act and all applicable filings, determine whether the analyst noted any unusual items or areas of concern, not previously noted, that indicate further review is warranted.
- If concerns exist regarding underwriting results for individual plans, consider requesting and reviewing additional information from the insurer on
  - Causes and plans to address poor underwriting performance and negative results (high MLR, rebates, risk sharing payments, line of business [LOB] operating losses, etc.).
  - Planned changes in market focus for federal Affordable Care Act (ACA) business (entering or exiting exchanges, entering or exiting states/regions, etc.).
  - Status of recent and pending rate increases
- Determine if there are concerns regarding recent rate filing requests:
  - Contact internal state insurance department staff responsible for the rate review and request information on any recent rate reviews. Determine whether any concerns were noted by the rate review staff (e.g., were rate adjustment requests disapproved or modified)?.
  - Review the trend in rate filing requests. Determine whether there are any concerns with the frequency or amount of the requests.
  - Review the Financial Profile Report's PMPM premium data and compare it to rate increases.

Annual Pricing and Underwriting Risk Assessment~~Quantitative and Qualitative Data and Procedures~~ – Health

Poor Overall Underwriting Performance - Health

~~***PROCEDURE #1***~~ ~~assists analysts in~~ Review the annual statement, summary of operations, and determininge whether concerns exist regarding the pricing of the health entity's products. To the extent the health entity's premium PMPM has not increased by an amount that approximates the expected increase in health care costs PMPM, this may be an indication that the health entity's premium rates may not be able to keep pace with the health entity's medical inflation. Although this ratio is a measure of what has occurred since the prior year, it can be used as a gauge in evaluating whether a health entity may be exposed. The ratio is also limited since it can't be applied at the product level using Annual Financial Statement information. However, the purpose of the ratio is to provide analysts some sense of how the entity's premium rate changes compare with medical inflation in general. Analysts should also use the ratio of change in claims PMPM to change in premium PMPM. A result greater than zero indicates that claims increased from the prior year at a faster rate than premiums have increased from the prior year. A result less than zero would indicate that premiums have increased from the prior year at a faster rate than claims have increased from the prior year. The use of PMPM allows the ratio to be broken down to a more meaningful comparison. One other item that analysts should consider is the health entity's use of multiple year provider contracts. Multiple-year provider contracts allow a health entity and a provider to lock in agreed upon rates for an extended period of time. Although not necessarily an indication of underpricing, clearly it is much more difficult to predict the cost of health care three years out than it is one year out. As a result, multiple year contracts by their nature lend themselves to greater pricing risk. Analysts should be aware of the use of these contracts and the extent to which they are used.

If there are concerns, analysts may also consider procedures to assess if one or more of the health entity's products may be underpriced. Although it may be difficult to determine if any specific products are underpriced, one procedure analysts may want to consider is the level of losses on the individual statutory lines of business. To the extent the health entity had a combined ratio of greater than 105% on any line of business; it may be an indication that the product is underpriced. To the extent a health entity has underpriced a product; the financial impact could be significant depending upon the health entity's leverage and the type of product. Analysts should also consider the need to determine if the health entity has established a premium deficiency reserve on a line of business. As discussed in the Health Reserves and Liabilities section, this reserve is established when future premiums and current reserves are not sufficient to pay future claims and expenses. This type of reserve is established because it meets the definition of a loss contingency and should therefore be considered in evaluating the current financial position of the health entity. Analysts should use the information, along with any information from the health entity, to better assess the current financial position of the health entity. Other information could include a monthly assessment from the health entity on the adequacy of the current deficiency reserve based upon updated information. Since the reserve is essentially an estimate of the expected losses from one or more contracts, updated information can assist in ensuring that the reserve continues to be adequate and that the health entity's financial position has not materially deteriorated.

Procedures/Data

- Medical loss ratio (does not represent the calculation for the medical loss ratio (MLR) under the Affordable Care Act).
- Change in medical loss ratio
- Underwriting gain/loss
- Determine whether there have been operating losses in two or more of the past three years.
- Premium per member per month compared to prior year
- Determine whether the change in claims per member per month less the change in premium and risk revenue per member per month is greater than zero (See Financial Profile Report) Display the change in claims per member per month, the change in premium per member per month and the variance between the two.
- Direct commissions to direct premium ratio

Additional Review Considerations

- Review the five-year trend with the Annual Financial Profile Report, Annual Statement of Revenue and Expenses, and the Management Discussion and Analysis (MD&A) for the following measures of operating performance, and note any unusual fluctuations, events or trends between years for each:
  - Underwriting gain
  - Medical loss ratio
- Describe any known trends that have had or that the insurer reasonably expects will have a material impact on net revenues or underwriting income, or a material impact on the relationship between benefits, losses and expenses.
- Review the Annual Financial Statement, Analysis of Operations by Line of Business and the Financial Profile Report and:
  - Determine which lines of business were profitable for the insurer and which lines of business generated an underwriting loss.
  - Determine if any lines of business indicate a negative trend in profitability over the past five years.
  - Determine whether commissions on any lines of business appear excessive based on the volume of premiums.
- Review the Annual Financial Statement, General Interrogatories, Part 2, #9.1 and #9.2 and RBC Other Underwriting Risk (XR014-XR016). Ascertain whether the insurer has a significant amount of multi-year contracts with premium rate guarantees.
- Identify if any premium rates are locked for the year. Determine if there are any concerns regarding underpricing of these rates.
- Determine whether a premium deficiency reserve has been established by the insurer on any products in question.
- For lines of business for which a premium deficiency reserve has been established, request information monthly from the insurer that details estimates of how actual claims compare with expected claims and details the estimated impact on the reserve established.
- If concerns exist regarding underwriting results, consider requesting and review additional information from the insurer:
  - Causes of poor underwriting performance.
  - Plans to address poor underwriting performance (e.g., changes in underwriting, rate changes, etc.).
  - Explanations for unusually high loss and combined ratios.
  - Descriptions of underwriting practices and policies.
  - Descriptions of pricing practices (e.g., frequency of review) and policies.
  - Rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.

Poor Underwriting Performance for Medicare Part D Prescription Drug - Health

PROCEDURE #2 assists analysts in Review the annual financial statement, Medicare Part D Coverage Supplement and evaluatingdetermine whether concerns exist regarding –the insurer's underwriting performance of the Medicare Part D Prescription Drug coverage. The procedures utilize data in the Annual Financial Statement, Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, analysts should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated when the contract was made. If the insurer is reporting unusual results, analysts should consider if any delays in payments from the federal Centers for Medicare & Medicaid Services (CMS) are affecting results.

Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for a period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If policyholders utilize more benefits than were projected in the contract, the insurer may experience losses because the income from CMS is set for a full year. Analysts should consider obtaining and reviewing information on the contracted benefits, premium, and cost-sharing with CMS. Analysts should also evaluate a comparison of premiums, reserves, expected utilization, and benefit costs to actual experience on each plan.

Procedures/Data
Consider evaluating the following items to determine whether concerns exist regarding the insurer's Medicare Part D coverage:

- Underwriting loss of either group or individual coverage
- Medical loss ratio of either group or individual coverage
- Expense loss ratio of either group or individual coverage
- Combined ratio of either group or individual coverage

Additional Review Considerations

- Obtain and review information regarding the contracted benefits, premium and cost sharing with the federal Centers for Medicare & Medicaid Services (CMS).
- Review the types of products being written, including any enhanced benefit products.
- Request information on and review the assumptions for reserves, utilization, and benefit costs projected in the development of the contract.

If concerns exist regarding operating performance, request, review and evaluate information from the insurer regarding its plans to address the issues.

Poor Underwriting Performance on A&H – Health

PROCEDURE #3 assists analysts in eEvaluateing the underwriting performance of the individual A&H lines of business through a review of the Annual Financial Statement, A&H Policy Experience Exhibit (April 1 filing),, including a review of the loss ratio by line and consideration of multiyear trend analysis by line.

Procedures/Data

- Ascertain whether the insurer reported an underwriting loss on any line of business as reported on the Analysis of Operations by Line of Business page of the Annual Financial Statement.

Additional Review Considerations

- If underwriting losses were reported on the Analysis of Operations by Lines of Business page, review the A&H Policy Experience Exhibit to further identify specific health lines that may be experiencing losses.
- Compare results with prior years to identify any concerns with multiyear trends in premium, benefit, loss ratios or membership.

Poor Underwriting Performance on Long-Term Care Insurance – Health

PROCEDURE #4 assists analysts in eEvaluatinge the underwriting performance of the long-term care insurance (LTCI) line of business through a review of the Annual Financial Statement, Long-Term Care Experience Reporting Forms (April 1 filing), the Actuarial Guideline-51 reporting, actuarial memorandum or any other related actuarial information filed to the department including trends in premiums, claims and loss ratios. Analysts should consider requesting the assistance of the department actuary to review trends in reserving that may affect underwriting results. (See additional guidance in the Reserving Risk Repository Analyst Reference GuideAssessment of this Handbook).

Procedures/Data

- Ascertain whether the insurer reported an underwriting loss on the "Other Health" line of business on the Analysis of Operations by Line of Business page of the Annual Financial Statement, and determine whether the insurer writes long-term care insurance (LTCI).
  If "yes," further investigate the underwriting loss by reviewing the Annual Financial Statement, LTC Experience Reporting Forms, A&H Policy Experience Exhibit, and the Actuarial Guideline-51 reporting. Request a department actuary to assist in the review, if available.
- Review the operational results in conjunction with the actuarial review of the LTC Experience Reporting Forms, the Actuarial Guideline-51 reporting, actuarial memorandum, or other related information filed to the department:
  - Identify by policy form or in aggregate trends in premiums, benefits and the LTC loss ratio (benefits divided by premiums).
  - Identify trends in under-reserving that may affect underwriting results. (Refer to the Actuarial Risk Assessment for A&H and Statement of Actuarial Opinion review procedures.)
- Compare results to prior years to identify any concerns with multi-year trends.

Concerns over Premium Production, Concentration and Writings Leverage – Health

The following are examples of risks that may be identified related to premium production.

- **Concerns over Changes in Premium Production—**See below.
- **Concentration of Writings**—See below.
- **Lack of Underwriting Expertise**—A lack of underwriting expertise may result in underpricing or faulty risk acceptance if the insurer is not experienced in underwriting a new line of business
- **Lack of Sufficient Underwriting Standards**—A lack of sufficient underwriting policies and procedures may results in underpricing, acceptance of unknown/excessive risks, etc.
- **Negative Variance on Projected Premium/Sales to Actual**—Actual premium volume or new sales results vary materially from projections, leading to an inability to fulfill the strategic plan
- **Rapid Expansion/Growth**—Rapid growth or expansion into new geographic areas or new states may result in a higher-than-expected strain on surplus.
- **Declining Premium Volume** Declines in premium volume may result in insufficient revenue to sustain current operations.
- **Lack of Clear Underwriting/Marketing Strategy**—Failure to define and update the underwriting/marketing strategy of the insurer may lead to inconsistent results, inappropriate risk acceptance, etc.
- **High Writings Leverage [or Trend]** —A high writings leverage trend may indicate concentrations, overexposure to certain insurance risks and/or a lack of support from ownership/parent. See below.
- **Lack of Underwriting Expertise** —A lack of underwriting expertise may result in underpricing or faulty risk acceptance if the insurer is not experienced in underwriting a new line of business
- **Lack of Sufficient Underwriting Standards** —A lack of sufficient underwriting policies and procedures may results in underpricing, acceptance of unknown/excessive risks, etc.
- **Negative Variance on Projected Premium/Sales to Actual** —Actual premium volume or new sales results vary materially from projections, leading to an inability to fulfill the strategic plan
- **Rapid Expansion/Growth** —Rapid growth or expansion into new geographic areas or new states may result in a higher-than-expected strain on surplus.
- **Declining Premium Volume** —Declines in premium volume may result in insufficient revenue to sustain current operations.

- **Lack of Clear Underwriting/Marketing Strategy** —Failure to define and update the underwriting/marketing strategy of the insurer may lead to inconsistent results, inappropriate risk acceptance, etc.

PROCEDURE #5 assists analysts in dDetermineing the business stability of the insurer. Determine whether concerns exist regarding changes in the volume of premium, enrollment levels or changes in the insurer's mix of business (lines of business and/or geographic location). As previously discussed, a significant increase in premiums and enrollment may indicate rapid growth, which can present many different types of problems to a health entity or can also be an indication of the health entity's entrance into new lines of business or sales regions. Significant increases in premiums might also be an indication that the health entity is attempting to increase cash inflow to cover current benefit payments, particularly if the health entity primarily writes longer tail insurance.

If there are concerns analysts may also consider procedures to assess the financial impact of fluctuations in premiums or changes in business mix (line of business written and/or geographic location of premiums written) may have on the insurer's financial position. Analysts should consider comparing any significant changes in premiums to the health entity's most recent projections and business plan. Variances could suggest that consumers have responded to the health entity differently than anticipated. As previously discussed, growth can have a material impact on the operations of a health entity, and analysts should gain more information from the health entity when this has occurred, including how current and future growth is expected to be supported. However, decreases in premium can also place some pressure on the health entity through forced expense reductions. Analysts should attempt to understand how decreases in premiums are expected to impact this issue. If new lines of business are being written or if premiums are being written in new regions, analysts should review the health entity's MD&A for related information. Otherwise, information may be requested from the health entity showing operating results vs. projections for the new lines of business or territories and describing any changes in implementation strategy or revisions in financial projections for future periods. Analysts should also consider determining if, as a result of increases in sales regions, how the health entity prices its products, the contracts used with providers and any future expected changes in the health entity's business. The business of health insurance is very localized and the health entity must have a reasonable understanding of that market to be successful.

Procedures/Data

- Change in enrollment from the prior year-end. Display the percent change and the enrollment for each of the past five years.
- Change in net premium income from the prior year
- Change in direct premiums written for any line of business
- Does the insurer write long-term care and disability income (long-tailed lines) premium? If "yes," list the percentage of total direct premium.
- If premiums are being written in any new lines, do they account for more than 10% of the total net premium income
- Determine if any direct business is being written in a state in which there were no prior writings [Annual Statement, Schedule T]

Additional Review Considerations

- Review the mix of business in the Annual Financial Profile Reports. If significant changes in premium volume are identified, consider the following procedures:
  - Determine which lines of business and types of are being written.
  - Determine whether there has been a significant increase or decrease or shifts in direct premiums written for any line of business.
  - Determine whether any new lines of business are being written.

- Determine if the changes are consistent with the insurer's most recent projections and business plan. Request additional information for variances not discussed in the most recent plan.
- For an overall increase in premium, obtain specific information on when additional funds are expected to be deposited into the insurer to support the growth.
- For an overall decrease, determine the insurer's plans for addressing its expense structure under its new premium base.
- Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.

- If the insurer writes LTC or Disability. (long-tailed lines) is "yes," consider the impact that a reserve shortfall could have on the insurer's overall leverage risk.
- Request and review additional information from the insurer (if necessary)
    - Source(s) of significant changes in premium volume.
    - Insurer's expertise in the lines of business written.
    - How the insurer shares risk with other entities in order to minimize the overall underwriting risk to the insurer.
    - How the insurer intends to address its operating leverage issue.
    - Explanations for significant shifts in geographic concentrations, lines of business, amounts of premium written, etc.
    - Information regarding contracted benefits, premium and cost sharing with the U.S. Centers for Medicare and Medicaid Services.
- Review the insurer's marketing strategy included in its business plan.
    - If the insurer is writing a material new line of business or writing in a new state, evaluate the insurer's marketing and expansion plans in those states.
    - Is the insurer planning expansion into new states or premium growth in the future?
    - Has the insurer applied for or received new licenses in other states?
    - Has the insurer reported that it has ceased writing new business, a line of business or writing in a certain location?
    - Does the insurer have closed block operations?
      Does the insurer's marketing strategy and projected premium growth match actual results reported in the current period? If materially different, evaluate the reasons why, or ask the insurer for an explanation.
    - Distribution channels/networks, planned growth or cessation of business, expansion into new states or regions, management of closed block operations, etc.
    - Financial projections for expected premium/sales.

  In new or increasing lines of business, determine whether the insurer has the expertise (distribution networks, systems, underwriting, claims and reserving) needed. Consider reviewing the insurer's Management's Discussion and Analysis and or seeking additional information from the insurer to determine the insurer's expertise in the lines of business written.

- If the insurer has entered a new region or has significantly increased the business written in an existing region, request information on how the insurer establishes product prices in those regions, the provider contracts used by the insurer in that region and a discussion of the insurer's future expected changes in the region. Compare this information with information available from the insurer's competitors.

High Health Writings Leverage [or Trend] - Health

~~***PROCEDURE #6*** assists analysts in d~~Determine~~ing~~ whether the health entity is excessively leveraged due to its volume of business. Capital and surplus can be considered as underwriting capacity. The ratios of net premiums and risk revenue to capital and surplus measures the extent to which that capacity is being utilized and the adequacy of the health entity's capital and surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A net premium and risk revenue to capital and surplus ratio greater than 10 to 1 (8 to 1 for non-health maintenance organizations (HMOs)) may indicate that the health entity is excessively leveraged. Special attention should be given to the type of coverage provided and the extent to which the health entity is able to transfer some of the risk from the business to another entity. Two health entities both with a 10 to 1 ratio may have different leverage depending on the type of coverage that they write. For example, to the extent the health entity has written primarily comprehensive business for many years in the same region, and is able to capitate some of its business, it may not be as risky as a health entity which has just begun writing Medicare business in a new region and is unable to transfer any of its risk. Even if both of these health entities have the same leverage ratio results, the one starting Medicare Risk coverage will have a riskier financial position. Analysts should also specifically consider if a significant portion of the premium is written on longer tail lines. On these lines, the ultimate experience may not be known for some time, thereby increasing the risk of reserve understatement. Analysts should also determine whether there has been an increase in the writing's ratio or an increase in the amount of long-tail business that is being written, to assist in identifying future trends.

If there are concerns analysts may also consider procedures to assess whether the health entity may be excessively leveraged due to its volume of business. Generally, the threshold for health business on leverage ratios is set at a much higher level than for property/casualty business. This is because property/casualty business tends to carry more catastrophic risk (risk of large loss) than health business, due in part to the long-tailed nature of property/casualty major lines of business. The threshold for HMOs tends to be set at a higher level than other health entities. This is because to some extent, HMOs are able to transfer some of their risk to other entities, thereby reducing their overall risk in comparison to their premium volume. Because of the above, a 10 to 1 threshold is generally used for HMOs (8 to 1 for most other health entities). However, analysts should consider the type of business written by the health entity and the health entity's use of risk transfer in considering the extent to which a health entity may be leveraged. These procedures assist by directing analysts to consider how these items may impact the health entity's overall leverage. Once analysts have a better understanding of these issues for a health entity, analysts may want to consider requesting additional information from the health entity on how it intends to address this issue.

Fluctuations in premium or enrollment may also indicate a reason for concern. Uncontrolled, excessive growth has been found to be one of the major causes of insolvency. If the growth is not accompanied by additional surplus, the capital and surplus may not be able to support the additional exposure. Growth is often times driven by a health entity's desire for greater market share. Many times, the health entity is able to gain that market share by lowering its prices or setting prices below the rest of the market. This desire for greater market share can lead to considerable underpricing. This underpricing can increase the amount of risk to the health entity for every dollar of premium written. Additionally, in many cases, the health entity may establish reserves as a percentage of premiums when it enters a new market, which can lead to additional risk. Therefore, if the product is underpriced, it's possible the reserves may be understated. As a result, growth by a health entity is often associated with underpricing and under reserving, which is a risky combination. In effect, the company may need to establish a greater reserve when unsure about its pricing.

In addition, growth can make administering the operations difficult and can create claims inventory backlogs. A change in premium might also reflect a health entity's entrance into new lines of business or sales regions. This could result in financial problems if the health entity does not have expertise in these new lines of business or regions. This is particularly true in the health insurance market where margins are traditionally very thin and critical mass is necessary in establishing new provider contracts. Finally, significant increases in premiums might

also be an indication that the health entity is attempting to increase cash inflow in order to cover current benefit payments, particularly if the health entity is writing more longer tail insurance (e.g., long-term care).

In cases where premium or enrollment has not significantly changed, analysts should still assess the level of business written by the health entity by comparing premium and risk revenue to capital and surplus. This comparison should include premium, and risk revenue recorded by the health entity in its income statement since both sources of revenue represent exposure to the health entity. This type of comparison is generally considered a measure of a health entity's operating leverage and is important in determining the potential losses to the health entity. The higher the writings ratio, the more likely the health entity will record a material loss when morbidity spikes. For example, if a health entity is writing at a 5 to 1 ratio and reports a combined ratio of 105% (assuming no investment income and no federal income taxes) the health entity would report a 25% decrease in capital and surplus based upon the net loss alone. Therefore, for every $5 in writings at a loss of 5%, surplus would be impacted 5 times greater and incur a 25% loss. If a health entity is writing at a 10 to 1 ratio and reports a combined ratio of 105% (assuming no investment income and no federal income taxes) the health entity would report a 50% decrease in capital and surplus. Therefore, for every $10 in writings at a loss of 5%, surplus would be impacted 10 times greater and incur a 50% loss.

Procedures/Data
- Premiums and risk revenue to capital and surplus for HMOs
- Premiums and risk revenue to capital and surplus for non-HMOs
- Change in ratio of premiums and risk revenue to capital and surplus

Additional Review Considerations
- Compare ratios of premiums and risk revenue to capital and surplus to industry averages to determine any significant deviations from the industry averages.
- Request and review additional information from the insurer (if necessary), on how the insurer intends to address its operating leverage issue.

Poor Underwriting Performance for Medicare Part D Prescription Drug - Health

PROCEDURE #2 assists analysts in Review the annual financial statement, Medicare Part D Coverage Supplement and evaluatingdetermine whether concerns exist regarding -the insurer's underwriting performance of the Medicare Part D Prescription Drug coverage. The procedures utilize data in the Annual Financial Statement, Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, analysts should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated when the contract was made. If the insurer is reporting unusual results, analysts should consider if any delays in payments from the federal Centers for Medicare & Medicaid Services (CMS) are affecting results.

Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for a period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If policyholders utilize more benefits than were projected in the contract, the insurer may experience losses because the income from CMS is set for a full year. Analysts should consider obtaining and reviewing information on the contracted benefits, premium, and cost-sharing with CMS. Analysts should also evaluate a comparison of premiums, reserves, expected utilization, and benefit costs to actual experience on each plan.

Procedures/Data

Consider evaluating the following items to determine whether concerns exist regarding the insurer's Medicare Part D coverage:

- Underwriting loss of either group or individual coverage
- Medical loss ratio of either group or individual coverage
- Expense loss ratio of either group or individual coverage
- Combined ratio of either group or individual coverage

Additional Review Considerations

- Obtain and review information regarding the contracted benefits, premium and cost sharing with the federal Centers for Medicare & Medicaid Services (CMS).
- Review the types of products being written, including any enhanced benefit products.
- Request information on and review the assumptions for reserves, utilization, and benefit costs projected in the development of the contract.
- If concerns exist regarding operating performance, request, review and evaluate information from the insurer regarding its plans to address the issues.

Poor Underwriting Performance on Long-Term Care Insurance [Health]

~~***PROCEDURE #4***~~ ~~assists analysts in e~~Evaluat~~ing~~e the underwriting performance of the long-term care insurance (LTCI) line of business through a review of the Annual Financial Statement, Long-Term Care Experience Reporting Forms (April 1 filing), the Actuarial Guideline-51 reporting, actuarial memorandum or any other related actuarial information filed to the department including trends in premiums, claims and loss ratios. Analysts should consider requesting the assistance of the department actuary to review trends in reserving that may affect underwriting results. (See additional guidance in the Reserving Risk ~~Repository Analyst Reference Guide~~Assessment of this Handbook).

Procedures/Data

- Ascertain whether the insurer reported an underwriting loss on the "Other Health" line of business on the Analysis of Operations by Line of Business page of the Annual Financial Statement, and determine whether the insurer writes long-term care insurance (LTCI).
  If "yes," further investigate the underwriting loss by reviewing the Annual Financial Statement, LTC Experience Reporting Forms, A&H Policy Experience Exhibit, and the Actuarial Guideline-51 reporting. Request a department actuary to assist in the review, if available.
- Review the operational results in conjunction with the actuarial review of the LTC Experience Reporting Forms, the Actuarial Guideline-51 reporting, actuarial memorandum, or other related information filed to the department:
  - Identify by policy form or in aggregate trends in premiums, benefits and the LTC loss ratio (benefits divided by premiums).
  - Identify trends in under-reserving that may affect underwriting results. (Refer to the Actuarial Risk Assessment for A&H and Statement of Actuarial Opinion review procedures.)
- Compare results to prior years to identify any concerns with multi-year trends.

Financial Impact of the Federal Affordable Care Act [Health]

~~***PROCEDURE #7A–F***~~ ~~assists analysts in~~ Determine whether there are concerns ~~reviewing~~regarding the impact ~~the~~of underwriting gains or losses by line of business and assessing the impact of each line to the insurer's total operating results and financial solvency. Note that the preliminary medical loss ratio (MLR) included in this

supplemental health care exhibit (for any given state) is not the MLR that is used in calculating the federal mandated rebates.

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

Despite the differences, the validity and reasonableness of the ACA MLR calculation, and therefore of the rebate calculation can be assessed using the data from the Annual Financial Statement, Supplemental Health Care Exhibit (SHCE). The following elements from the SHCE and the rebate calculation can be used for such an assessment.

For the following items, there should be little or no difference between the amounts in the SHCE and the rebate calculation:

- Earned premium.
- Federal and state taxes and licensing or regulatory fees.
- Expenses to improve health care quality.

For other items, there are expected to be differences between the SHCE and the rebate calculation due to the difference in the time of reporting between the two:

- Paid claims, unpaid claim reserve, and incurred claims.
- Experience rating refunds and reserves for experience rating refunds.
- Change in contract reserves.
- Incurred medical pool incentives and bonuses.
- Net healthcare receivables.

For the Contingent Benefit Reserve, the expected relationship between the SHCE and the rebate calculation is unknown as yet.

~~***PROCEDURE #7G*** assists analysts in i~~Identify~~ing~~ any risks or concerns ~~with~~regarding recent rate filings and reviews. The rate review process may be performed by the U.S. Department of Health and Human Services (HHS) or by the state department of insurance (DOI), depending on the states' authority. Analysts should review any recent rate reviews performed (or if a different department, communicate with the rate review staff) and assess if any concerns exist. An analyst should also consider how the increase in the per member per month (PMPM) premiums compares with approved rate increases. Consider that there may have been different rate increases for different plans. Also consider the overall increase in premium PMPM for reasonableness compared to the approved rate increase.

In 2010, the NAIC adopted a form used to meet the requirements of Section 2794 of the federal Patient Protection and Affordable Care Act (PPACA) that specifies insurers must provide justifications for any rate filing request that meets an "unreasonable" threshold. The form is not an endorsement of any definition of "unreasonable" that HHS may develop. The form does not apply to large group business.

Analysts should have a general understanding of the states' rate regulation laws and practices. Currently, states have a number of ways to regulate rates. In the individual market, the majority of states rely on actuarially justified ratings, while some states rely on community ratings, adjusted community ratings and rating bands. In the small group market, rating bands are more prevalent, while a small number of states utilize community ratings and adjusted community ratings. Rating bands limit the variation in premiums attributable to health status and other characteristics. Community ratings prohibit the use of any case characteristics besides geography to vary premium. Adjusted community ratings prohibit the use of health status or claims experience in setting premiums. Actuarial justification requires the insurer to demonstrate a correlation between the case characteristics and the increased medical claims costs. The NAIC has adopted safe harbors for case characteristics commonly used for setting premiums without providing justification. For further guidance, refer to the applicable state law or regulation.

Procedures/Data

- Review the preliminary medical loss ratio (MLR) by line of business (either the national Preliminary MLR or the state-level MLR). If any of the following benchmarks are met, assess the financial solvency of the plan and the impact of the plan on the overall financial solvency of the insurer.
  - Individual comprehensive.
  - Small group employer comprehensive
  - Large group employer comprehensive
  - Individual mini-med
  - Small group employer mini-med
  - Large group employer mini-med
  - Small group expatriate plans
  - Large group expatriate plans
  - Student health plans
- Analyze the underwriting gain/(loss) result by line of business and determine whether any line of business on the SHCE reported an underwriting loss.
  - Individual comprehensive.
  - Small group employer comprehensive
  - Large group employer comprehensive
  - Individual mini-med
  - Small group employer mini-med
  - Large group employer mini-med
  - Small group expatriate plans
  - Large group expatriate plans
  - Student health plans

Additional Review Considerations

- If any line of business in reported an underwriting loss, determine the reasons for the loss and assess the impact of each line of business to the overall operating results of the insurer.
- Compare the results of your analysis of the Preliminary MLR to your analysis of the existing MLR calculations [refer to Financial Profile Report or Operations Risk Assessment] and assess the impact to the overall solvency of the insurer.
- During the review of the health care business pursuant to the Public Health Service Act and all applicable filings, determine whether the analyst noted any unusual items or areas of concern, not previously noted, that indicate further review is warranted.
- If concerns exist regarding underwriting results for individual plans, consider requesting and reviewing additional information from the insurer
  - Causes and plans to address poor underwriting performance.

  - o Explanations of negative results (high MLR, rebates, risk sharing payments, line of business [LOB] operating losses, etc.).
  - o Planned changes in market focus for ACA business (entering or exiting exchanges, entering or exiting states/regions, etc.).
  - o Status of recent and pending rate increases.
- Determine if there are concerns regarding recent rate filing requests:
  - o Contact internal state insurance department staff responsible for the rate review and request information on any recent rate reviews. Determine whether any concerns were noted by the rate review staff (e.g., were rate adjustment requests disapproved or modified)?.
  - o Review the trend in rate filing requests. Determine whether there are any concerns with the frequency or amount of the requests.
  - o Review the Financial Profile Report's PMPM premium data and compare it to rate increases.

~~Additional Analysis and Follow-Up~~ADDITIONAL ~~Procedures~~PROCEDURES APPLICABLE TO PRICING AND UNDERWRITING RISK

Examination Findings

~~*EXAMINATION FINDINGS* direct the analsyt to c~~Consider a review of the most recent examination report, ~~s~~Summary ~~r~~Review ~~m~~Memorandum (SRM) and communication with the examination staff to identify if any pricing and underwriting risk issues were discovered during the examination. If outstanding issues are identified, perform follow-up procedures as necessary to address the concerns.

- ~~*INQUIRE OF THE INSURER* directs analysts to consider requesting additional information from the insurer if pricing and underwriting risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of pricing and underwriting risk for specific topics where concerns have been identified.~~

Own Risk and Solvency Assessment (ORSA) Summary Report:

~~*OWN RISK AND SOLVENCY ASSESSMENT (ORSA)* directs analysts to o~~Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing risks faced by the insurer.

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

- Determine whether the ORSA Summary Report analysis conducted by the lead state indicates any pricing and underwriting risks that require further monitoring or follow-up.
- Determine whether the ORSA Summary Report analysis conducted by the lead state indicates any mitigating strategies for existing or prospective pricing and writing risks.
- Determine whether the ORSA Summary Report presents the results of the modeled CAT exposure analysis at various levels, on both a gross and net basis [Property & Casualty]

Holding Company Analysis

~~*HOLDING COMPANY ANALYSIS* directs analysts to o~~Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

- Ascertain whether the Holding Company analysis conducted by the lead state indicates any pricing and underwriting risks impacting the insurer that require further monitoring or follow-up.
- Determine whether the Holding Company analysis conducted by the lead state indicates any mitigating strategies for existing or prospective risks impacting the insurer.

Example Prospective Risk Considerations

The table provides analysts with example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general discription of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the pricing and underwriting risk category.

Discussion of Quarterly Pricing and Underwriting AssessmentProcedures

The Qquarterly Ppricing and Uunderwriting Rrisk Repository procedures are designed to identify the following:

Poor Overall Underwriting Performance – P/CConcerns with the insurer's underwriting performance

Determine whether concerns exist regarding the insurer's underwriting performance including the impacts of premium revenue, incurred losses, loss adjustment expenses and commissions expenses.

Procedures/Data

- Change in net premiums earned from prior year-to-date
- Change in net incurred losses from prior year-to-date
- Net loss ratio
- Change in pure loss ratio from prior year-to-date
- Change in direct loss incurred for any line of business from prior year-to-date [quarterly financial statement, Part 1]

Additional Procedures

- Review the trend in the Financial Profile Report, for the following measures of operating performance and note any unusual fluctuations, events (e.g., catastrophes) or trends between years for each ratio:
  - Loss ratios
  - Incurred loss and loss adjustment expense (LAE)
- Review the write-ins for underwriting deductions in the Quarterly Financial Statement, Statement of Income and the Financial Profile Report, and note any unusual fluctuations or trends.
- If concerns exist regarding underwriting results, consider the following procedures:
  - Request and review additional information from the insurer on the causes of poor underwriting performance.
  - Request, review, and evaluate information from the insurer regarding its plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
  - Inquire of the rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.

Concerns with Premium Production, Concentration, and Writings Leverage – P/C

Determine whether Cconcerns exist with theregarding changes in volume of premiums written, changes in the insurer's mix of business (lines of business and/or geographic location) and changes in writing leverage

Procedures/Data

- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis.
- Change in direct premiums written (DPW) for any line of business
- Ratio of DPW for new lines of business to total DPW
- Change in DPW in any one state when DPW is greater than 10% of DPW in either the current or prior year

- Ratio of DPW in new states to total DPW
- Ratio of net writings leverage (rolling year)

Additional Procedures

- If significant changes in premium volume are identified, consider the following procedures:
  - Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.
  - Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.
- Review, by line of business, premiums written by year in the Financial Profile Report for shifts in the mix of business between years and gain an understanding of lines of business written.
- Review Quarterly Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.
- Review Quarterly Financial Statement, Schedule T and the writings section in the Financial Profile Report to evaluate the top states in terms of direct premiums and the percentage of total DPW in those states. Based on the lines of business written, determine whether large concentrations of premiums are written in areas prone to catastrophic events.
- Determine whether the company is diversified in terms of product lines and geographical exposure. If not, request and review information from the insurer regarding mitigation strategies to limit exposure concentrations.
- Review the insurer's underwriting/marketing strategy included in its business plan.
  - If 2.d is "yes," evaluate the insurer's marketing and expansion plans in that state.
  - Make an inquiry to the insurer whether it is planning expansion into new states or premium growth in the future.
  - Inquire of the insurer whether the insurer has applied for or received new licenses in other states.
  - Determine whether the insurer has reported that it has ceased writing new business, a line of business or writing in a certain geographical location.
  - Determine whether the insurer have closed block operations.
  - Determine whether the insurer's marketing strategy and projected premium growth match actual results reported in the current period. If materially different, evaluate the reasons why, or ask the insurer for an explanation.
- Determine whether the insurer has expertise (e.g., distribution network, underwriting, claims and reserving) in the lines of business written.

Quarterly Pricing and Underwriting Assessment – Life, A&H

Review the quarterly financial statement, summary of operations, and determine whether concerns exist regarding the insurer's underwriting performance including the impacts of premium revenue, incurred losses, loss adjustment expenses and commissions expenses.

Procedures/Data

- Ratio of operating income to total income (before realized capital gains and losses).
- Determine where there has been operating losses in two or more of the past three consecutive quarters.
- Accident and health (A&H) loss ratio.
- Total Commissions and Incurred Expenses to Gross Premiums
- Total Commissions and Incurred Expenses to Gross Premiums Total Commissions and Incurred Expenses to Gross Premiums

Additional Procedures

- Review the five-year trend with the Quarterly Financial Statement, Summary of Operations, Quarterly Financial Profile Report, for the following measures of operating performance, and note any unusual fluctuations, events or trends between quarters for each:
  - Operating income, ratios.
  - A&H loss ratio.
- Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on net revenues or net income, or a material impact on the relationship between benefits, losses and expenses.
- If concerns exist regarding underwriting results, consider the following procedures:
  - Request and review additional information from the insurer on the causes of poor underwriting performance.
  - Request, review and evaluate information from the insurer regarding its plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
  - Inquire of the rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.
  - Review the components of the Quarterly Financial Statement, Summary of Operations line items Aggregate Write-ins for Miscellaneous Income and Aggregate Write-ins for Deductions for reasonableness.

Poor Underwriting Performance – Life/A&H

Review the Quarterly Financial Statement, Summary of Operations, and determine whether concerns exist regarding the insurer's underwriting performance

Procedures/Data

- Ratio of operating income to total income (before realized capital gains and losses).
- Have there been operating losses in two or more of the past three consecutive quarters?
- Accident and health (A&H) loss ratio.
- Total Commissions and Incurred Expenses to Gross Premiums

Additional Procedures

- Review the five-year trend with the Quarterly Financial Statement, Summary of Operations, Quarterly Financial Profile Report, for the following measures of operating performance, and note any unusual fluctuations, events or trends between quarters for each:
  - Operating income, ratios.
  - A&H loss ratio.
- Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on net revenues or net income, or a material impact on the relationship between benefits, losses and expenses
- If concerns exist regarding underwriting results, consider the following procedures:
  - Request and review additional information from the insurer on the causes of poor underwriting performance.
  - Request, review and evaluate information from the insurer regarding its plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
  - Inquire of the rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy
- Review the components of the Quarterly Financial Statement, Summary of Operations line items Aggregate Write-ins for Miscellaneous Income and Aggregate Write-ins for Deductions for reasonableness.

Concerns over Change in Premium Volume – Life/A&H

Determine whether concerns exist regarding changes in the volume of premiums and deposit-type contract funds or changes in the insurer's mix.

Procedures/Data

- Ratio of change in net premiums, annuity considerations, from the prior year, same quarter
- Change in direct premiums for any line of business the prior year, same quarter? [Quarterly Financial Statement, Exhibit 1]
- Review the direct premium written by state:
  - Significant change in direct premiums written in any one state in which the current or prior year direct premium exceeds 10% of total direct premium.
  - Premiums being written in any new state where that state's premiums exceed total direct premiums written.

Additional Procedures

- Review the mix of business in the Quarterly Financial Profile Reports:
  - Determine which lines of business are being written.
  - Determine whether there has been a significant increase or decrease or shifts in direct premiums written for any line of business.
  - Determine whether any new lines of business are being written.
- If significant changes in premium volume are identified, consider the following procedures:
  - Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.
  - Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.
- Review Quarterly Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.
- Review information provided in the Quarterly Financial Statement and supporting schedules (e.g., Schedule T, the writings section in the Financial Profile Report, etc.) to identify potential risk concentrations in terms of product types, geographical exposures, etc. If concerns are identified, request and review information from the insurer regarding mitigation strategies to limit exposure concentrations
- Review the insurer's marketing strategy included in its business plan.
  - If 2.d above is "yes," evaluate the insurer's marketing and expansion plans in that state.
  - Is the insurer planning expansion into new states or premium growth in the future?
  - Has the insurer applied for or received new licenses in other states?
  - Has the insurer reported that it has ceased writing new business, a line of business or writing in a certain location?
  - Does the insurer have closed block operations?
  - Does the insurer's marketing strategy and projected premium growth match actual results reported in the current period? If materially different, evaluate the reasons why, or ask the insurer for an explanation.
- Determine whether the insurer has expertise (distribution network, underwriting, claims and reserving) in the lines of business written.

High A&H Writings Leverage – Life/A&H

Determine whether the insurer may be excessively leveraged due to its volume of accident and health (A&H) business.

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Procedures/Data

- Determine if A&H Business is material. Ratio of A&H business to net premiums and annuity considerations is material. If so, review,
  - Ratio of gross A&H premiums to capital and surplus.
  - Ratio of net A&H premiums to capital and surplus.

Additional Procedures

- Compare ratios of gross A&H premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to determine any significant deviations from the industry averages.
- Review the A&H loss percentage ratio (Quarterly Financial Profile Reports) for unusual fluctuations or trends between quarters.

Financial Impact of the Federal Affordable Care Act (ACA) – Life/A&H

Determine whether there are concerns regarding the impact of the federal Affordable Care Act (ACA) to the insurer's overall operating results and financial solvency.

Procedures

- Determine whether the insurer wrote accident and health insurance premium which is subject to the Affordable Care Act risk-sharing provision and if the amount of premium written exceeded projections and ascertain whether the insurer's level of capital can support the impact of underestimation of the qualified premium.
- Review the insurer's current RBC to identify if it is at a deteriorating level due to ACA risk-sharing provisions or as a result of the ACA fee assessment payable.
- Review the reinsurance and risk-adjustment accruals to identify insurers that:
  - Might not be adequately accruing liabilities for premium adjustments payable and for risk adjustment user fees payable.
  - That might be overestimating premium and adjustments receivables, or;
  - That might have liquidity issues because payments will be delayed until final determination can be made.

Poor Underwriting Performance – Health

Review the Quarterly Financial Statement, Summary of Operations, and determine whether concerns exist regarding the insurer's underwriting performance

Procedures/Data

- Medical loss ratio (MLR)
- Change in MLR from prior-year end
- Change in MLR from prior-year-to-date

Additional Procedures

- Review the five-year trend with the Quarterly Financial Statement, Statement of Revenue and Expenses, Quarterly Financial Profile Report, for the following measures of operating performance, and note any unusual fluctuations, events or trends between years for each:
  - Operating income, ratios
  - MLR

- Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on net revenues or net income, or a material impact on the relationship between benefits, losses and expenses.
- If concerns exist regarding underwriting results, consider the following procedures:
  - Request and review additional information from the insurer on the causes of poor underwriting performance.
  - Request, review and evaluate information from the insurer regarding its plans to address poor underwriting performance (e.g., tightening underwriting standards, rate changes, etc.).
  - Inquire of the rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.

Concerns over Change in Premium Volume – Health

Determine whether concerns exist regarding changes in the volume of premium, enrollment levels or changes in the insurer's mix of business (lines of business and/or geographic location) and changes in writings leverage.

Procedures/Data
- Change in premium income from prior year-to-date
- Change in enrollment from the prior year-end
- Change in direct premium written for any line of business
- If premiums are being written in any new lines, do they account for more than 5% of the total earned premiums?
- Determine if any direct business is being written in a state in which there were no prior writings [Quarterly Financial Statement, Schedule T]

Additional Procedures
- Review the mix of business in the Quarterly Financial Profile Reports. If significant changes in premium volume are identified, consider the following procedures:
  - Determine which lines of business are being written.
  - Determine whether there has been a significant increase or decrease or shifts in direct premiums written for any line of business.
  - Determine whether any new lines of business are being written.
  - Determine if the changes are consistent with the insurer's most recent projections and business plan. Request additional information for variances not discussed in the most recent plan.
  - For an overall increase in premium, obtain specific information on when additional funds are expected to be deposited into the insurer to support the growth.
  - For an overall decrease, determine the insurer's plans for addressing its expense structure under its new premium base.
  - Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.
  - Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.
- Review Quarterly Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.
- Review information provided in the Quarterly Financial Statement and supporting schedules (e.g., Schedule T, the writings section in the Financial Profile Report, etc.) to identify potential risk concentrations in terms of product types, geographical exposures, etc. If concerns are identified, request and review information from the insurer regarding mitigation strategies to limit exposure concentrations.
- Review the insurer's marketing strategy included in its business plan.
  - If 2.f. above is "yes," evaluate the insurer's marketing and expansion plans in that state.

  - Is the insurer planning expansion into new states or premium growth in the future?
  - Has the insurer applied for or received new licenses in other states?
  - Has the insurer reported that it has ceased writing new business, a line of business or writing in a certain location?
  - Does the insurer have closed block operations?
  - Does the insurer's marketing strategy and projected premium growth match actual results reported in the current period? If materially different, evaluate the reasons why, or ask the insurer for an explanation.
- Determine whether the insurer has expertise (e.g., distribution networks, underwriting, claims and reserving) in the lines of business written.

High A&H Writings Leverage – Health

Determine whether the insurer is excessively leveraged due to the volume of premiums written.

Procedures/Data
- Premiums and risk revenue to capital and surplus for HMOs
- Premiums and risk revenue to capital and surplus for non-HMOs
- Change in ratio of premiums and risk revenue to capital and surplus

Additional Procedures
- Compare ratios of gross accident and health (A&H) premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to determine any significant deviations from the industry averages.
- Review the A&H loss percentage ratio (Quarterly Financial Profile Reports) for unusual fluctuations or trends between years.

Concerns with Product Pricing – Health

Determine whether concerns exist regarding the pricing of the insurer's products.

Procedures
- Increase in premium per member per month compared to prior year-end
- Change in claims per member per month less the change in premium and risk revenue per member per month from the prior year-end [Financial Profile Report]

Financial Impact of the Federal Affordable Care Act (ACA) – Health

Determine whether there are concerns regarding the impact of the federal Affordable Care Act (ACA) to the insurer's overall operating results and financial solvency.

Procedures
- Determine whether the insurer wrote accident and health insurance premium which is subject to the Affordable Care Act risk-sharing provision and if the amount of premium written exceeded projections and ascertain whether the insurer's level of capital can support the impact of underestimation of the qualified premium.
- Review the insurer's current RBC to identify if it is at a deteriorating level due to ACA risk-sharing provisions or as a result of the ACA fee assessment payable.
- Review the reinsurance and risk-adjustment accruals to identify insurers that:

- Might not be adequately accruing liabilities for premium adjustments payable and for risk adjustment user fees payable.
- That might be overestimating premium and adjustments receivables, or;
- That might have liquidity issues because payments will be delayed until final determination can be made.

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

Reputational Risk Assessment

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

The objective of Reputational Risk Assessment analysis is to focused primarily on how changes in the way the insurer is perceived can affect its solvency position. As such, risks in this area are often prospective in nature and may require consideration of third-party information to understand and assess their potential impact. For example, analysts may monitor news reports and movements in a company's stock price to identify risks and trends that may be affecting the insurer's reputation.

The following discussion of procedures provides suggested data, benchmarks and procedures analysts can consider in his/her review. An Aanalysts' risk-focused assessment of reputational risk should take into consideration the following areas (but not be limited to):

- Reputational impact of legal risks
- Reputational impact of operational risks
- Reputational impact of strategic risks
- Potential impairment of goodwill
- Agency ratings and outlooks
- News reports
- Press releases
- Stock trends
- Volume and trends in company complaints
- Market conduct violations and findings

Discussion of Annual ProceduresGENERAL GUIDANCE

Using the Repository

To assessThe reputational risk, repository is aconsider the list of possible quantitative and qualitative procedures, including specific data elements, metrics and benchmarks in this chapter.and procedures from which analysts may select to use in their review of reputational risk. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.

The placement of the following data and procedures in the reputational risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositoriesrisk categories. Therefore, analysts may need to review other repositoriesrisk assessments in conjunction with reputational risk.

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

Analysts are not expected to respond to document every all procedures, data or benchmark results listed in the repository. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document

~~completion~~the applicable details within ~~of~~ the analysis. Results of reputational risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.~~The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.~~
~~In using procedures in the repository, a~~Analysts should ~~review the results~~ complete their reputational risk assessment in conjunction with:

- A review of ~~-~~the Supervisory Plan, Insurer Profile Summary and the prior period analysis.
- Communication and/or coordination with other internal departments~~ are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures in the repository~~.
- ~~Analysts should also consider t~~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 placement of the following data and procedures in the reputational risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with reputational risk.~~

~~***ANALYSIS DOCUMENTATION:*** Results of reputational risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.~~
The following is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

~~Quantitative and Qualitative Data and Procedures~~ANNUAL REPUTATIONAL RISK ASSESSMENT

~~**Reputational Impact of Other Risks**~~

Reputational Impact of Other Risks

~~***PROCEDURE #1*** directs analysts to i~~Identify and assess risks associated with other branded risk classifications on the insurer's reputation. While risks that are primarily addressed in any of the eight other branded risk classifications might have the potential to harm the insurer's reputation, the classifications most likely to directly affect reputational risk are legal risk, operational risk and strategic risk. Therefore, these ~~procedure~~possible considerations references~~s~~ a number of common risk factors/components associated with each of these classifications for consideration of their impact on the insurer's reputation. For example, reports of fraud, problems in operating performance, and significant turnover in senior management all have the potential to result in reputational risk. Therefore, the procedure encourages the reputational impact of these risks to be considered and assessed, if applicable. In addition, the procedure asks analysts to consider the reputational impact of any other significant risks identified throughout the risk assessment process, including the impact of goodwill impairment on the insurer or insurance group's reputation.

Procedures
- Identify and evaluate the impact of legal risks on the insurer's reputation, such as:
  - Violations of legal and regulatory requirements
  - Ongoing regulatory investigations
  - Significant ongoing litigation

- Reports of fraud or fraud investigations
- Ethical violations

- Identify and evaluate the impact of operational risks on the insurer's reputation, such as:
  - Information technology (IT) security concerns
  - Weak or ineffective corporate governance
  - Problems in operating performance
  - Third-party administrator (TPA) or managing general agent (MGA) relationships
- Identify and evaluate the impact of strategic risks on the insurer's reputation, such as:
  - Significant turnover at the board and senior management level
  - Merger and acquisition activity
  - Changes in business plan or strategic direction
  - Increasing leverage or concerns over capital adequacy
- Identify and evaluate the impact of an impairment of goodwill of any investment in parent, subsidiaries or affiliates (PSA) and the causes for such impairment on the insurer's reputation.
- Identify and evaluate the impact of all other significant risks with the potential to affect the insurer's reputation.

Additional Review Considerations

- Inquire of the Insurer:
  - The financial impact to the insurer and/or group's operations and surplus
  - Disclosures of financial impact to the public and agent distribution force
  - The insurer's efforts to mitigate any impact of the risk. For ORSA filers, this may be identified in the ORSA Summary Report for certain risks.
  - Policies and procedures in place to mitigate adverse publicity
  - Revised business plan

~~Ratings~~

Poor, Downgrade, or Negative Trends in Ratings (Financial Strength or Credit) and Outlooks

~~***PROCEDURE #2*** directs analysts to d~~Determine if concerns exist regarding the insurer or insurance group's ratings. Ratings received from a rating agency, as well as changes in the ratings and company/industry outlooks, can have a significant impact on the insurer or insurance group's reputation. A rating decline or a poor rating could negatively affect the insurer's ability to write new business, or it may affect other business operations. For example, debt covenants often include requirements to maintain ratings above a certain level. Therefore, analysts are strongly encouraged to monitor agency ratings and outlooks when assessing an insurer's exposure to reputational risk. The primary agencies that issue ratings to insurers include A.M. Best, Fitch Ratings, Moody's Investors Service, Standard & Poor's and Weiss Financial Group. For more information on these agencies and their ratings processes, see I. Introduction C. External Information. In reviewing agency ratings, reports and outlooks, analysts should consider and assess the reputational impact of any negative movements or trends with the potential to impact the insurer, as such trends may limit the insurer's ability to write new business or otherwise affect ongoing operations.

Procedures

- Review the most recent report from a credit rating provider (e.g., A.M. Best, Moody's, Standard & Poor's, Fitch, and Weiss) for the current financial strength and credit ratings and outlook, as well as an explanation of any change in the ratings.

Additional Review Procedures

- If concerns exist regarding a poor financial strength or credit rating, a negative outlook, or a rating change for the insurer or the insurance holding company, review the most recent report from the credit rating provider (CRP) to determine if the rating is at a level that may impact the insurer's ability to continue to write new business or that may impact other business functions (e.g., terms of debt covenants, ability to attract financing, ability to place reinsurance, etc.).
- Inquire of the insurer:
  - Strategies for maintaining or improving ratings.
  - Dependency on quality ratings.
  - Information from the insurer on the impact of ratings or changes in ratings to the insurer and/or group's operations.
  - If the insurer is downgraded or has a low rating, request information on any efforts to restore its rating.
  - Outcome of recent meetings with rating agencies.
  - Revised business plan, sales and marketing strategies.
  - If rating downgrades occur at the parent or affiliate, what impact do those changes have on the insurer.

Poor Star Rating (Health Only)

Star Ratings ~~Procedure 2.c.~~ appl~~ies~~y ~~only~~ to health insurers and the procedures instructs the analyst to obtain and review the most recent information about Centers for Medicare and Medicaid Services (CMS)'s Star Rating of the insurer, as well as an explanation of any change in the rating. Star ratings are calculated by CMS based on the insurer's performance and member satisfaction data for Medicare plans including Medicare Advantage and Medicare Part D prescription drug plans. The ratings measure various factors and assign ratings on a scale from 1 to 5 stars, where 5 is the best. Star ratings help consumers compare the quality of Medicare plans. Performance data including Star ratings are available on the following CMS website:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData

A low or lowering of the Star rating may result in concerns regarding the insurer's reputation leading to loss of membership, decrease in underwriting results, and changes in future strategic plans. Where concerns exist, the analyst should consider gaining an understanding of the reasons for the low or lowering of the Star rating from the insurer, and how it impacts membership and future operations.

Also noteworthy is that insurers with Star ratings of 4 or higher receive annual bonus payments from CMS, which is required to be spent on extra benefits for members, which benefits consumers. Plans that receive at least four out of five stars have their benchmark increased. Total Spending on Medicare Advantage plan bonus payments have risen every year. The growth in spending on bonus payments has coincided with the increase in Medicare Advantage enrollment. Annual bonus payments from the federal government to Medicare insurers have reached an all-time high at a time when the Medicare program is facing growing fiscal pressures. The analyst should consider the amount of the bonus payments relative to the overall profit/loss and assess the reliance on those bonus payments and the possible impact should the insurer no longer receive them.

Procedures

- Health Lines of Business Only (filing on either Health or Life/A&H financial statements): Obtain and review the most recent information about Centers for Medicare & Medicaid Services' (CMS) Star Rating of the insurer, as well as an explanation of any change in the rating, to determine if concerns exist regarding the impact to the insurer's reputation, pricing and underwriting, and/or future strategic plans. Also note whether if the insurer has received a Star Rating of 4 or more and in turn received annual bonus payments from CMS to be spent on extra benefits for its members. Assess the reliance on bonus payments and the possible impact should the insurer no longer receive them.

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News, Press Releases and Industry Reports

Negative Publicity [or Negative Trends] in News, Press Releases and Industry Reports

PROCEDURE #3 directs analysts to dDetermine if concerns exist regarding news, press release, stock movements or industry reports involving the insurer or insurance group. The focus of this procedure is on reviewing sources of information outside of the regulatory filings to identify and assess relevant issues for their potential impact on the insurer's reputation. Negative publicity for the insurer or its affiliates could affect the insurer's ability to write new business or retain its current business. To obtain information from these sources, analysts should consider performing internet searches, subscribing to news feeds and taking other steps as necessary to accumulate and collect relevant information. In addition, analysts should consider using information accumulated and provided by the NAIC for this purpose, including industry snapshots and industry analysis reports, Capital Markets Bureau reports and solvency monitoring risk alerts. For insurers that are part of publicly traded groups, movements and trends in stock price may be indicative of potential reputational issues and should, therefore, be reviewed and assessed.

Procedures

- Review insurer or insurance group press releases to identify if any negative publicity or other issues have the potential to adversely impact the insurer's reputation.
- Review any insurance, marketplace or economic industry reports, news releases, and emerging issues to identify if any issues have the potential to negatively impact the insurer's reputation.
    - Examples: NAIC "Insurance Industry Snapshots" and "Insurance Industry Analysis Reports," NAIC Capital Markets Bureau reports, rating agency reports, insurance news sources, NAIC Risk Alerts, etc.

Additional Review Procedures

- If concerns exist regarding a recent industry report, news release, stock movement or emerging issue, determine if the news or industry issue has the potential to impact the insurer's reputation, operations or financial solvency.
- Review movements and trends in the insurer's or group's stock price and trading volume to assist in identifying and assessing reputational risk.
- Perform additional non-routine procedures where applicable (e.g., survey or questionnaire, stress testing, etc.).
- Inquire of the insurer:
    - Policies and strategies for mitigating reputational damages or crises sustained by the insurer or insurance group
    - Assessment of emerging risks in the industry and economic impacts on ongoing business plans. (If an Own Risk and Solvency Assessment (ORSA) filer, this may be included in the ORSA Summary Report)

Market Conduct

Market Conduct Violations/Issues

Market Conduct Examination Findings [or Corrective Action Plan]

Financial Impact of Remediation of Market Conduct Violations

PROCEDURE #4 directs analysts to dDetermine if reputational concerns exist as a result of market conduct

issues, ~~such as~~including complaints, market conduct actions, issues raised by market conduct staff, etc. In identifying and assessing reputational risks emerging as a result of market conduct considerations, analysts should review information available through NAIC market analysis tools and databases(e.g., Market Analysis Procedures (MAP), the Market Analysis Review System (MARS), the Market Action Tracking System (MATS), the Regulatory Information Retrieval System (RIRS), the Market Conduct Annual Statement (MCAS), Complaints, etc.). These tools are made available to financial analysts through links on iSITE+ and can be a valuable resource in identifying issues with the potential to harm the insurer's reputation. If any concerns are identified through use of the tools, financial analysts are encouraged to contact market conduct regulators in their state to investigate further, discuss and follow-up on the issues identified. In addition, analysts should routinely reach out to market conduct regulators to inquire regarding any significant issues they are aware of that could affect the insurer's reputation or solvency position.

Material findings or corrective actions, including large fines, settlements or required remediation (e.g., re-reviewing denied claims), may have a current or prospective financial impact on the insurer. (E.g., if corrective actions extend into future years and result in future costs or changes in operating practices)

Procedures

- Review any market conduct information available from the NAIC market analysis tools and databases (MAP, MARS, MATS, RIRS, MCAS, and Complaints). Note any unusual items or negative trends that translate into financial risks or indicate further review is needed.
  - Count of total confirmed complaints
    - Current year
    - Prior year
    - Second prior year
  - Confirmed complaint index (nationwide)
    - Current year
    - Prior year
    - Second prior year

Additional Review Considerations

- Review any market conduct information, including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee). Note any unusual items that translate into financial risks or indicate further review is needed.
- Review any inter-departmental communication, as well as communication with other state, federal or international insurance regulators and the insurer. Note any unusual items or prospective risks that indicate further analysis or follow-up is necessary.
- If market conduct information is unusual and indicates the potential for reputational damage, perform the following procedures:
  - Describe and document the findings of the most recent market conduct examination and analysis and communication with the insurance department's market conduct staff.
  - Describe any current or future actions of the insurance department, other state insurance departments or other regulatory bodies against the insurer related to market conduct violations.
- Inquire of the insurer:
  - Its assessment of the financial impact to operations and surplus of market conduct examination findings, fines, settlements or remediation.
  - Claims payment policies (including use and oversight of third parties)

~~Additional Analysis and Follow-Up Procedures~~ ADDITIONAL PROCEDURES APPLICABLE TO REPUTATIONAL RISK

Examination Findings

~~***EXAMINATION FINDINGS*** directs analysts to consider a r~~Review ~~of~~ the most recent examination report, ~~s~~Summary ~~r~~Review ~~m~~Memorandum (SRM) and communication with the examination staff to identify if any reputational risk issues were discovered during the examination.

Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding reputational risks. If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

~~***REQUEST AND ASSESS POLICIES & STRATEGIES*** directs analysts to obtain and review information from the insurer regarding its policies and strategies for dealing with reputational risk, including strategies for maintaining or improving ratings and policies and strategies for mitigating reputational damages or crises sustained by the insurer or insurance group.~~

~~***INQUIRE OF THE INSURER*** directs analysts to consider requesting additional information from the insurer if reputational risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of reputational risk for specific topics where concerns have been identified.~~

Own Risk and Solvency Assessment (ORSA) Summary Report

~~***OWN RISK AND SOLVENCY ASSESSMENT (ORSA)*** directs analysts to o~~Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing reputational risks faced by the insurer.

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

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

Holding Company Analysis

~~***HOLDING COMPANY ANALYSIS*** directs analysts to o~~Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing reputational risks that could impact the insurer.

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

Prospective Risk Considerations

The table provides analysts with example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general discription of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the reputational risk category.

Discussion of Quarterly Reputational Risk AssessmentProcedures

The Qquarterly Rreputational Rrisk Repository assessment procedues are designed to identify the following.:

Reputational Impacts of Other Risks

Evaluate the impact of risks associated with other branded risk classifications may emerge from other branded risks.

Procedures

- Whether reputation risks may emerge from other branded risk classifications
  - Identify and evaluate the impact of legal risks on the insurer's reputation, such as:
    - Violations of legal and regulatory requirements
    - Ongoing regulatory investigations
    - Significant ongoing litigation
    - Reports of fraud or fraud investigations
    - Ethical violations
  - Identify and evaluate the impact of operational risks on the insurer's reputation, such as:
    - Information technology (IT) security concerns
    - Weak or ineffective corporate governance
    - Problems in operating performance
    - Third-party administrator (TPA) or managing general agent (MGA) relationships
  - Identify and evaluate the impact of strategic risks on the insurer's reputation, such as:
    - Significant turnover at the board and senior management level
    - Merger and acquisition activity
    - Changes in business plan or strategic direction
    - Increasing leverage or concerns over capital adequacy
  - Identify and evaluate the impact of an impairment of goodwill of any investment in parent, subsidiaries, or affiliates (PSA) and the causes for such impairment on the insurer's reputation.
  - Identify and evaluate the impact of all other significant risks with the potential to affect the insurer's reputation.

Poor, Downgrade, or Negative Trends in Ratings (Financial Strength or Credit) and Outlooks

Determine if concerns exist regarding the insurer's or group's ratings.

Procedures

Concerns regarding the insurer's or group's ratings

- Review the most recent report from a credit rating provider (e.g., A.M. Best, Moody's, Standard & Poor's, Fitch, and Weiss) for the current financial strength and credit ratings and outlook, as well as an explanation of any change in the ratings.

- If concerns exist regarding a poor financial strength or credit rating, a negative outlook, or a rating change for the insurer or the insurance holding company, review the most recent report from the credit rating provider (CRP) to determine if the rating is at a level that may impact the insurer's ability to continue to write new business or that may impact other business functions (e.g., terms of debt covenants, ability to attract financing, ability to place reinsurance, etc.).

Poor Star Rating (Health Only)

Procedures

- Health Lines of Business Only (filing on either Health or Life/A&H financial statements): Obtain and review the most recent information about CMS's Star Rating of the insurer, as well as an explanation of any change in the rating, to determine if concerns exist regarding the impact to the insurer's reputation, pricing and underwriting, and/or future strategic plans. Also note whether the insurer has received a Star Rating of 4 or more and in turn received annual bonus payments from CMS to be spent on extra benefits for its members. Assess the reliance on bonus payments and the possible impact should the insurer no longer receive them.

Negative Publicity [or Negative Trends] in News, Press Releases and Industry Reports

Determine if concerns existregarding news, press release or industry reports involving the insurer or insurance group.

Procedures

~~Concerns with news, press release or industry reports involving the insurer or insurance group~~

- Review insurer or insurance group press releases to identify if any negative publicity or other issues have the potential to adversely impact the insurer's reputation.
- Review any insurance, marketplace or economic industry reports, news releases and emerging issues to identify if any issues have the potential to negatively impact the insurer's reputation.
  - Examples: NAIC "Insurance Industry Snapshots" and "Insurance Industry Analysis Reports," NAIC Capital Markets Bureau reports, rating agency reports, insurance news sources, NAIC risk alerts, etc.
- If concerns exist regarding a recent industry report, news release or emerging issue, determine if the news or industry issue has the potential to impact the insurer's reputation, operations or financial solvency.

Market Conduct Violations/Issues

Market Conduct Examination Findings [or Corrective Action Plan]

Financial Impact of Remediation of Market Conduct Violations

Determine if ~~C~~concerns exist ~~with~~regarding market conduct issues, including complaints, market conduct actions, issues raised by market conduct staff, etc. If concerns exist, communicate risks/issues to the state insurance department's market conduct unit to conduct further investigation.

Procedures / Data

- Review any market conduct information available from the NAIC market analysis tools and databases (MAP, MARS, MATS, RIRS, and Complaints). Note any unusual items or negative trends that translate into financial risks or indicate further review is needed.
  - Count of total confirmed complaints
    - Current year-to-date

    - Prior year-to-date
    - Second prior year-to-date
  - Confirmed complaint index (Nationwide)
    - Prior Year-End
    - Second Prior year-end
    - Third prior year-end

Additional Review Considerations

- Review any market conduct information, including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee). Note any unusual items that translate into financial risks or indicate further review is needed.
- Review any inter-departmental communication, as well as communication with other state, federal or international insurance regulators and the insurer. Note any unusual items or prospective risks that indicate further analysis or follow-up is necessary.
- If market conduct information is unusual and indicates the potential for reputational damage, perform the following procedures:
  - Describe and document the findings of the most recent market conduct examination and analysis and communication with the insurance department's market conduct staff.
  - Describe any current or future actions of the insurance department, other state insurance departments or other regulatory bodies against the insurer related to market conduct violations.

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

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Reserving Risk Assessment

Reserving Risk: Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

The objective of the Reserving Risk Assessment is focused primarily on two key aspects of reserving: 1) reserve valuation and 2) reserve adequacy. Analysis of reserves relies heavily on the review of the Statement of Actuarial Opinion (SAO) and other related filings. The following Overview and Discussion of Procedures provides information on health entity reserving and suggested data, benchmarks and procedures analysts can consider in his/her review. In analyzing reserving risk, analysts may analyze specific types of reserves established by health entities, reserving methodologies and various aspects of health insurance that affect reserving. For example, an analyst's risk-focused assessment of reserving risk may consider the following areas (but not limited to):

- Reserve valuation in accordance with the appropriate valuation requirements
- Reasonableness of valuation bases utilized, testing, assumptions, and methodologies to determine reserves
- Adequacy of assets to support policyholder benefits
- Appropriate reporting of reserves
- Lines of business written by the insurer
- Types of reserves for health lines of business
- Reserve development
- Reinsurance
- Loss adjustment expenses (LAE)
- Claims adjudication

DISCUSSION OF STATEMENT OF ACTUARIAL OPINION WORKSHEET

Using the Worksheet

The Statement of Actuarial Opinion Worksheet is intended to provide procedures for reviewing the Actuarial Opinion and other actuarial filings for compliance and assessment of risks. In many states, actuarial staff review the Actuarial Opinion and related filings. Whether the analyst or the actuary performs the SAO review, the Worksheet provides for the results of the SAO review to be documented and communicated to the analyst. Analysts should document overall results of the actuarial opinion analysis and risk identified in Section III: Risk Assessment of the insurer within reserving risk or other relevant risk category. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the worksheet document.

Discussion of Annual Reserving Risk RepositoryGENERAL GUIDANCE

Using the Repository

The To assess reserving risk, repository is a list of possible quantitative and qualitative dataconsider the procedures, including specific data elements, metrics, and benchmarks and procedures from which the analyst or actuary may select to use in his/her review of reserving riskin this chapter. The following is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which there is no procedure available

should be analyzed by the state insurance department based on the nature and scope of the risk.

The placement of procedures, metrics, and data within reserving risk is based on “best fit.” Analysts should use their professional judgement in categorizing risks when documenting financial determinations of the analysis.

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

Analysts are not expected to ~~respond to all~~document every procedure~~s~~, data, or benchmark result~~s listed in the repository~~. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document ~~completion of~~ the applicable details within the analysis. Results of reserving risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risk and reflect the strengths and weaknesses of the insurer. ~~The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the department based on the nature and scope of the risk.~~

Results of risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.

~~In using procedures in the repository, a~~Analysts should ~~review the results~~complete their reserving risk assessment in conjunction with:

- A review of the Supervisory Plan and Insurer Profile Summary and the prior period analysis.
- ~~. Communication~~ Communication and/or coordination with other internal departments. ~~are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures in the repository.~~
- ~~Analysts should also consider t~~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 placement of the following data and procedures in the reserving risk repository is based on “best fit.” Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories.~~

~~***ANALYSIS DOCUMENTATION:*** Results of reserving risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.~~

STATEMENT OF ACTUARIAL OPINION ASSESSMENT WORKSHEET

The Statement of Actuarial Opinion Worksheet is intended to provide procedures for reviewing the Actuarial Opinion and other actuarial filings for compliance and assessment of risks. In many states, actuarial staff review the Actuarial Opinion and related filings. Whether the analyst or the actuary performs the SAO review, the Worksheet provides for the results of the SAO review to be documented and communicated to the analyst.

Refer to the Overview section at the end of this chapter for more guidance on the SAO.

The SAO must be issued by the Appointed Actuary who is a qualified health actuary appointed by the board of directors. For purposes of the health SAO, the Health Annual Statement Instructions define a qualified health

actuary as a member in good standing of the Academy or a person recognized by the Academy as qualified for such health actuarial valuation.

***PROCEDURE #1A*.** ~~assists analysts in d~~Determin~~e~~ing that the Table of Key Indicators has been completed. ~~Analysts should n~~Note that within each section of the Table, only one box should be checked. ~~The Table assists analysts in i~~Identify~~ing~~ those sections of the SAO for which it may be appropriate to perform additional analysis, specifically when "Prescribed Wording with Additional Wording" or "Revised Wording" has been checked.

***PROCEDURES #1B–#1E*.** ~~assists analysts in d~~Determin~~e~~ing that the SAO was prepared by a qualified actuary and that the reserve amounts agree with the Annual Financial Statement.

***PROCEDURE #1F*.** ~~assists analysts in d~~Determin~~e~~ing if the health entity's actuary, the health entity's accounting firm, or an officer of the health entity has verified the accuracy and completeness of source data.

***PROCEDURES #2A AND #2B*.** ~~assists analysts in d~~Determin~~e~~ing if the health entity's actuary has covered the required reserves.

***PROCEDURE #3A*.** ~~assists analysts in d~~Determin~~e~~ing that the health entity's actuary's SAO on reserves is in accordance with the criteria found in the *Health Annual Financial Statement Instructions* Section 7 and in particular that the SAO states that the reserves meet the requirements of the state of domicile. The *Annual Financial Statement Instructions* list certain items to include in the SAO paragraph, A through H. Certain other items have been included as separate lines in the past. For 2009, these items should be included within item H. ~~Analysts should also d~~Determine the actuary's conclusion concerning reserve adequacy in total. It is important for the actuary to document the reasons for his or her conclusion, which should be available upon request by analysts.

***PROCEDURES #3B AND #3C*.** ~~are intended to assist analysts in d~~Determin~~e~~ing that the health entity's actuarial methods, considerations and analyses used in forming the actuary's opinion conform to the relevant Standards of Practice as promulgated by the Actuarial Standards Board.

***PROCEDURES #4 AND #5*.** ~~are p~~Perform~~ed~~ only in the situation where an asset adequacy test has been performed by the actuary. ~~These procedures assist analysts in r~~Review~~ing~~ the actuary's asset adequacy testing and actuarial memorandum that supports the SAO. The *Annual Financial Statement Instructions* and *Health Insurance Reserves Model Regulation* (#10) do not specifically require asset adequacy testing for health entities but may be required by actuarial standards of practices in some specific situations. A small number of health entities hold life insurance licenses and may, therefore, be subject to the asset adequacy and memorandum regulations. Analysts should become familiar with his or her state requirements and special situations that may exist.

For the small number of health entities that are subject to actuarial memorandum requirements, the actuarial memorandum is a comprehensive document that provides an understanding of the health entity's reserves, the assets available to support the reserves, and the projected impact on the health entity's financial condition of varying economic and interest rate projection scenarios. It is not automatically filed with the Annual Financial Statement but is provided to the regulator only upon request. The decision as to whether to request the actuarial memorandum is an important one. The actuarial memorandum should be requested for health entities with known financial problems, significant changes in product mix or investment strategy, or significant growth in a particular product line. The Regulatory Asset Adequacy Issues Summary (RAAIS), which is filed with the Annual Financial Statement, assists the regulatory actuary in determining whether to request the actuarial memorandum. The RAAIS would include the following eight data requests, many of which may not apply to health asset adequacy analysis. (Refer to the NAIC *Actuarial Opinion and Memorandum Regulation* (#822), Section 7.):

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1. For interest sensitive products, the amount of any negative ending surplus values on a market value basis under each of the Required Interest Scenarios.
2. The extent to which the Appointed Actuary uses assumptions in the asset adequacy analysis which are materially different than the assumptions used in the previous asset adequacy analysis.
3. The amount of reserves and the identity of the product lines which have been subject to asset adequacy analysis in the prior SAO but were not subject to such analysis for the current SAO.
4. The number of additional interest rate scenarios that were tested identifying separately the number of deterministic scenarios and stochastic scenarios. Also, identify the number of such scenarios which produced ending negative surplus values on market value basis.
5. If sensitivity testing was performed, identify the assumptions tested and describe the variation in ending surplus values on a market value basis from the base case values.
6. Comments should be provided on any interim results that may be of significant concern to the Appointed Actuary.
7. The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested.
8. Whether the actuary has verified that all options embedded in fixed income securities and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

~~Quantitative and Qualitative Data and Procedures~~ANNUAL RESERVING RISK ASSESSMENT

~~Reserve Adequacy and Valuation~~

Refer to the Overview section at the end of this chapter for more guidance on health reserves.

Adverse Findings from Statement of Actuarial Opinion Assessment

Risks may include:

- **Minimum Statutory Standards Not Met**
  - Analyst identifies that certain minimum statutory reserving standards have not been met as required by state law/regulation.
- **Management Changes - Change in Opining Actuary**
  - If there is a change in actuary, consider if the management change results in any changes in reserving assumptions, methodologies, etc.

~~***PROCEDURE #1*** asks analysts to r~~Review and incorporate~~s~~ any concerns or issues noted in the review of the Actuarial Opinion into the review of the valuation of the health entity's health reserves. The valuation of these reserves should be in accordance with Appendix A-010 of the AP&P Manual. Issues noted in the review of the Actuarial Opinion may be relevant to aspects of reserve risk identified in other procedures, and risks should be assessed concurrently with those procedures.

Issues or concerns identified through a review of the actuarial opinion assessment may indicate prospective risks. Examples include concerns regarding the qualifications of the appointed actuary, limitations in the scope of the opinion, an inability to reconcile to the Annual Statement, problems with the nature of the opinion, etc.

Procedure

- Review the results of the Statement of Actuarial Opinion Worksheet. Were any concerns noted regarding the valuation of the insurer's reserves in accordance with minimum statutory valuation standards?

Additional Review Considerations

- If questions or concerns are noted, contact the qualified actuary who signed the insurer's actuarial opinion to discuss the nature and scope of the health reserve valuation procedures performed.
- If questions or concerns are noted, request a copy of the qualified actuary's actuarial memorandum and review the actuary's comments regarding the analysis performed and conclusions reached regarding health reserves.
- Request information from the insurer on who ultimately determines the level of reserves to be booked by the insurer and the board of director's role in overseeing the reserving process.
- If filed on an insurance entity basis or if your state is the lead state, review the insurer's Corporate Governance Annual Disclosure (CGAD) filing to understand and assess the board of director's' role in overseeing the reserving process. If your state is not the lead state, rely on the information provided in the Group Profile Summary (GPS) or provided by the lead state, where the CGAD is filed on a group basis.

Adequacy of Health Reserves (High Reserve Leverages / Large Reserve Adjustments)

Determine whether an understatement of health reserves would be significant to the health entity.

High reserve leverage is represented by a high ratio of net claim unpaid and net aggregate health reserves to capital and surplus. If claims unpaid, claims reserve, policy reserve and premium deficiency reserve computations are not performed correctly or the selected estimates are unreasonable, capital and surplus could be negatively affected.

In evaluating these leverage ratios, also consider the nature of the health entity's business. For example, a health entity that has written primarily health business for many years and has proven that it can manage the business profitably is probably less risky than a health entity that has just begun writing health business, even if both entities have the same leverage ratio results.

Reserve adjustments made or anticipated to correct assumptions or other estimates result in a reduction to surplus.

PROCEDURE #2 assists analysts 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%, a 33% understatement of its health reserves would eliminate its entire surplus.

Procedures/Data

- Ratio of gross claims unpaid and gross aggregate health reserves to capital and surplus.
- Ratio of net claim unpaid and net aggregate health reserves to capital and surplus.
- Determine if The effect of a reduction in capital and surplus of 10% of the net claim reserve on risk-based capital (RBC) indicates if there would be result in a potential solvency problem if reserves were understated by 10%.

  A 200% RBC ratio is the Company Action Level of concern according to the NAIC *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315). A ratio below 200% indicates a health entity must file an RBC plan with the domiciliary state.

Additional Review Considerations

- If questions or concerns are noted, obtain information from the insurer regarding health claims paid after year-end, which were incurred prior to year-end, and test the reasonableness of the year-end claim liabilities established, by the insurer.

In evaluating these leverage ratios, analysts 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 #3 assists analysts in reviewing reserve development as an indicator in determining whether health policies appear to have been adequately reserved.

Part 2B – Analysis of Claims Unpaid - Prior Year-Net of Reinsurance of the Underwriting and Investment Exhibit provides information that allows analysts to determine if the health entity has had adverse reserve development in the past year. Using this exhibit, a ratio of the paid claims plus reserves for prior periods to the reserves established in the prior year can be calculated. A positive result (ratio > 1) for this ratio represents additional or "adverse" development on the reserves originally established by the health entity (the estimated amount of the original reserves has proven to be understated based on subsequent activity). The amount of reserve deficiency is compared to the reserve to determine if the deficiency was > 10%.

Part 2C – Development of Paid and Incurred Health Claims of the Underwriting and Investment Exhibit shows a history of reserve development. If the health entity's ratio results consistently show additional development, this could be an indication that the health entity is understating its health reserves. Analysts should review this exhibit to determine if there have been any adverse trends or fluctuations and if reserves have been adequate to pay actual claims.

Inappropriate or Inaccurate Valuation of Health Reserves
Adverse Reserve Development, or Negative Reserve Development Trend

- Review reserve development as an indicator in determining whether health policies appear to have been adequately reserved. Reserve development can be used as a measure to assess the insurer's ability to accurately estimate reserves. Analysts also should consider the reserve development trend.

Procedures/Data

- Compare the one-year reserve development to capital and surplus and review and explain any adverse loss development results. [Annual Financial Statement, Underwriting and Investment Exhibit – Part 2B]
  - Determine if the insurer reported a reserve deficiency that was material to capital and surplus.
  - Determine if there has been an increase or decrease in the claim reserve and claim liability as a percentage of incurred claims since prior year-end.
- Review the Annual Financial Statement, Underwriting and Investment Exhibit – Part 2C. Determine if there has been an adverse trend or unusual fluctuation over the last five years.
- Review the Annual Financial Statement, Underwriting and Investment Exhibit – Part 2B and Part 2C. Determine if the reserve has been adequate to pay actual claims.
- Review the Annual Financial Statement, Underwriting and Investment Exhibit to determine which lines of business may have been under reserved at the prior year-end.
- If significant concerns regarding reserve development are identified, request the assistance of a department or consulting actuary in reviewing and assessing the adequacy of the reserves carried by the insurer.

Reserve Adequacy – Loss Ratio Assessment

PROCEDURE #4 provides Assess loss ratio and underwriting gain/loss indicators that assist analysts into determineing if health policies appear to be adequately reserved. Significant increases in the loss ratio might be indicative of additional health reserves being established due to prior understatements while significant decreases might be indicative of current health reserve understatements.

Typically, significant increases in membership will result in lower loss ratios since first year claims experience is typically lower in the first year. Dropping membership accompanied with increasing loss ratios may indicate that healthier individuals and groups are leaving. This is often the first sign of a potential adverse selection rate spiral where rates force healthier individuals to leave resulting in inadequate rates. Reviewing the per-member per-

month medical expense in the prior year or quarter may be further indication of problems, especially if membership is dropping.

By compare the health entities medical claims expense per member per month (PMPM) and claims unpaid ratio to similarly situated industry peers, if significant variances from industry peers are noted, the analyst may need to gain a better understanding of the health entity's claim experience.

A deficiency reserve is required when future premiums are not sufficient to pay future claims and expenses. If a line of business is showing an underwriting loss there may be a need for a deficiency reserve. It is possible that premium increases have been implemented to correct the deficiency, but the situation should be considered.

A significant decrease in health reserves to incurred claims may indicate that reserves have been weakened. Note, there are other possible explanations for this type of change such as a shift in provider contracting or product design, however analysts should investigate if material changes occur.

Analysts should review the percentage of claims paid on a capitated basis. If this percentage is decreasing, indicating a shift from capitated to fee-for-service, there should be an increase in health reserves in proportion to incurred claims. A shift in the other directions should have the opposite effect.
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.
• Procedures/Data

- The lLoss ratio for each product line should also be reviewed as a part of this procedure.
- Change in the loss ratio from the prior year.
- Analysts 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.

Additional Review Procedures
- Compare the direction of any changes in the loss ratio to the direction of changes in membership.
- Review the ratio of claims unpaid plus aggregate health reserve to incurred claims by line of business for past years to determine unusual fluctuations or trends between years.
- Compare the annual per member per month medical claims expense increased from last year-end compared to similarly situated health entities.
- Compare the ratio of claims unpaid plus aggregate health reserve to incurred claims to similar companies in the industry to determine any significant deviations from the industry average.
- Review the percentage of claims paid on a capitated basis.

PROCEDURE #4D

PROCEDURE #4E instructs analysts in comparing the health entities medical claims expense per member per month (PMPM) and claims unpaid ratio to similarly situated industry peers. If these claim results are significantly different from industry peers, analysts may need to gain a better understanding of the health entity's claim experience.**Understatement of Reserves due to Delayed Claims Adjudication/Payment**

PROCEDURE #5: The ratio of claims in process of adjudication to the average incurred non-capitated claims per day measures the average number of days of reported unpaid claims in inventory by reducing annual incurred claims to a daily average. An unusual result may indicate problems with claims administration or cash flow.

To determine the size of the backlog you must first determine the average daily-incurred claim expense less capitation. Once you have determined this amount, then determine the amount of claims in the process of adjudication, excluding capitation, divided by the average daily-incurred claim expense, to determine the average number of days of claims backlog.

Results for a recently licensed or rapidly growing health entity may have a high ratio because the growth of the numerator will be faster than the growth of the denominator. Reporting inventory valuation problems may also skew results for this ratio. Also, any IBNR changes will affect any results of this ratio.
Please note that a similar ratio might be calculated based on average daily paid claims instead of average daily incurred medical expense less capitation.

Procedure(s)/Data

- Determine if the amount of claims in process of adjudication to the average incurred non-capitated claims per day is greater than 30.

High Unpaid Claims Adjustment Expsenses

~~***PROCEDURE #6*** provides metrics for assessing unpaid claims adjustment expenses~~Assess unpaid claims adjustment expenses.

Procedures/Data

- Ratio of unpaid claims adjustment expenses to claims unpaid.
- Ratio of unpaid claims adjustment expenses to incurred claims adjustment expenses.

Reasonableness of Actuarial Methodologies and Assumptions

Reasonableness may be identified through follow-up to the examination, review of actuarial filings that summarize changes in assumptions/methodologies, discussions with the company, etc. ~~***PROCEDURE #7*** provides procedures analysts may consider in assessing~~Assess the lines of business written by the health entity, business plans, policy benefits offered, and RBC information in order to~~ and~~ gain~~ing~~ an understanding of the impact differences in the types of plans may have on reserving risk.

Procedures

- Determine which health lines of business are being written by the insurer.
- Review the insurer's risk-based capital filing to better understand the types of risk and risk management techniques being used, such as the types of managed care arrangements being used.
- Request a copy of the insurer's business plan and review the insurer's plans to assess and mitigate reserve risks.
- Review the Annual Financial Statement, Notes to Financial Statements, MD&A or other correspondence with the insurer to determine if the insurer initiated any internal changes that may impact the reserve estimates.
- Review the insurer's health insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific features and benefits.
- Contact the policy forms section of the insurance department and inquire as to whether the insurer has filed any new and unusual health policy forms during the past year.

Additional Review Procedures

- Request and review assumptions for reserve, utilization and benefit costs projected in the development of the contracts.
- Request information regarding any significant changes in reserve methodologies and assumptions, underwriting practices, case reserving, or claims handling practices with the potential to affect reserve setting.

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Adequacy of Long-Term Care (LTC) Insurance Reserves (Risk of Understatement of Reserves)

PROCEDURE #8 instructs analysts to rReview the LTC Experience Reporting Form of the Annual Financial Statement and the Actuarial Guidelines 51 reporting filed to the department if the insurer writes LTCI to gain an understanding of the reserve adequacy of the LTC line of business. If concerns exist, consider requesting additional information as necessary to assess actual vs. projected results, legacy vs. newer blocks of business separately, any recent rate increases and capital support. If the insurer has recently filed for rate increases on LTCI blocks, consider intra-departmental discussion with the rate increase analysis and outcome with the rate review staff (if a different person than the analyst/actuary performing the valuation reserve analysis).

Procedures

- Review the information reported in the LTC Experience Reporting Form of the Annual Statement, the *Actuarial Guideline LI -The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG51)* reporting, actuarial memorandum or any other related actuarial information filed to the department, and identify any concerns with reserve adequacy of the LTC insurance business. Request a department actuary to assist in the review, if available.
  - Gain an understanding of the asset adequacy and cash-flow testing for LTCI on a stand-alone basis.
  - Consider any negative development in total LTCI reserve, asset adequacy reserves (if available), active life reserves, disabled lives reserves and premium deficiency reserves over the last five years.
    - Evaluate the appropriateness of investment return assumptions factoring in the status of the current economic and low interest rate environment.
- If concerns exist:
  - Evaluate actual results vs. original or revised assumptions and financial projections to identify trends and concerns.
  - Consider evaluating legacy blocks of business separately from newer blocks of business.
  - Rate Increases: Obtain and review the following information related to the status of rate increases and reduced benefit options. Consider that some information may be available from rate review staff for recent rate increase filings:
    - Track the progress of rate increases across states where a material amount of business is written.
    - Review projections illustrating the impact of proposed rate increases or reduced benefit options on the company's future profitability.
    - Determine the extent that future rate increases are included in the amount ($) of reserve offsets, asset adequacy/cash-flow testing and the reasonableness of the assumptions.
    - Consider the impact of historical approvals on the company's ability to obtain the rate increases presented in the projections. If concerns are identified in this area, obtain and review information on the company's plans to address these issues.
    - Compare the average percent of rate increases requested to the average approved.
    - Identify the amount of written premium change due to approved rate increases.
  - Regarding the adequacy of internal capital to support the LTCI business, compare the current total LTC reserves (active life and other), net of reinsurance, to the amount of internal capital the company has set aside for LTCI (e.g., internal capital per ORSA if applicable, or rating agency if higher than internal). If necessary, request information to gain an understanding of the degree of conservatism in such capital assumptions.

Impact of Changes in Valuation Bases of Reserves

PROCEDURE #9 provides for a rReview of the Annual Financial Statement to determine whether there has been a change in the valuation basis of the health policies during the year. Analysts should cConsider a review of changes that result in a decrease in health reserves in an amount greater than 5% of capital and surplus.

Procedures

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- Review the insurer's description of the valuation standards used in calculating the additional contract reserves (which is required to be attached to and filed with the Annual Financial Statement) and consider whether the reserve bases, interest rates, and/or methods appear reasonable.

Additional Analysis and Follow-Up Procedures

Examination Findings: direct analysts to cConsider a review of the recent examination report, summary review memorandum (SRM) and communication with the examination staff to identify if any reserving risk issues were discovered during the examination. If outstanding issues are identified, perform follow-up procedures as necessary to address concerns.

Inquire of the Insurer directs analysts to consider requesting additional information from the insurer if reserving risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of reserving risk for specific topics where concerns have been identified, such as reserve methodologies, assumptions and oversight of reserve setting.

Own Risk and Solvency Assessment OWN RISK AND SOLVENCY ASSESSMENT (ORSA): directs analysts to oObtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing reserving risks faced by the insurer.

- Determine if the ORSA Summary Report analysis conducted by the lead state indicated any reserving risks that require further monitoring or follow-up.
- Determine if the ORSA Summary Report analysis conducted by the lead state indicated any mitigating strategies for existing or prospective reserving risks.

HOLDING COMPANY ANALYSISHolding Company Analysis: directs analysts to oObtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing reserving risks that could impact the insurer.

- Determine if the Holding Company analysis conducted by the lead state indicated any reserving risks impacting the insurer that require further monitoring or follow-up.
- Determine if the Holding Company analysis conducted by the lead state indicated any mitigating strategies for existing or prospective reserving risks impacting the insurer.

Example Prospective Risk Considerations

The table provides analysts with example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general discription of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the reserving risk category.

DISCUSSION OF QUARTERLY PROCEDURESRESERVING RISK ASSESSMENT

The Qquarterly Rreserving Rrisk Repository procedures are intended to identify if an understatement in reserves would have a potential impact on the health entity's solvency and if significant changes in health reserves or health benefits have occurred since the prior year Annual Financial Statement.

PROCEDURE #2 assists analysts in dDetermineing whether health policies appear to have been adequately reserved. A change in reserves of greater than 10% may indicate reserves should be looked at more closely. Actual claim payments and the current reserve for prior periods are reviewed in relationship to the prior year-end reserves to determine if the year-end reserve was adequate in light of subsequent experience.

Enrollment, premium, and utilization are reviewed to determine if there have been large changes in these key elements. Increasing utilization may lead to increasing loss ratios if premiums are not increased adequately. Large increasing enrollment may require increasing reserves and large decreases in enrollment may result in increasing loss ratios due to the loss of healthier individuals. This particularly happens when there are large rate

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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.

~~Analysts should c~~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. ~~Analysts should a~~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, ~~analysts 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.) ~~Analysts might want to c~~Contact the qualified actuary who signed the health entity's actuarial opinion to discuss the nature and scope of the valuation procedures performed and/or request a copy of the qualified actuary's actuarial memorandum to review for comments regarding the analysis of reserves performed and the conclusions reached.

Understatement of Health Reserves
Determine whether an understatement of health reserves would be significant.

Procedures/Data
- Ratio of net claims unpaid and net aggregate health reserves to capital and surplus.
- Determine if the current estimate of the insurer's claims unpaid and aggregate claim reserves would drop the insurer's prior year risk-based capital ratio below 200%.

Changes in Health Reserves and Reserve Adequacy
Determine whether health policies appear to have been adequately reserved.

Procedures/Data
- Change in claims unpaid, the aggregate policy reserves, or aggregate claim reserves from the prior year-end.
- Change in the claim reserve and claim liability as a percent of incurred claims since prior year-end. [Quarterly Financial Statement, Underwriting and Investment Exhibit]
- Change in member months for any line of business from the prior year, same period. [Quarterly Financial Statement, Exhibit of Premiums, Enrollment, and Utilization]
- Point change in the medical loss ratio for any product line from the same period in the prior year.
- Compare the direction of any changes in loss ratio to the direction of changes in membership. Determine if there is an indication that increased loss ratios may be resulting from falling membership.
- Compare to peer health entity results.
    - Increase in the annual per member per month hospital and medical claims expense since last year-end and/or since last quarter, more than similarly situated health entities.

~~Other steps for analysts 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, analysts 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, analysts 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.~~

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

~~OVERVIEW OF~~ ACTUARIAL OPINION ASSESSMENT OVERVIEW

The Table of Key Indicators included in the SAO notes where prescribed language has not been used, as well as if the Statement is other than unqualified. Generally, analysts can focus on the following four steps to compose much of the initial Actuarial Opinion Assessment Procedures.

1. Review Table of Key Indicators for use of other than prescribed language.
2. Review Table of Key Indicators for use of an unqualified opinion.
3. Determine if the Company has provided a notification letter to the domiciliary state describing the appointment of the actuary.
4. Determine if a certification letter is attached if the actuary has relied upon someone for data.

As noted in the discussion of the Actuarial Opinion Assessment Procedures below, in most instances proper review and analysis of the SAO beyond the Actuarial Opinion Assessment Procedures will use in-depth knowledge of actuarial science where most SAOs will be reviewed in detail by actuarial staff members. However, it is up to each state to determine how best to address this review with available resources.

The following provides an in-depth description of elements of the SAO.

The Health Annual Statement instructions contain 10 sections that provide instructions for the SAO, including instructions relevant to the Actuarial Memorandum that supports the SAO. These 10 sections are summarized below.

Section 1 requires a Qualified Health Actuary (actuary) to render the SAO. For this SAO, an actuary means a member of the American Academy of Actuaries (Academy), or a person recognized by the Academy as qualified for such actuarial valuation. The actuary must be appointed (Appointed Actuary) by the board of directors (or a committee of the board) to render the SAO. Section 1 includes specific responsibilities of the insurer regarding the appointment of the Appointed Actuary and addresses documentation, and replacement requirements. Requirements include notification of any replacement of the Appointed Actuary to the commissioner with disclosure of any disagreements with the prior actuary relevant to the SAO. Requirements are also provided regarding a responsive letter from the prior actuary addressing agreement or disagreement to reasons for replacement provided by the company. When reviewing compliance with Section 1, note that the publication of the changes to the Health Actuarial Opinion Annual Statement Instructions in September 2009 may impact the timeliness of notification and compliance. Section 1 also provides for reporting and documentation requirements between the Appointed Actuary and the board of directors or the Audit Committee. Section 1A provides definitions, Section 1B discusses exemption options and Section 1C provides requirements for the Actuarial Memorandum which supports the SAO.

An insurer who intends to file for one of the exemptions under this Section must submit a letter of intent to its domiciliary commissioner no later than Dec. 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to Dec. 31 of the same year if he or she deems the exemption inappropriate. A copy of the approved exemption must be provided in lieu of the SAO with the Annual Statement in all jurisdictions in which the company is authorized.

To qualify for an exemption, an insurer must meet one of the four following criteria:

1. An insurer that reports less than $1,000,000 total gross written premiums during a calendar year, and less than $1,000,000 total gross loss and loss adjustment expense reserves at year-end, in lieu of filing the SAO required for the calendar year, may instead file an affidavit under oath of an officer of the insurer that specifies the amounts of gross written premiums and gross loss and loss adjustment reserves.

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2. Unless ordered by the domiciliary commissioner, an insurer that is under supervision or conservatorship is exempt from the filing requirements.
3. An insurer otherwise subject to the requirement and not eligible for any of the exemptions previously described, may apply to its domiciliary commissioner for an exemption based on the nature of business written.
4. An insurer otherwise subject to this requirement and not eligible for any of the previously discussed exemptions may apply to the commissioner for a financial hardship exemption. A financial hardship exists if the projected reasonable cost of the SAO would exceed the lesser of:
    a) 1% of the insurer's capital and surplus as stated in the insurer's latest quarterly statement for the calendar year for the calendar year for that the exemption is sought; or
    b) 3% of the insurer's gross premium written during the calendar year for which the exemption is sought as projected from the insurer's latest quarterly statements filed with its domiciliary commissioner.

Section 2 requires that the SAO contain four clearly designated sections: Identification, Scope, Reliance, and Opinion. A fifth section, Relevant Comments, may be provided at the option of the actuary. A Table of Key Indicators must be provided which indicate whether these five sections use prescribed wording only, prescribed wording with additional wording, or revised wording. The Table of Key Indicators also provides whether the SAO is unqualified, qualified, adverse, or inconclusive.

Section 3 provides a Table of Key Indicators, which indicates whether the sections of Identification, Scope, Reliance, or Opinion use prescribed wording only, prescribed wording with additional wording, or revised wording. The Relevant Comments section provides boxes to be checked that indicate if there is revised wording or if any of the actuary's work, as detailed in the Actuarial Memorandum deviates from Actuarial Standards of Practice. The Table of Key Indicators also provides whether the SAO is unqualified, qualified, adverse, or inconclusive.

Section 4 (Identification section) is self-explanatory.

Section 5 (Scope section) is also self-explanatory where all actuarial items listed in the instructions should be provided even if amounts are zero.

Section 6 (Reliance section) requires the actuary to identify any person upon whom the actuary relied for data used in the reserve analysis. A statement from the person relied on is also required by this section. The actuary may choose to accept responsibility for the data without reliance on another. The actuary would state this by using prescribed language in this section.

Section 7 (Opinion section) provides the prescribed statements the actuary is to make that opine on the items identified in Section 5. This is a key section to review for deviations from prescribed language that form the basis for whether the SAO is unqualified, qualified, adverse, or inconclusive as indicated in Section 3.

Section 8 (Relevant Comments section) is optional. The actuary may use this section to state a qualification of his or her opinion or provide greater explanation of that qualification. The actuary may also address topics of regulatory importance or explain some aspect of the annual statement. Examples may include explanations of any material changes in assumptions or methods that were made during the year.

Section 9 of the SAO instructions provides additional guidance to the actuary regarding adverse, qualified, or inconclusive opinions. The determination of adverse, qualified, or inconclusive must be explicitly stated in the Table of Key Indicators provided in the Opinion. It is expected that adequate explanation of this determination be provided in the Opinion.

Section 10 of the Opinion provides for signatures which is self-explanatory.

Considerations

Requirements for the SAO provide for conformance with specific Standards of Practice adopted by the Actuarial Standards Board (ASB) of the Academy, including standards relating to follow-up studies and standards of what should be included in a SAO. For managed-care health plans, ASB standards for SAPs (ASOP 5, “Incurred Health and Disability Claims” or ASOP 42,” Determining Health and Disability Liabilities Other than Liabilities for Incurred Claims”) require consideration by the actuary of any capitated risk contracts that exist. Such consideration should also include or indicate whether the actuary has evaluated the financial position of the provider entities.

There is a significant difference between the SAO requirements as found in the Life, Accident & Health or Property & Casualty Annual Financial Statements and the Health Annual Financial Statement. Effective for 2003 Statutory Statements, companies with over 95% of specific types of health insurance would file the Health Annual Financial Statement regardless of their state license. Such companies must comply with not only the SAO requirements of the Health Annual Financial Statement but also with the SAO requirements based on their state license. For example, life insurance companies who file the Health Annual Financial Statement are still subject to any asset adequacy SAO requirements as required by the SAO and Memorandum Regulation pursuant to the Standard Valuation Law.

The NAIC *Health Insurance Reserves Model Regulation* (#10) if implemented by a state with respect to health entities defines the minimum reserve requirements. The NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) Appendix A-010 defines minimum health reserve requirements when there are no other state specific requirements[1]. Although Appendix A-010 describes the separate minimum standard for each type of reserve separately, *Statement of Statutory Accounting Principles (SSAP) 54R—Individual and Group Accident and Health Contracts* requires a health entity’s health insurance reserves to also be tested in total using the gross premium valuation method. The SAO for the Health Annual Financial Statement is required to address certain other liabilities as well as these specific reserves. The *Annual Financial Statement Instructions* specifically include:

A. Claims unpaid (Page 3, Line 1).

B. Accrued medical incentive pool and bonus payments (Page 3, Line 2).

C. Unpaid claims adjustment expenses (Page 3, Line 3).

D. Aggregate health policy reserves (Page 3, Line 4) including unearned premium reserves, premium deficiency reserves, and additional policy reserves from the Underwriting and Investment Exhibit – Part 2D.

E. Aggregate life policy reserves (Page 3, Line 5).

F. Property/casualty unearned premium reserves (Page 3, Line 6).

G. Aggregate health claim reserves (Page 3, Line 7).

H. Any other loss reserves, actuarial liabilities, or related items presented as liabilities in the annual statement.

I. Specified actuarial items presented as assets in the annual statement.

Although the instructions specifically identify the above actuarial items for review, certain other actuarial items also require review as provided in the general item H above. Some actuarial items are often incorporated into the required items while others have not been incorporated in the required list.

Actuarial reserves and liabilities that are incorporated into the required items above are as follows (note items 1a & 1b are specifically referenced in item D in the list above):

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

1. Aggregate Health Policy Reserves (Page 3, Line 4) includes:
    a. Unearned Premium Reserve (Underwriting and Investment Exhibit – Part 2D, Line 1).
    b. Additional Policy Reserves (Underwriting and Investment Exhibit – Part 2D, Line 2).
    c. Reserve For Future Contingent Benefits (Underwriting and Investment Exhibit – Part 2D, Line 3).
    d. Reserve For Rate Credits or Experience Rating Refunds (Underwriting and Investment Exhibit – Part 2D, Line 4).
    e. Aggregate Write-ins for Other Policy Reserves (Underwriting and Investment Exhibit – Part 2D, Line 5).
2. Aggregate Health Claim Reserves (Page 3, Line 7) includes:
    a. Present Values of Amounts Not Yet Due on Claims (Underwriting and Investment Exhibit – Part 2D, Line 9).
    b. Reserve For Future Contingent Benefits (Underwriting and Investment Exhibit, Part 2D, Line 10).
    c. Aggregate Write-ins for Other Claim Reserves; Actuarial Reserves Should Be Included in the SAO (Underwriting and Investment Exhibit – Part 2D, Line 11).

Note that additional policy reserves include premium deficiency reserves. Premium deficiency reserves are identified in Underwriting and Investment Exhibit – Part 2D, Footnote a.

Scope section, discussed above for Section 5 of the Annual Statement SAO Instructions, should specifically identify those items and amounts to which the actuary is expressing an opinion, including but not limited to the above specifically identified lines from the Annual Financial Statement. Where the actuary determines that no liability exists, the value $0.00 should be entered. Lines should not be deleted.

If there has been a material change in the actuarial assumptions from those previously employed, that change should be described in the Annual Financial Statement and in the Relevant Comments section of the SAO. (See Section 8 of the Annual Statement SAO Instructions and summarized above.)

If the actuary has not examined the underlying records, but has relied upon product definitions, computer listings and summaries of enrollment and claims payments prepared by the health entity, a prescribed statement to this effect is required by the Reliance section of the SAO. A signed statement by the person relied on is also required by this Reliance section for items provided, confirming the accuracy, completeness, and/or reasonableness of the items. Instructions for the Reliance section of the SAO are provided in Section 6 of the Annual Statement SAO Instructions.

Most health coverages do not require extensive cash flow testing, due to the short duration of the claim liabilities. The ASB has issued Actuarial Standards of Practice to guide actuaries in determining when an asset adequacy analysis should be performed and methods of asset adequacy analysis to consider. One of these is a prospective gross premium valuation. There is also guidance in the *AP&P Manual*, Appendix A-822 Asset Adequacy Analysis Requirements. If required by either regulation or professional standards, the actuary should have included an opinion of the asset adequacy.[2] Unlike life insurance opinions, there is currently no specific guidance for health asset adequacy opinions.

As provided in the instructions and mentioned above, the SAO can take four forms:

- Unqualified SAO
- Qualified SAO

2 *Accounting Practices and Procedures Manual, Appendix A-822* provides guidance for Asset Adequacy Analysis Requirements. The only companies filing the Health Annual Financial Statement that are subject to the requirements of Appendix A-822 are those licensed as life insurance companies.

- Adverse SAO
- Inconclusive SAO

In cases where the SAO is other than unqualified, analysts should determine what the weakness is that prevents an unqualified SAO. A qualified SAO would state that the reserves may be adequate, but there are somewhat likely circumstances under which they would not be adequate. An adverse SAO is one in which the amounts reviewed do not satisfy opining statement "D" in the SAO section of the SAO. This opining statement "D" reads as, "Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements." An adverse SAO implies that amounts reviewed are not adequate under state regulations and/or actuarial standards. If the actuary's SAO is adverse or qualified, the actuary should specifically state the reason(s) for such an SAO in the Opinion section and/or Relevant Comments section of the SAO. If the actuary is unable to form an opinion, the actuary should issue an inconclusive SAO and specifically state the reason(s) for this.

~~OVERVIEW OF~~ RESERVING RISK ASSESSMENT OVERVIEW

Health reserves are intended to: 1) cover claims payments for claims that have been incurred prior to the valuation date and have not yet been paid; or 2) to retain a portion of current revenues to cover future incurred claims that the company anticipates it will be obligated to pay. The NAIC *Annual Financial Statement Instructions* and the AP&P Manual contain specific guidance for distinguishing between certain types of claim liabilities. Specifically, SSAP No. 54R and *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* differentiate between claims that have accrued costs (claim liabilities) and claims that may have been incurred but for which costs will be accrued in the future (claim reserves). For this handbook the term reserve will be used in its broader sense to include items denoted as reserves as well as other items called liabilities.

When there are reserves and liabilities for claim amounts to be paid in the future there will also be expenses associated with paying these claims. The liability for the administrative expense associated with paying these claims is entered in "Unpaid Claims Adjustment Expenses."

The incurred date of a claim is the first date on which the company has an obligation to pay for a contracted benefit. The incurred date of a claim depends on the type of product and the contract language. Some examples of incurred date determination would include:

- Hospital claims are incurred on the date of admission.
- Some claims related to one diagnosis may be grouped and considered incurred on first date of service.
- Maternity claims are incurred on the date of the first service related to the maternity.
- Other medical, dental and vision services are incurred on the date of service.
- Disability income claims are incurred on the date of disability.
- Long term care claims are incurred on the date of eligibility for benefits or date of first service, depending on the reserving method.
- Stop loss claims are incurred based on the contract specifications.

Other reserves are associated with provider contracts and experience rating contracts with employer groups. Provider contracts often result in funds being held for future payment based on claims experience for the members assigned to a provider group. Similarly, some contracts with employer groups result in future premium due or premium refunds owed based on actual claims experience.

Health reserves and methods used for their estimation are discussed in detail in the NAIC *Health Reserve Guidance Manual*. Analysts should be familiar with the information addressed in that manual and should use it as a reference when looking for guidance about a particular item under review. Before contacting a company or

a company's actuary, analysts should review the NAIC *Health Reserves Guidance Manual* to become more familiar with the terms and techniques for reserve estimation.

Due to the variety of types of health policies issued and the complexity of determining the aggregate reserves and liabilities for health policies, most health entities rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some health entities do not use actuaries to actually set the health reserves, health entities are required to annually obtain an opinion regarding the reasonableness of the established health reserves by a qualified actuary. Therefore, qualified actuaries are involved in setting and/or reviewing the health reserve liabilities established for virtually all health entities.

There are eight categories of health reserves and liabilities:

1. **Unearned premium reserves**

   The unearned premium reserve is the amount of paid premium covering future periods. For example, an annual premium paid on January first is 75% unearned at the end of the first quarter. Health products often have monthly premiums that do not require unearned premium reserves if coverage is from the first of the month to the end of each month (typically the case for employer-based coverage).

   If a premium is paid before it is due it is considered an advanced premium. For example, if January's monthly premium is paid on December 15 of the prior year it is advanced premium. Advanced premiums are entered in premiums received in advance on the Annual and Quarterly Financial Statements. See SSAP No. 54R for further guidance on this distinction.

2. **Claim reserves**

   Claim reserves are intended to cover claims that have been incurred but have not been paid. They can be further divided into three categories based on where the claim is in the process of being reported, approved and paid. The allocation among these categories is usually based on past statistics and they are usually not estimated separately. In general, incurred claims are estimated using one of the techniques described in the NAIC *Health Reserves Guidance Manual* and paid claims are deducted from the incurred claims to get a claim reserve. Other methods may be used for non-medical lines of business.

   Claim reserves can fluctuate as a percentage of incurred claims. A possible reason for this fluctuation is a large increase or decrease in the health entity's claims inventory. This often happens when a new claims system is installed. Other reasons for fluctuations in claims inventory can include a larger than normal turn over in claims processors, changes in the percentage of claims submitted electronically, changes in provider agreements such as moving to or from capitation arrangements and adding large amounts of new business. One concern may be that a change in the ratio of claim reserve to incurred claims could indicate that reserves are being lowered to improve profits or raised to justify rate increases.

   a. <u>Claims reported and in process of adjudication:</u>

      Claims reported and in process of adjudication may be waiting for additional information or may be ready for payment. States have different laws and regulations concerning the maximum number of days between the time that a claim is received and paid or otherwise adjudicated. An average backlog can be very roughly estimated by comparing the Reported in Process of Adjustment in the Underwriting and Investment Exhibit – Part 2A to the average daily-incurred claims amount (incurred claims divided by 365).

      i. Due and unpaid claims:

         These are claims that have been received, approved and adjudicated, but have not yet been paid. They generally represent a very small part of the claim reserve compared to the incurred-but-not-reported liability. Typically claims are considered paid when the check is issued.

      ii. Claims in course of settlement:

These are claims that have been received by the company but have not been paid. They are often claims that are waiting for some additional information before they can be adjudicated and approved for payment.

b. Incurred but not reported (IBNR) claims:

Although claim reserves are often called IBNR, technically the only part of the reserve that is IBNR is the part that represents claims that have NOT been reported to the company. This is almost always the largest part of the claim reserve.

Historically, physician claims take longer to be reported than hospital claims, but electronic filing of claim information is shortening the lag between the date of service and the date that a claim is submitted to the health entity.

The amount of claim reserve per member or per incurred claim dollar differs significantly between types of companies. If a company pays most of its claims on a capitated basis, its claim reserve will result only from services that are not covered by the capitation. Claims not covered by the capitation generally include claims for out-of-area emergencies and claims for referrals to non-capitated specialists. Also, because some companies pay a budgeted amount to the largest hospitals providing services to their insured's with a periodic reconciliation for actual claims, there are additional reporting rules for these payments. *SSAP No. 84—Health Care and Government Insured Plan Receivables* defines these payments as advances or loans to providers and distinguishes between advances to hospitals and advances to non-hospital providers. Regarding advances to hospitals, as long as a reconciliation is performed within the strict parameters set forth in SSAP No. 84, these advances are admitted assets up to the estimated amount of incurred claims still unpaid to the hospital (includes IBNR). For non-hospital providers, and when the advances to a hospital do not meet the specific reconciliation requirements of SSAP No. 84, the admitted asset is limited to the amount of claims due and unpaid or in course of settlement (does not include IBNR) to that particular provider. The claim reserve is not to be reduced in either situation. Accounting guidance found in *SSAP No. 25—Affiliates and Other Related Parties* should be followed for loans and advances to related party providers.

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

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

c. Disabled life reserves:

Disabled life reserves are reserves for individuals who are currently eligible for claim payment on coverage such as disability income and long-term care (LTC). These claims will continue to be paid even

if the contract ends until the individual is no longer eligible for claim payments due to an improvement in health status. More guidance can be found in SSAP No. 54R under claim reserves.

3. **Reserves for future contingent benefits**

In some situations and for some types of products, benefits resulting from an incurred claim can extend beyond the valuation date and may extend even beyond the end of the contract period. For a hospitalization that extends past the end of the contract period, either the contract itself or state law may require payment of charges up to a specific time past the end of the contract period. Maternity claims may also result in a reserve for future contingent benefits, if the delivery is covered even if the contract is terminated. The federal Health Insurance Portability and Accountability Act (HIPAA) places restrictions on pre-existing condition exclusions resulting in new policies being responsible for continuing hospitalizations and maternity benefits, thus reducing the need for future contingent benefit reserves, but under state laws the prior carrier may still remain liable for the claim. A contingency benefit reserve may still be needed since there may be no replacement policy or the replacement policy may not cover all of the benefits of the old policy. Company experience and tabular methods are used to calculate these types of reserves.

Future benefits for disability income and LTC claims are included in disabled life reserves rather than as reserves for future contingent benefits.

4. **Claims or LAE liability**

When incurred claims have not been paid as of the valuation date and a reserve is set up for their future payment, there will generally be an expense to process and pay the claims. This expense, although paid in the future, is associated with claims incurred prior to the valuation date. To achieve consistent financial reporting a liability is set up for the future claims payment expense.

Also, when provider contract provisions require a payment at the end of the contract period for financial and/or operational performance, there will be a cost of determining and paying the contingent payment. A liability should be included for the expense of processing the provider liability.

5. **Contract reserves**

Contract reserves are in addition to claim and premium reserves. A contract reserve is a reserve set up when a portion of the premium collected in the early years is meant to help pay for higher claim costs arising in later years. The reserve is calculated using actuarial assumptions and techniques, and in general, equates to the amount that the present value of future benefits exceeds the present value of a consistent portion of future premiums (the portion of the “gross premium” used for contract reserves is called the “net premium”).

Contract reserves are needed when premiums are collected in the early years of a policy and are intended to offset increasing claims in later years. This is usually seen when premiums are level over the life of a policy, but can occur when premiums are structured to increase, but still are not proportional to expected claims. Issue age rated policies often fall into this category where premiums can increase, but the ratio of expected claims to premiums are lower in early durations, by design, in order to avoid rate increases at later durations (or at least reduce their size).

The types of products that generally require contract reserves include: 1) individual disability income (if premiums are not based on attained age); 2) LTC; and 3) issue age rated medical policies (including those for specified diseases). Issue age rated medical policies are rare except for issue age Medicare Supplement and some issue age hospital indemnity policies. Many other types of health policies (accident coverage or AD&D coverage) may not need contract reserves because the likelihood of claims is the same for each age. Those contracts (most employer-based coverage) that are re-rated each year to cover the expected claims for the year do not need contract reserves.

Contract reserves may be needed for policies with multi-year rate guarantees. Many medical policies with multi-year rate guarantees have built in rate increases to cover anticipated increases in claims cost, but if premiums are level, contract reserves will be needed.

Appendix A-010, *Minimum Reserve Standards for Individual and Group Health Insurance Contracts*, (Appendix A-010) of the AP&P Manual prescribes the minimum standards used in determining the health policy reserves and specify some of the assumptions to use such as morbidity tables, maximum interest rate and valuation method. Health entities may establish health policy reserves that equal or exceed these minimum standards. Analysts should review that all changes to contract reserve assumptions for in force policies have been approved in accordance with State regulations.

6. **Premium stabilization reserves**

These are reserves set aside to reduce the potential for large rate increases and smooth out the underwriting cycle. They are often associated with retrospectively rated contracts that require additional premium if claims are more than a specific percentage over expected or a premium refund if claims are less than a specific percentage of expected claims. The use of premium stabilization reserves due to retrospectively rated contracts is described in *SSAP No. 66—Retrospectively Rated Contracts*.

There are other experience rating arrangements besides retrospectively rated contracts that build up premium stabilization reserves. These reserves are used in years of higher-than-expected claims cost and result in a smoothing effect on premiums since premiums will not have to be increased to compensate for one year of poor experience.

Most premium stabilization reserves are determined by contract, but a company may use a similar concept on a block of business. Care should be taken to ensure that positive reserves from one contract are not used to offset material claims on other contracts that should be recognized. The reserve would be used to smooth out the need for large rate increases by building up a reserve in years when claims are less than expected and then drawing it down in years of larger than expected claims.

7. **Provider liabilities**

There are many types of provider contracting arrangements in the marketplace today. Many of these arrangements base some portion of the amount paid to the provider on financial and/or operational goals that are measured periodically. Under these types of arrangements, payment for reaching goals is not dependent on any specific service, but rather is based on overall performance. As of the valuation date, a payment for performance under a provider contract may have been earned, but not paid. This payment must be set up as a liability to the company.

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

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

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8. **Premium deficiency reserves**

When future premiums and current reserves are not sufficient to pay future claims and expenses, a premium deficiency reserve is required. HIPAA requires that all individual and small group medical products be issued on a basis that allows termination only of an entire line of business. These requirements may increase the number of instances where premium deficiency reserves will need to be reported for blocks of business. Analysts should be aware that some states have stricter termination rules than those imposed by HIPAA.

If contracts not protected by HIPAA or state termination restrictions are not profitable, they can be canceled. The contracts with many large groups allow them to be canceled. Also, certain lines of business can be canceled in total. In spite of contractual provisions, companies may decide not to cancel and therefore a deficiency reserve may be required. A company may not want to cancel a large group or a line of business in a state either because of the effect on its reputation or because the membership represented gives it bargaining power with providers.

A reserve may even be required for an Administrative Service Only (ASO) or Administrative Services Contract (ASC) agreement if administrative fees are not sufficient to cover administrative expenses. An insufficient administrative fee may be acceptable to the health entity when the importance of writing a large group due to prestige or bargaining power is provided to the health entity. Analysts should refer to *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* for a discussion of the reporting of loss contingencies.

In instances where future premiums can be increased to cover projected claim levels for a block of business, these increases may cause better risks to drop coverage. This will result in even higher claims costs and potentially continuing deficient premiums. It is difficult to predict the effect of this type of selection, but the health entity's actuary should attempt to include the effect of selection in his or her determination of the need for a deficiency reserve.

There is some state variation concerning limits on the assumptions that can be used in calculating premium deficiency reserves. Since these variations are not currently documented, analysts should contact the department actuary for input on any guidance that has been given to health entities in the state.

Areas of confusion and inconsistency include:

- How to define a block of business for calculation of deficiency reserves.
- The time period to use for calculation of deficiency reserves.
- Assumptions to use concerning enrollment changes, premium increases, and marginal versus allocated expenses.
- The level of claim reserves and claim reserve conservatism to be available at the end of the time period and thus included in the deficiency reserve.

For a thorough discussion of deficiency reserves and an up-to-date position on issues surrounding deficiency reserves analysts should refer to SSAP No. 54R and the *Health Reserves Guidance Manual*.

LONG-TERM CARE INSURANCE (LTCI) RESERVES OVERVIEW

"Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic,

preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital3[3]. Historically, insurers that wrote LTCI encountered difficulties accurately projecting claims costs, lapse rates, investment returns and other factors associated with LTCI, and subsequently many writers have experienced unprofitability in older (legacy) blocks of LTCI business. This has led many companies to request significant rate increases, modify product benefits, or exit the product line altogether. Therefore, many insurers continue to experience significant solvency challenges related to this line of business, and state insurance regulators should continue to carefully evaluate and monitor the solvency position of all insurers with a material amount of LTCI business.

These same risks also affect reinsurers, because the reinsurance contract may not arbitrarily allow for ceded premium increases. Additionally, in order to effectuate a true transfer of risk, the reinsurer may not have the ability to require the direct writer to request rate increases[4]. As some insurers look for avenues to minimize or eliminate its risk from the LTCI block, they may look to new reinsurance opportunities or non-traditional buyers.

In addition, periods of economic downturn and low interest rates increase the risk that LTCI writers will be challenged to generate sufficient returns to support this line. In addition, declines in projected investment returns could have a significant impact on LTCI reserve assumptions.

Actuarial Guideline 51—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51)

Effective for reserves reported with the Dec. 31, 2017, financial statement, Actuarial Guideline 51 — The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) now applies. The *Health Insurance Reserves Model Regulation* (#10) and the *Valuation Manual* VM-25, Health Insurance Reserves Minimum Reserve Requirements, contain requirements for the calculation of LTCI reserves. AG 51 requires companies with more than 10,000 LTCI enrollees to submit standalone LTCI asset adequacy analyses to the state. AG 51 is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to a company's LTCI block of contracts. AG 51 requires reporting to the department within the appointed actuary's actuarial memorandum required by VM-30, Actuarial Opinion and Memorandum Requirements, or in a special actuarial memorandum containing LTCI-specific information on the results of the analysis, assumptions on mortality, voluntary lapse, morbidity, investment returns and rate increase assumptions.

Factors Impacting LTCI Reserves and Rates

This following guidance provides additional information that may assist state insurance department staff in understanding the differences in premium rate review and approval, and valuation review of reserve adequacy assumptions in order to maintain or improve state insurance departments' current intra-departmental coordination/communication practices between the states' rate reviewers, valuation actuaries and analysts/examiners.

Reserve Increase Factors

1. Background

Ever since asset adequacy testing became a requirement for life insurers in the 1980s, actuaries have been required to analyze reserve adequacy assumptions on an annual basis and make the assumptions more conservative when experience or expectations become more adverse. If the result of the more

[3] Definition per NAIC *Long-term Care Insurance Model Act* (#640) Section 4.A.
[4] Refer to the NAIC *Life and Health Reinsurance Agreements Model Regulation* (#791) with respect to qualifying for risk transfer and reinsurance accounting within life and health reinsurance agreements.

conservative assumptions was inadequate reserves, companies have been required to establish higher reserves to ensure future claims could be paid in the more adverse environment.

In some cases, the chain of events is straightforward. For instance, for life insurance, if more people die at earlier ages than expected and the experience is highly credible, then the actuary increases mortality rates in the upcoming year-end filing, leading to higher reserves being established.

In other cases, the chain of events is less straightforward. For instance, it is expected that cash surrenders on deferred annuity products will increase if interest rates rise. However, most deferred annuities have been sold during a period of decreasing interest rates. Actuarial and regulatory practice require reserves to be adequate in moderately adverse conditions, even if those conditions have not been recently experienced. There is typically judgment by the company actuary and another layer of judgment by regulators in play in this type of complex situation. The *Standard Valuation Law #820* (SVL), the Valuation Manual, and the *Actuarial Standards Board's* (ASB's) *Actuarial Standards of Practice* (ASOPs) describe how these complex situations should be handled.

2. Long-Term Care Insurance

For LTCI blocks of business that experience higher morbidity than expected, this experience will likely lead to changes in expectations on future morbidity for both the observed block and other blocks.

With LTCI, some factors are likely to play out in a straightforward manner. A combination of higher life expectancy and lower lapses will lead to more people than expected reaching prime LTCI claims ages of 80 and above, which leads to companies holding higher reserves than originally anticipated. Similarly, all companies have experienced the decreasing interest rate environment, which has led to lower-than-expected investment returns and the need to hold higher reserves, because investment income is relied upon to help pay claims.

Mortality, lapse, and interest rate factors become observable and can develop credibility during the premium-paying years prior to policy years when significant claims tend to occur.

3. Morbidity Assumptions:

Morbidity, however, has tended to fall into the category of a complex factor. The three main aspects of LTCI morbidity are: (1) incidence, the percentage of people at a given age who start a claim; (2) average length of claim; and (3) utilization, which is less than 100% if, e.g., the daily nursing home cost is lower than the maximum daily benefit in the insurance policy.

There has not been uniform experience development in morbidity, except that length of claim has tended to increase, likely because cognitive (e.g., dementia and Alzheimer's disease) claims tend to be longer than average and incidence has been higher than expected, likely due to more people reaching the age when cognitive claims tend to occur.

Because of divergent experience among companies and because morbidity becomes observable and credible during the later claim-paying years, establishing and regulating LTCI morbidity assumptions has not been straightforward. However, as with other factors and other products, the handling of these situations is addressed in *Model #820, Valuation Manual, and ASOPs*. Examples of these standards include:

- Model #820 12A(3)(a): "Assumptions shall, to the extent that company data is not available, relevant, or statistically credible, be established using other relevant, statistically credible experience."
- Model #820 Section 12A (4): "Provide margins for uncertainty … such that the greater uncertainty the larger the margin and resulting reserve."

- AG 51 (providing guidance on VM-30) Section 4.B.: "The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks. Material assumptions associated with the LTCI business shall be determined testing moderately adverse deviations in actuarial assumptions."

- *Acounting Practices and Procedures Manual (AP&P Manual)*, Appendix A-010 paragraph 48.e (referenced in VM-30): "The total contract reserve established shall incorporate provisions for moderately adverse deviations."

- AP&P Manual, Appendix A-010 paragraph 51 (referenced in VM-30): "Annually, an appropriate review shall be made of the insurer's prospective contract liabilities… and make appropriate increments… if such tests indicate that the basis of such reserves is no longer adequate."

The result is that whether credible experience exists or not, the company actuary needs to set assumptions underlying reserves, and the factors underlying the assumptions are often complex and frequently changing. Company and regulatory actuaries are experienced in working in this complex, changing environment with many life insurer products, such as variable annuities, indexed products, and LTCI having product features and factors underlying reserves that are complex and changing.

4. **Rate Increases:**

A unique aspect of LTCI products is being a long-term product with rate increases that require review by states. Besides states with the largest insurance departments, the actuaries reviewing LTCI reserves are often the same staff reviewing LTCI rate increases. For larger states, there is typically coordination or training to ensure the reserve and rate teams are on the same page regarding developments in for example, life expectancy and morbidity. State insurance regulator experience in reviews of LTCI reserves and rate increase filings show that reserve increases and requests for rate increases are due to similar factors including higher life expectancy, lower lapses, lower investment returns, and worsened morbidity.

There has been additional regulatory attention on ensuring the companies asking for rate increases based on adversity of certain factors are holding reserves based on at least the same level of adversity in those factors. The questions used in many states' rate increase reviews require the company to explain the consistency between the rate increase filing assumptions and reserve adequacy assumptions.

To date, the most common complex, non-straightforward case is the applicability of a company's adverse morbidity experience of an older LTCI block to morbidity assumptions on a newer block. This complex dynamic comes into play when establishing reserve and rate increase assumptions.

The reserve assumption changes can occur with initiation by the company, through formal or informal agreement between regulators or companies, or by relying on Model #820 Section 11.6., which allows a commissioner to require a company to change reserve assumptions and adjust reserves.

Example:

A typical example of a chain of events would first involve a block issued in 1995 to 1998 to policyholders with issue ages ranging from 52 to 62. By 2019, enough policyholders have reached prime LTC claim ages of 80+. This experience is what drives reserve assumption changes. As policyholders enter ages in the upper 80s and 90s, additional experience will be attained that will predict future LTCI costs and result in further changes in reserve assumptions. The development of older-age morbidity experience is expected to generate volatility in LTCI reserves. For some companies, the older-age morbidity experience will likely be unfavorable, with increased reserves needed. For most other companies, the older-age morbidity experience will likely be as expected, leading to no significant, unforeseen reserve increases.

Companies will be expected to apply lessons learned from older blocks of business to their newer blocks. Those lessons will likely differ by situation. For example, to the extent underwriting is different, the newer and older blocks may experience different morbidity trends.

5. Rate Increase Factors

Factors impacting LTC reserves, including higher life expectancy, lower lapses, lower investment returns, and changes in morbidity, also potentially impact LTC rate increases.

If a company's reserve adequacy testing is dependent upon assumption of future LTC rate increases, the state insurance department staff performing reserve valuation should evaluate that assumption for reasonableness. The company's rate increase assumptions and documentation should be consistent with the requirements specified in AG 51 related to rate increase plans. The state insurance department staff performing reserve valuation may wish to coordinate and communicate with the state's rate review staff to help evaluate the appropriateness and reasonableness of the company's future rate increase assumption.

6. Intra-Department Communication and Coordination of Actuarial Review Work

While every state insurance department may be structured differently, many state insurance departments have the same staff members perform work on both LTCI reserve valuation analysis and rate increase reviews, while other have separate staff perform these functions. In the latter instance, department staff should be aware of or coordinate the intra-department review work related to each function.

The following are suggested steps a state may consider to ensure that actuarial assumptions associated with the rate increase request are consistent with the assumptions embedded in the asset adequacy testing.

- Inquire of the company's actuary or senior management regarding:
    - The relationship of the actuarial assumptions embedded in the rate filing versus those made for annual statement reporting.
    - Explanation if there is inconsistency between assumptions reported.
    - How AG 51 affects the company's rates and reserves.
    - Affirmation that the assumptions underlying the projections are consistent with the assumptions used in asset adequacy analysis.
    - A copy of the company's rate increase plan when rate increase filings disclose that future rate increase filings, beyond what is currently being requested, are planned.
- Consider reviews of different filings for consistency. For example:
    - Compare reserving assumptions to rate increase assumptions,
        - e.g., review the RAAIS and the Actuarial Opinion and Memorandum (AOM) to ensure that assumptions used for pricing and reserving are similar in nature.
- Identify assumptions underlying the asset adequacy testing memorandum that appear.

Reserving Risk Assessment

Reserving Risk: Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

The objective of the Reserving Risk Assessment analysis is focused primarily on two key aspects of reserving: 1) reserve valuation; and 2) reserve adequacy. Analysis of reserves relies heavily on the review of the Statement of Actuarial Opinion (SAO) and other related filings. The following overview and discussion of procedures provides information on life insurer reserving and suggested data, benchmarks, and procedures the analyst can consider in his/her review. In analyzing reserving risk, the analyst may analyze specific types of reserves established by life insurers, reserving methodologies and various aspects of life insurance that affect reserving. For example, an analyst's risk-focused assessment of reserving risk may consider the following areas (but not limited to):

- Reserve valuation in accordance with the appropriate valuation requirements.
- Reasonableness of valuation bases utilized, testing, assumptionsassumptions, and methodologies to determine reserves.
- Adequacy of assets to support policyholder benefits.
- Appropriate reporting of reserves.
- Lines of business written by the insurer.
- Types of reserves for life, accidentaccident, and health (A&H) and annuity lines of business.
- Reserve development.
- Reinsurance.
- Reserving for guarantees on separate accounts.

Discussion of Actuarial Opinion Risk Assessment Procedures

Using the Repository

The Actuarial Opinion Repository is intended to provide procedures for reviewing the Actuarial Opinion and other actuarial filings for compliance and assessment of risks. In many states, the Actuarial Opinion and related filings are reviewed by actuarial staff. Whether the SAO review is performed by the analyst or the actuary, the Repository provides for the results of the SAO review to be documented and communicated to the analyst.

Analysts should document overall results of the actuarial opinion analysis and risk identified in Section III: Risk Assessment of the insurer within reserving risk or other relevant risk category. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.

STATEMENT OF ACTUARIAL OPINION BASED ON AN ASSET ADEQUACY ANALYSIS

To assess reserving risk, consider procedures for reviewing the Actuarial Opinion and other actuarial filings for compliance and assessment of risks. In many states, the Actuarial Opinion and related filings are reviewed by actuarial staff. Whether the SAO review is performed by the analyst or the actuary, the risk assessment provides for the results of the SAO review to be documented and communicated to the analyst.

Refer to the Overview sections at the end of this chapter for more guidance on the SAO and Asset Adequacy Analysis.

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***PROCEDURES #1A AND #1B*.** ~~assist the analyst in d~~Determine~~ing~~ that the SAO was prepared by a qualified actuary and that the reserve amounts agree with the Annual Financial Statement.

***PROCEDURES #1C–#1F*.** ~~assist the analyst in d~~Determine~~ing~~ that the insurer's policy reserves were calculated properly in accordance with the minimum standards required by the NAIC Model Standard Valuation Law, and that the insurer's assets will adequately support the insurer's future policy obligations. The qualified actuary's opinion that the insurer's assets are adequate with regard to policy reserves provides significant comfort to the analyst that policy obligations will be met in the future.

RAAIS AND ACTUARIAL MEMORANDUM WORKSHEET

***PROCEDURES #2 AND #3*.** ~~request the analyst to r~~Review the RAAIS and document any concerns noted. For example, the analyst should further review any comments made by the appointed actuary on any interim results that may be of significant concern.

Additional prospective risk procedures the analyst may consider performing are provided if concerns exist based on the review of the RAAIS. The analyst should take into consideration the current economic environment (i.e., interest rate trends) when performing the analysis.

***PROCEDURE #4*.** ~~assists the analyst in r~~Review~~ing~~ the actuarial memorandum that supports the SAO. The actuarial memorandum is a comprehensive document that provides an understanding of the insurer's reserves, the assets available to support the reserves, and the projected impact on the insurer's financial condition of varying economic and interest rate projection scenarios. It is not automatically filed with the Annual Financial Statement but is provided to the regulator only upon request. The decision as to whether to request the actuarial memorandum is an important one. The actuarial memorandum should be requested for insurers with known financial problems, significant changes in product mix or investment strategy, or significant growth in a particular product line.

The RAAIS is filed with the Annual Financial Statement and is designed to assist the regulatory actuary in determining whether to request the actuarial memorandum. The RAAIS includes the eight data requests shown below. Note that some items, such as 1), 2) and 5) specifically refer to cash flow testing results.

1) The number of additional interest rate scenarios that were tested identifying separately the number of deterministic scenarios and stochastic scenarios. Also identify the number of such scenarios which produced ending negative surplus values on market value basis.
2) If sensitivity testing was performed, identify the assumptions tested and describe the variation in ending surplus values on a market value basis from the base case values.
3) If negative ending surplus results under certain tests in the aggregate, the amount of additional reserve which, if held, would eliminate the aggregate negative ending surplus values.
4) The extent to which the appointed actuary uses assumptions in the asset adequacy analysis which are materially different than the assumptions used in the previous asset adequacy analysis.
5) The amount of reserves and the identity of the product lines which have been subject to asset adequacy analysis in the prior opinion but were not subject to such analysis for the current opinion.
6) Comments should be provided on any interim results that may be of significant concern to the appointed actuary.
7) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested.
8) Whether the actuary has verified that all options embedded in fixed income securities and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

While most states do not require the New York 7 actuarial interest rate scenario tests, states do require other stochastic scenario tests for life insurers and many life insurers, even though not required, still run the New York 7 interest rate scenario tests. The New York 7 interest rate scenario test which is an immediate decrease of 3% and then level would highlight the impact of prolonged low interest rates given the current interest rate environment. Also, the stochastically generated interest rate scenarios will also likely contain an interest rate scenario that represents a prolonged ~~low interest rate~~low-interest rate environment.

The Department actuary and analyst should understand each scenario in the insurer's scenario testing and its limitations and assess the likelihood of each scenario in the current economic environment. For example, the New York 7 interest rate scenarios consist of the following scenarios:

- Level with no deviation.
- Uniformity increasing over 10 years at 0.5% per year and then level.
- Uniformity increasing at 1% per year over five years and then uniformly decreasing at 1% per year to the original level at the end of the 10 years and then level.
- An immediate increase of 3% and then level.
- Uniformly decreasing over 10 years at 0.5% per year and then level.
- Uniformly decreasing at 1% per year over five years and then uniformly increasing at 1% per year to the original level at the end of 10 years and then level. An immediate decrease of 3% and then level.

Procedures 4.f. asks the analyst if an insurer that is within the scope of AG-53 has filed the required reporting within the AOMR. Further guidance on that reporting is provided below in procedure #5.

PROCEDURE #5. ~~asks the analyst to d~~Document any concerns based on the review of the actuarial memorandum. Additional procedures the analyst may consider performing are provided if additional concerns exist based on the review of the RAAIS, the actuarial memorandum and the asset adequacy testing performed. The procedures should be used to help identify how the insurer will fund a negative cash flow. Procedures 5.a. through 5.d. are applicable to insurers utilizing the New York 7 actuarial interest rate scenario tests. Procedure 5.e. is applicable to other cash flow scenario testing. Explanations of negative cash flow provided by the appointed actuary should explain how the insurer will: 1) sell marketable assets and which type; or 2) borrow, with an explanation of any existing agreements to include security, duration and notice period required. If the appointed actuary wrote in his/her report that the insurer expects to sell assets, the modeling should be consistent for the sale of assets. Likewise, if the appointed actuary wrote that the insurer expects to borrow, then the modeling should be consistent with borrowing. If the insurer expects to borrow, the analyst should consider asking the insurer if a formal Lending Agreement is in place.

Procedure 5.f. is applicable to AG-53 reporting on high-yield complex assets. Refer to the guidance above regarding the scope of which insurers are included in this reporting requirement. In line with the goals of AG-53 to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for asset adequacy analysis performed by life insurers, the analyst or reviewing state actuary, should consider if the reporting identifies any concerns, including the following examples that may warrant further investigation or follow-up with the insurer.

1. Reserve adequacy and claims-paying ability in moderately adverse conditions, including conditions negatively impacting cash flows from complex ~~assets;~~assets.
2. Rationale supporting changes in assumptions, year-over-~~year;~~year.
3. Expected gross returns and related risks (including default rates~~);~~).
4. Factors supporting margins on asset-related ~~assumptions;~~assumptions.

5. That assumptions fit reasonably within the risk-return spectrum;spectrum.
6. The extent to which high-yielding assets are supporting major product categories;categories.
7. Sensitivity testing results regarding reinvested complex assets supporting life insurer business;business.
8. Identifies expectations in practice regarding the valuation of complex assets within asset adequacy analysis.; and,
9. Investment fee income relationships with affiliated entities or entities close to the company.

NON-GUARANTEED ELEMENTS OPINION (IF APPLICABLE)

PROCEDURE #6. assists the analyst in dDetermineing that a qualified actuary prepared the non-guaranteed elements opinion.

PROCEDURES #6B AND #6C. assist the analyst in reReviewing the non-guaranteed elements opinion in order to determine that the insurer's reserves were determined in a manner that considered the non-guaranteed elements for individual life and annuities policies.

Discussion of the RESERVE RISK ASSESSMENT Repository

The Annual Reserve Risk Assessment Procedures are designed to identify potential areas of concern to the analyst. While the underlying actuarial techniques relating to life reserves are quite complicated, the analyst should remember that there are two basic objectives regarding life reserves. The first objective is that the insurer's life reserves are calculated using the appropriate valuation methodology (formula or principle-based), and the second objective is that the insurer's assets are adequate to support the future policy obligations. To meet the first objective, reserves for policies and contracts subject to the formula-based valuation methodology, including the formula reserves required by VM-20, should be calculated in accordance with the minimum formula statutory valuation standards, using the appropriate valuation assumptions and valuation methods. For policies and contracts subject to a principle-based valuation methodology, in addition to the formula reserves, reserves should be calculated in accordance with the principle-based valuation requirements of VM-20.

Instructions for Using the Reserving Risk RepositoryGENERAL GUIDANCE

The Annual Reserve Risk Assessment Procedures are designed to identify potential areas of concern to the analyst. While the underlying actuarial techniques relating to life reserves are quite complicated, the analyst should remember that there are two basic objectives regarding life reserves. The first objective is that the insurer's life reserves are calculated using the appropriate valuation methodology (formula or principle-based), and the second objective is that the insurer's assets are adequate to support the future policy obligations. To meet the first objective, reserves for policies and contracts subject to the formula-based valuation methodology, including the formula reserves required by VM-20, should be calculated in accordance with the minimum formula statutory valuation standards, using the appropriate valuation assumptions and valuation methods. For policies and contracts subject to a principle-based valuation methodology, in addition to the formula reserves, reserves should be calculated in accordance with the principle-based valuation requirements of VM-20.

To assesshe reserve risk repository is a list of possibleconsider the quantitative and qualitative data, benchmarks, and procedures in this chapter. from which the analyst or actuary may select to use in his/her review of reserving risk. Analysts are not expected to respond to all procedures, data or benchmark results listed in the repository. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document completion of the analysis. The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is

available should be analyzed by the state insurance department based on the nature and scope of the risk.

The placement of the following data and procedures in the reserving risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting financial determinations of the analysis. Key insurance operations/activities or lines of business, for example, may have related risks addressed in different risk categories. Therefore, the analyst may need to review other risks in conjunction with reserves. For example:

- Reserves are also addressed in the Actuarial Opinion Worksheet.
- Separate Accounts are also addressed in the Operations and Liquidity Risks.
- Surrender activity is also addressed in the Liquidity Risk.

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

Analysts are not expected to document every procedure, data or benchmark result. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document the applicable details within the analysis.

Results of risk analysis should be documented in the Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.

~~In using procedures in the repository, the a~~Analyst should ~~review the results~~complete their reserve risk assessment in conjunction with:

- A review of the Supervisory Plan and Insurer Profile Summary and the prior period analysis. ~~The Insurer Profile Summary may be updated periodically to include information on policy forms sold in a state other than the state of domicile when a similar form is not used in the state of domicile.~~
- Communication with the company~~ is important. ~~.
- Communication and/or coordination with other internal departments. ~~are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures in the repository.~~

The analyst should also consider the ~~health entity~~insurer's corporate governance which includes the assessment of the risk environment facing the ~~health entity~~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 placement of the following data and procedures in the reserving risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Analysts should also recognize that examiners or company management may classify a risk differently from what is outlined in this repository. Key insurance operations/activities or lines of business, for example, may have related risks addressed in different repositories. Therefore, the analyst may need to review other repositories in conjunction with reserves. For example:~~

~~Reserves are also addressed in the Actuarial Opinion Risk Assessment Repository.~~

~~Separate Accounts are also addressed in the Operations and Liquidity Risk Assessment Repositories.~~

~~Surrender activity is also addressed in the Liquidity Risk Assessment Repository.~~

Involvement of an Actuary: The analyst should involve an actuary where indicated in the procedures or as needed. To stay within any required deadlines for reviews, the analyst should document any greater in-depth reviews

being performed by the actuary (such as involving the confidential actuarial memorandum or the confidential principle-based reserving (PBR) report for life reserves) and supplement the documentation when such actuarial review is complete. Questions or requests for assistance regarding PBR and for asset adequacy analysis may be made to the NAIC actuarial resources. Please see the NAIC website for the Valuation Analysis (E) Working Group for contact information regarding the use of NAIC actuarial resources and use of the Working Group if needed.

Depth of Review: Life, annuity, PBR and accident and health (A&H) involve many products and complex requirements. A complete determination of compliance with all of these requirements during the course of an annual financial analysis review is typically not practical for many companies. Judgment in a risk-focused approach will need to be exercised regarding greater focus and use of actuarial expertise in any procedure provided below.

~~***ANALYSIS DOCUMENTATION:*** Results of reserving risk analysis should be documented in the branded Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.~~

ANNUAL RESERVING RISK ASSESSMENT

Refer to the Overview sections at the end of this chapter for more guidance on Life, Annuity, A&H and Long-Term Care reserves.

~~Quantitative and Qualitative Data and Procedures~~

Inappropriate or Inaccurate Valuation of Life Reserves

Reasonableness of Actuarial Methodologies and Assumptions

- **High Expenses affecting Cash Flow Assumptions**
- **Potential for Understated Life Reserves due to Spread Analysis**

~~***PROCEDURE #1***~~ ~~assists the analyst in d~~Determin~~e~~~~ing~~ whether the insurer's life reserves for policies and contracts subject to a formula-based valuation methodology are valued in accordance with the minimum formula statutory valuation standards. Risks include that reserves may be understated due to reserve computations that are not performed correctly; assumptions that are unreasonable or not compliant with minimum requirements; high expenses leading to cash flow deficiencies; or, spread analysis that indicates either the need to record additional asset adequacy reserves (asset liability matching (ALM)), changes to policy design to limit guaranteed returns, or potential for investment portfolio changes to improve returns. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary, the information provided in the actuarial memorandum documenting all of the asset and liability assumptions, and the methods used, and scenarios run to determine the reserve adequacy.

Qualitative and Additional Review Considerations

- Review the results of the Statement of Actuarial Opinion worksheet. Identify any concerns regarding the valuation of the insurer's reserves in accordance with minimum statutory valuation standards.
- Review the Notes to Financial Statements, Note #31 – Reserves for Life Contracts and Annuity Contracts and note any unusual items regarding the valuation of life reserves.
- Review the trends of reserve amounts for the various basis groupings in Exhibit 5 over recent annual statements. Contact the state insurance department's actuary or other actuarial resource for assistance with this analysis.

- If questions or concerns are noted, contact the state insurance department's actuary or other actuarial resource to discuss the nature and scope of the life reserve valuation procedures performed.

- ~~***PROCEDURE #2*** provides procedures the analyst may consider in a~~Assess~~ing~~ the lines of business written by the insurer and gaining an understanding of the impact that the difference in types of plans may have on reserving ~~risk.~~assumptions and methodologies.
  - Through the analyst's interdepartmental communication with the policy forms department, inquire as to whether the insurer had any new and unusual policy forms approved during the past 12 months by either the department or Interstate Insurance Product Regulation Commission (IIPRC). Unusual filings could be product lines the company has not written before or contain new or innovative products or benefit designs.
  - If concerns are noted about the types of life policies written, review the insurer's life insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits.
  - If questions or concerns are noted, contact the state insurance department's actuary for assistance in completing the analysis.
  - If concerns are noted, consider a target examination of reserves in which the field examination staff request a valuation listing by plan and issue year, and test a sample of individual policy reserves from each of the major life insurance plans for accuracy.
  - In considering any limited scope examination or any analysis needed, the analyst may consider use of the state's equivalent authority to the NAIC Standard Valuation Law (#820), Section 11F, which provides the commissioner may engage a qualified actuary at the expense of the company to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in Model #820.

~~***PROCEDURE #3*** assists the analyst in d~~Determin~~ing~~e whether any changes in life reserve valuation bases during the year were proper for policies and contracts. From time to time, an insurer may decide to change the valuation basis for a particular segment of the business. The insurer may change the valuation mortality table used, the valuation rate of interest or the valuation method. Reserve strengthening occurs when the insurer substitutes a more conservative basis of valuation for any given block of business. Reserve weakening may also occur but normally requires approval of the domiciliary state and reserves cannot be reduced below the minimum reserve standard as defined in the Standard Valuation Law.

The analyst may also consider performing procedures that involve testing the actual reserve calculations for a sampling of individual life insurance policies to ensure that the minimum statutory valuation standards have been met.

Procedures / Data
- Has been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in the current year capital and surplus. [Annual Financial Statement, Exhibit 5A]

Qualitative and Additional Review Considerations
- Review the specific changes in valuation bases applied to life products noted in Annual Financial Statement, Exhibit 5A, and determine that individual changes in specific mortality tables, interest rates, or valuation methods meet the minimum statutory valuation standards.
- Identify if any changes in life reserve valuation bases did not receive appropriate regulatory approval, if required.
- Request from the insurer information regarding the reason for the change in valuation basis.

Inappropriate or Inaccurate Valuation of PBR Life Reserves

Accuracy of PBR Reserve (or Exemption) Computations

Reasonableness of PBR Methodologies and Assumptions

~~***PROCEDURE #4***~~ ~~assists the analyst in d~~Determine~~ing~~ whether the insurer's life reserves for policies and contracts subject to a principle-based valuation methodology appear to be valued in accordance with the requirements of VM-20. Risks include that reserves may be understated due to reserve computations that are not performed correctly or due to assumptions that are unreasonable or not compliant with minimum requirements; or, that exemption test are not computed correctly, resulting in inaccurate exemptions. In this regard, the analyst will need to review and rely on the VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Reserve Valuation, actuarial report that documents the deterministic and stochastic exemption tests, all company experience assumptions and margins, and all the procedures and processes used to calculate the reserves under a principle-based valuation methodology. In addition, the analyst will need to review the VM-20 supplement, which is part of the annual statement filing and contains the various components of the PBR. The analyst may seek the assistance of actuarial staff at the NAIC related to any verification of exclusion test calculations, as well as validation of PBR for a small random sample of policies and contracts subject to a principle-based valuation methodology. Please see the NAIC website for the Valuation Analysis (E) Working Group for contact information regarding the use of NAIC actuarial resources and use of the Working Group if needed.

Qualitative and Additional Review Considerations

- Review Section 1 of the VM-20 Supplement to the annual statement for the business PBR and the resulting reported PBR reserves. Consider the business PBR was applied with respect to the applicability of PBR provided in the *Valuation Manual* (VM), Section II for products within the scope of VM-20 requirements.
- Review Section 2 of the VM-20 Supplement to determine if the company has chosen to delay implementation of VM-20 requirements per Section II(c) of the VM.
- Review Section 3 of the VM-20 Supplement to the annual statement to determine if the company qualifies for the companywide exemption.
- Based on the judgment of the analyst and after discussing with the department actuary or the NAIC actuarial resources, determine if the VM-31, PBR Report Requirements, report should be requested from the company for review. The state insurance department actuary should perform the following procedures for any VM-31 Actuarial Report to be reviewed. The NAIC actuarial resources may be contacted for any questions or help in this review.
- Review the VM-31 Actuarial Report to identify the insurer's life insurance plan descriptions to understand the types of plans offered and the specific policy features and benefits.
- Review the VM-31 Actuarial Report to identify valuation assumptions based on company experience and valuation assumptions based on industry experience tables.
- For valuation assumptions based on company experience, contact the company valuation actuary to request to see the latest experience studies for those assumptions and evaluate the process used to establish the assumptions and the margins for those assumptions and the credibility factors used for each experience assumption.
- For mortality based on company experience, review the determination of the credibility percentage, the sufficient data period, the mortality segments, and the industry mortality tables to which company experience mortality is graded. Review whether the level of company mortality experience is appropriate in determining the credibility percentage and the sufficient data period. This is significant as the larger the body of experience used the smaller the resulting mortality margins and the lower the PBR reserves. Review to assure the use of

any larger body of aggregate mortality experience is appropriate. As mentioned above, the NAIC actuarial resources may be consulted for any questions or support in this review.

- Review the VM-31 Actuarial Report to determine the contracts or plans that passed the stochastic and deterministic exclusion tests. Consider requesting the assistance of the NAIC actuarial resources to independently verify that such contracts and plans do pass the deterministic and stochastic exclusion tests.
- Consider whether to request that a limited-scope examination (or interim examination procedures) be performed to address concerns by reproducing net premium reserve (NPR) calculations on a sample basis. Reproducing calculations may be conducted by asking the company to calculate NPR reserves for a sample of contracts and plans or requesting the NAIC actuarial resources to recalculate the NPR reserves for the same sample of contracts and plans and compare results. Also consider whether to request the NAIC actuarial resources for help in any testing of the deterministic (DR) and stochastic reserve (SR) if there are unusual relationships between the NPR, DR, and SR.
- In considering any limited scope examination or any analysis needed, the analyst may consider use of the state's equivalent authority to Model #820, Section 11F, which provides the insurance commissioner may engage a qualified actuary at the expense of the company to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this model.

~~Adequacy of Life Reserves~~Understatement of Reserves

Insufficient Asset Adequacy

~~PROCEDURE #5~~ ~~assists the analyst in d~~Determin~~ing~~e whether the insurer's underlying assets are adequate to support the future obligations of its life insurance policies. Risks may include the potential for understated reserves if unusual or specific policy features and benefits are not valued and reserved for correctly; or, if asset adequacy testing results reflect the assets held and may not be sufficient to support future policy obligations. If the insurer filed an SAO based on an asset adequacy analysis, then the SAO itself, and the supporting actuarial memorandum, if requested, can provide the analyst with comfort in this regard. If a SAO that does not include an asset adequacy analysis is filed, the analyst can review net interest spread ratios for insights regarding the relationship of investment income with tabular interest. Insurance Regulatory Information System (IRIS) ratio #11 is included in the procedures as a test of reserve consistency between the current year and the prior year.

The analyst may also consider performing a review of the actuarial memorandum, if available. This will provide the analyst with substantial analyses with regard to asset adequacy. If an actuarial memorandum is not available, the analyst should consider the need to have an independent asset adequacy analysis conducted. Additional procedures regarding the SAO are found in Section III.B.8.d~~b.ii.~~. Additional guidance for new reporting requirements for AG-53 regarding high-yielding complex assets is found above.

Procedures / Data

- Net interest spread on life reserves (net investment income, less tabular interest, divided by average life reserves)
- Change in Asset Mix (IRIS Ratio 11)

Qualitative and Additional Review Considerations

- If the insurer filed a Statement of Actuarial Opinion based on an asset adequacy analysis, review the results of the Actuarial Opinion Assessment, and note any concerns regarding the adequacy of the insurer's underlying assets to support future life insurance policy obligations.
- Pursuant to the review of the Regulatory Asset Adequacy Issues Summary (RAAIS) in the Actuarial Opinion Assessment, note whether the responses to the questions were satisfactory.
- If concerns still exist upon review of the asset adequacy analysis, discuss with the appointed actuary and the company, and request any additional information or work to be performed to address these concerns. If the

insurance commissioner determines that the supporting actuarial memorandum fails to meet the standards prescribed by the Valuation Manual or is otherwise unacceptable to the insurance commissioner, the insurance commissioner may engage a qualified actuary at the expense of the company to review the opinion and basis for the opinion and prepare the supporting actuarial memorandum required by the insurance commissioner. See the state's equivalent authority to NAIC Model #820, Section 3B(3)(b). This also is noted in the Actuarial Opinion Worksheet.

- Review the Actuarial Guideline 53 reporting relating to assumptions and sensitivity testing for reinvested high-yielding complex assets within the asset adequacy analysis, if applicable. Determine whether concerns exist in meeting asset adequacy requirements. See further guidance in the AOMR procedures and reference guide.

Understated Reserves ~~Requirements~~ Associated with Separate Account Products & Guarantees

~~***PROCEDURES #6–#9***~~ ~~assists the analyst in i~~Review and identify~~ing~~ situations where separate accounts products may be creating contingent liabilities to the general account that may not be sufficiently reserved for on the general account. This is largely a function of the types of separate accounts products offered by the insurer, and the analyst should rely on general knowledge of the insurer's products at this stage of the analysis.

The analyst should review disclosures in Separate Accounts General Interrogatories, Analysis of Operations by Line of Business (Page 6), Analysis of Increase in Reserves During the Year (Page 7) and the Notes to the Financial Statements of the general account to gain an understanding of the types of products included in the separate account and the general account guarantees on separate account products, as well as identify any concerns with reserving or asset adequacy that may require additional analysis of actuarial filings. The analyst should gain an understanding of any products in the separate account that contain guarantees that are held in the separate account instead of the general account and the types of guarantees (guaranteed minimum death benefit [GMDB], guaranteed minimum income benefit [GMIB], etc.).

Exposure to Separate Account Products & Guarantee Liabilities and Accuracy of Separate Account Reserve Liabilities

Procedures / Data

- Identify if any of the separate accounts have guarantees that are designed to mirror an established index (Annual Financial Statement, Note #35B).
- Identify if any of the separate accounts have material non-indexed guarantees. [Annual Financial Statement, Note #35B]

Qualitative and Additional Review Considerations

- If material guarantees exist, or if non-insulated products exist, determine whether the assets associated with these products are being invested in accordance with statutory guidelines.
- Review Separate Account General Interrogatory #5 to identify if the insurer reported a material amount of assets in the separate account at amortized cost rather than fair value. If yes, consider additional analysis of actuarial and asset adequacy reporting.
- Review Separate Account Analysis of Operations by Line of Business (Page 5) and Analysis of Increase in Reserves During the Year (Page 6) to identify if any concerns exist regarding the types of products included in the Separate Account and reserving for those products. If yes, consider additional analysis of actuarial and asset adequacy reporting.
- Based upon an overall understanding of the insurer's separate accounts products, assess if there is evidence that such products may be creating contingent liabilities to the general account with product features such as minimum guaranteed death benefits, minimum guaranteed interest rates, etc.
- If concerns or questions are noted, contact the state insurance department's actuary or other actuarial resource to discuss the nature and scope of the valuation procedures performed relating to guarantees

included with separate accounts products. If determined to be necessary, contact the company's qualified actuary.

- Determine whether growth in separate accounts appears to be financed through borrowings of the general account and, if so, whether any concerns exist regarding the terms of repayment or collateralization.
- Determine whether the insurer writes any modified guaranteed annuities and, if so, the overall materiality and potential negative impact on the insurer's general account.
- Through the analyst's quarterly interdepartmental communication with the policy forms department, inquire as to whether the insurer filed any new and unusual separate account policy forms during the past 12 months.
- If concerns are noted about the types of policies included in separate accounts, review the insurer's separate accounts plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits, particularly minimum guarantees.
- If concerns are noted about reserving for separate accounts, consider a target examination of reserves, request that the field examination staff request a valuation listing by plan and issue year, and test a sample of the individual policy reserves for accuracy.
- Assess if there is any indication of contingent liabilities created by the separate accounts for the general account.
- Assess if separate account assets and liabilities were subject to asset adequacy analysis. If "no," review the actuarial opinion for an explanation.
- Request from the insurer separate accounts plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits, particularly minimum guarantees.
- Request information from the insurer regarding any significant changes in reserve methodologies and assumptions, underwriting practices, case reserving, or claims handling practices with the potential to affect reserve setting.

Exposure to Maximum Guarantees to the Separate Account

Qualitative and Additional Review Considerations

- Identify the variable annuity account value - general account. Document the variable annuity account value, percentage of capital and surplus, and percentage of total admitted assets.
- Assess if any separate accounts have collected amounts from the general account within the past five years related to separate account guarantees. [Annual Financial Statement, Separate Account General Interrogatories, #2.2]
    - If "yes," identify any concerns regarding the amounts or trend of guarantees paid.
    - If "yes," determine if guarantees were appropriately reserved for in the general account.
- Perform an industry peer comparison of the total maximum guarantee and the guaranteed amounts paid by the general account on a company-by-company basis to determine if the amounts appear reasonable.

Risk of Providing Guarantees While Not Receiving Risk Fees

~~***PROCEDURE #8***: The analyst should note that,~~ Identify if the insurer reports a maximum guarantee exposure amount in Separate Accounts Annual Financial Statement, General Interrogatory #2.2 and guarantees paid in Separate Accounts General Interrogatory #2.3 but does not report risk charges paid in Separate Accounts General Interrogatory #2.6, which indicates the insurer is providing guarantees and may not be receiving a risk fee in return for that guarantee. Note that, while group products require risk charges, there may be no requirements for risk charges on individual products. Also note that in some instances, risk fees may be imbedded in the management fees paid to the general account. The analyst should gain an understanding of how risk fees are reported by the insurer and if concerns exist regarding the risk fees, the analyst should consider requesting additional details from the insurer. Additional procedures assist the analyst in determining that contingent liabilities to the general

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account of the insurer created by separate accounts assets are properly recorded. Guarantees included with separate accounts products must be recorded as a liability of the general account.

Qualitative and Additional Review Considerations

- Determine if there have been any risk charges paid to the general account related to separate account guarantees. [Annual Financial Statement, Separate Account General Interrogatories, #2.6]
- Determine if the insurer reported maximum guarantees that the general account would provide or pay amounts on guarantees in the current year and report no risk charges to the general account.

Inappropriate or Inaccurate Valuation of Annuity Reserves

~~***PROCEDURE #10 AND #11***~~ ~~assists the analyst in d~~Determine~~ing~~ whether the insurer's annuity reserves are valued in accordance with the minimum formula statutory valuation standards. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary. The analyst can also gain comfort in this regard by evaluating the change in reserves in relation to increases or decreases in premiums during the year.

Procedures / Data

- Determine if anything has occurred since the last reporting period to raise concern that the insurer's annuity contracts are not valued in accordance with the minimum formula statutory valuation standards.
- Change in individual annuity reserves for the year as a percentage of individual annuity premiums (plus annuity investment income less annuity benefits and other fund withdrawals).
- Change in group annuity reserves as a percentage of group annuity premiums (plus annuity investment income less annuity benefits and other fund withdrawals).

Qualitative and Additional Review Considerations

- Review the results of the Actuarial Opinion assessment. Identify any concerns regarding whether the valuation of the insurer's reserves is in accordance with minimum statutory valuation standards.
- Review the Annual Financial Statement, Notes to Financial Statements, Note #31 – Reserves for Life Contracts and Annuity Contracts and note any unusual items regarding the valuation of annuity reserves (surrender values promised in excess of the reserve, significant changes in components of reserves, etc.).
- Review the trends of reserve amounts for the various basis groupings in Exhibit 5 over recent Annual Statements. Contact the state insurance department's actuary or other actuarial resource for assistance with this analysis.
- If questions or concerns are noted, contact the state insurance department's actuary or other actuarial resource to discuss the nature and scope of the annuity reserve valuation procedures performed. If determined to be necessary, contact the company's qualified actuary.

Assess information on annuity contract benefits offered that may indicate the impact of type of business, reserving assumptions and methodologies.

- Through the analyst's quarterly interdepartmental communication with the policy forms department, inquire as to whether the insurer filed new and unusual policy forms during the past 12 months.
- If concerns are noted about the types of policies, review the insurer's annuity plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits.
- If concerns are noted about reserving for annuity products, consider a target examination of reserves, request that the field examination staff request a valuation listing by plan and issue year, and test a sample of individual policy reserves from each of the major annuity plans for accuracy.
- In considering any limited scope examination or any analysis needed, the analyst may consider use of the state's equivalent authority to Model #820, Section 11F, which provides the insurance commissioner may engage a qualified actuary at the expense of the company to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this model.

- Request a spread analysis where the current spread earned is compared to the original pricing spread on the annuity block in question. Products with higher guaranteed minimum interest rates relative to the current interest environment. The state insurance department actuary can assist in this review.

~~***PROCEDURE #12***~~ ~~assists the analyst in d~~Determineing whether any changes in annuity reserve valuation basis during the year were appropriateer. From time to time, an insurer may decide to change the valuation basis for a particular segment of the business. The insurer may change the mortality table used, the rate of interest or the valuation method. Reserve strengthening occurs when the insurer substitutes a more conservative basis of valuation for any given block of business. Reserve weakening may also occur but normally requires approval of the domiciliary state.

The analyst may also consider testing the actual reserve calculations for a sampling of individual annuity policies to ensure that the minimum statutory valuation standards have been met.

Procedures / Data

- Note whether there has been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in capital and surplus. [Annual Financial Statement, Exhibit 5A – Changes in Bases of Valuation During the Year]

Qualitative and Additional Review Considerations

- Review the specific changes in valuation basis applied to annuity products noted in Annual Financial Statement, Exhibit 5A – Changes in Bases of Valuation During the Year and determine that individual changes in specific mortality tables, interest rates, or valuation methods meet the minimum statutory valuation standards.
- Determine if changes in annuity reserve valuation bases received appropriate regulatory approval, if required.
- Test check the calculations involved in applying a change in valuation basis. Contact the state insurance department's actuary or other actuarial resource for assistance with this assessment.
- Request from the insurer information regarding the reason for the change in valuation basis.
- Request information from the insurer regarding any significant changes in reserve methodologies and assumptions, underwriting practices, case reserving, or claims handling practices with the potential to affect reserve setting.

Adequacy of Annuity Reserves (Risk of Understatement of Reserves)

~~***PROCEDURE #13***~~ ~~assists the analyst in d~~Determineing whether the insurer's underlying assets are adequate to support the future obligations of its annuity policies. If the insurer filed an SAO based on an asset adequacy analysis, then the actuarial opinion itself, and the supporting actuarial memorandum, if requested, can provide the analyst with comfort in this regard. If an SAO that does not include an asset adequacy analysis is filed, the analyst can review net interest spread ratios for insights regarding the relationship of investment income with tabular interest.

The analyst may also consider a review of the actuarial memorandum, is available, as this will provide the analyst with substantial analyses with regard to asset adequacy. If an actuarial memorandum is not available, the analyst should consider the need to have an independent asset adequacy analysis conducted.

Procedures / Data

- Net interest spread (net investment income, less tabular interest, divided by average annuity reserves) on individual annuity reserves.

- Net interest spread (net investment income, less tabular interest, divided by average annuity reserves) on group annuity reserves.
- Change in Asset Mix (IRIS Ratio 11)

Qualitative and Additional Review Considerations

- If the insurer filed a statement of actuarial opinion based on an asset adequacy analysis, review the results of the Actuarial Opinion Assessment, and note any concerns regarding the adequacy of the insurer's underlying assets to support future annuity policy obligations. Review the actuary's comments regarding the analysis performed and conclusions reached.
- If available, or if concerns or questions are noted, request and review the RAAIS, and note whether the responses to the questions were satisfactory.
- If concerns exist upon review of the asset adequacy analysis, conduct an independent asset adequacy analysis.

~~***PROCEDURE #14*** assists the analyst in i~~Identifying other areas of concern with withdrawal and surrenders that may affect annuity reserves. For example, annuities can have a significant impact on the insurer's liquidity position, particularly significant levels of GICs or amounts subject to withdrawal ~~at~~ with minimal or no surrender charge.

Procedures / Data

- Guaranteed interest contracts as percent of capital and surplus
- Annuity benefits, surrenders and other fund withdrawals for individual and group annuities as a percent of capital and surplus.
- Change in annuity benefits, surrenders, and other fund withdrawals for individual and group annuities and deposits, as a percentage of premiums
- Note significant amounts subject to withdrawal without any surrender charge or market value adjustment (i.e., as a percentage of total annuity reserves and deposit liability). [Annual Financial Statement, Notes to Financial Statements, Note #32]

Qualitative and Additional Review Considerations

- Request from the insurer and review the insurer's annuity plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy withdrawal features and surrender charges.

Adequacy of A&H Reserves (Risk of Understatement of Reserves / A&H Reserve Deficiency)

~~***PROCEDURE #15*** assists the analyst in d~~Determine ~~ing~~ 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.

Procedures / Data

- For non-life insurers, the gross A&H reserves to capital and surplus ratio.
- Net A&H reserves to capital and surplus ratio.

~~***PROCEDURE #16*** assists the analyst in d~~Determine~~ing~~ whether A&H policies appear to have been adequately reserved and valued in accordance with the minimum formula statutory valuation standards. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary. Therefore, the analyst should

review the results of the SAO Procedures to determine whether any concerns were noted regarding the valuation of the insurer's A&H reserves in accordance with Appendix A-010, *Minimum Reserve Standards for Individual and Group Health Insurance Contracts*, of the AP&P Manual.

The analyst might want to contact the qualified actuary who signed the insurer's SAO to discuss the nature and scope of A&H valuation procedures performed and/or request a copy of the qualified actuary's actuarial memorandum to review for comments regarding the analysis of A&H reserves performed and the conclusions reached.

Qualitative and Additional Review Considerations

- Review the results of the Actuarial Opinion Assessment. Note any concerns regarding the valuation of the insurer's reserves and if in accordance with minimum statutory valuation standards.
- Request and review the insurer's description of the valuation standards used in calculating the additional contract reserves (which is required to be attached to and filed with the Annual Financial Statement) and consider whether the reserve basis, interest rates and methods appear reasonable.
- If questions or concerns are noted, contact the qualified actuary who signed the insurer's Statement of Actuarial Opinion to discuss the nature and scope of the A&H reserve valuation procedures performed.
- Request from the insurer A&H insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific features and benefits.

~~PROCEDURE #17:~~ The ratio of A&H reserve deficiency measures the adequacy of A&H reserves established in the prior year. A positive result for this ratio represents additional or "adverse" development on the reserves originally established by the insurer (the amount by which the A&H reserves originally established have proved to be understated based on subsequent activity). Current or prospective reserve deficiency could represent a material impact on the insurer's capital and surplus. If the insurer's ratio results consistently show additional development, this could be an indication that the insurer is intentionally understating its A&H reserves. The A&H loss ratio is also reviewed as a part of this procedure. Significant increases in this ratio might be indicative of additional A&H reserves being established due to prior understatements while significant decreases might be indicative of current A&H reserve understatements. Other steps included in this procedure include the review of Exhibit 5A – Changes in Bases of Valuation During the Year, of the Annual Financial Statement to determine whether there has been a change in the valuation basis of the A&H policies during the year which resulted in a decrease in A&H reserves in an amount greater than 5% of capital and surplus.

The analyst may also consider reviewing Annual Financial Statement, Schedule H – Accident and Health Exhibit to determine which A&H lines of business are being written and which A&H lines of business had positive development in reserves during the year.

Procedures / Data

- A&H reserve deficiency ratio.
- Review the Schedule H claims test and note/explain any adverse trend or unusual fluctuation of one-year A&H loss development during the past five years.
- Assess loss ratios as indicators of reserve adequacy.
  - A&H Loss Ratio
  - Change in A&H loss ratio from the prior year.

Qualitative and Additional Review Considerations

- Review Annual Financial Statement, Schedule H – Accident and Health Exhibit, and perform the following:
  - Determine which A&H lines of business are being written by the insurer.
  - Review Schedule H – Part 3, to determine which A&H lines of business had positive development during the year.
- Review the A&H loss percentage ratio for unusual fluctuations or trends over a multiyear period.

- Compare the A&H loss percentage ratio to the industry average to determine any significant deviations from the industry average.
- Request an explanation from the insurer for any adverse loss development results or adverse trends indicated in the analyst's review of the Schedule H claims test.
- Request information from the insurer regarding A&H claims paid after year-end that were incurred prior to year-end and test the reasonableness of the year-end claim liabilities established by the insurer.

~~***PROCEDURE #18:*** The analyst should review of the A&H loss ratios 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.~~

~~***PROCEDURE #19:*** The analyst should also c~~Consider: 1) reviewing the insurer's A&H insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits; and 2) contacting the policy forms section of the insurance department and inquiring as to whether the insurer has filed any new and unusual A&H policy forms during the past year.

The analyst might also consider requesting that the field examination staff request a valuation listing of A&H reserves by policy and testing a sample of policies to determine that the reserve factors were appropriate and that the reserves were correctly computed. If the adequacy of claim liabilities is a concern, the analyst might want to request information from the insurer regarding claims paid after year-end that were incurred prior to year-end, in order to test the reasonableness of the year-end claim liabilities established by the insurer.

Qualitative and Additional Review Considerations

- Assess information on policy benefits offered that may indicate the impact of type of A&H business on reserving assumptions and methodologies.
  - Review the Notes to Financial Statements, MD&A, or other correspondence with the insurer and note whether the insurer initiated any internal changes that could impact the reserve estimates.
  - Through the analyst's quarterly interdepartmental communication with the policy forms department, inquire as to whether the insurer has filed any new and unusual A&H policy forms during the past year.
  - If concerns are noted about the types of policies, review the insurer's A&H insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific features and benefits.
  - If concerns are noted about reserving for A&H, consider a target examination of reserves, request that the field examination staff request a valuation listing of A&H policy reserves by policy and test a sample of policies to determine that the reserve factors used were appropriate and that the reserves were correctly computed.

Adequacy of Long-Term Care LTC Reserves (Risk of Understatement of Reserves)

~~***PROCEDURE #20*** instructs the analyst to r~~Review the LTC Experience Reporting Form of the Annual Financial Statement and the AG 51 reporting filed to the department if the insurer writes LTCI to gain an understanding of the reserve adequacy of the LTCI line of business. If concerns exist, consider requesting additional information as necessary to assess actual vs. projected results, legacy vs. newer blocks of business separately, any recent rate increases and capital support. If the insurer has recently filed for rate increases on LTCI blocks, consider intra-departmental discussion with the rate increase analysis and outcome with the rate review staff (if a different person than the analyst/actuary performing the valuation reserve analysis).

Qualitative and Additional Review Considerations

Review and assess long-term care (LTC) insurance reserves.

- Review the information reported in the LTC Experience Reporting Form of the Annual Financial Statement the Actuarial Guideline-LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) reporting, actuarial memorandum or any other related actuarial information filed to the department and

identify any concerns with reserve adequacy of LTC insurance business. Request a department actuary to assist in the review, if available.

- Gain an understanding of the asset adequacy and cash-flow testing for LTCI on a stand-alone basis.
- Consider any negative development in total LTCI reserve, asset adequacy reserves (if available), active life reserves, disabled lives reserves and premium deficiency reserves over the last five years.
- Evaluate the appropriateness of investment return assumptions factoring in the status of the current economic and interest rate environment.

- If concerns exist:
  - Evaluate actual results vs. original or revised assumptions and financial projections to identify trends and concerns.
  - Consider evaluating legacy blocks of business separately from newer blocks of business.
  - Rate Increases: Obtain and review the following information related to the status of rate increases and reduced benefit options. Consider that some information may be available from rate review staff for recent rate increase filings.
    - Track the progress of rate increases across states where a material amount of business is written.
    - Review projections illustrating the impact of proposed rate increases or reduced benefit options on the company's future profitability.
    - Determine the extent that future rate increases are included in the amount ($) of reserve offsets, asset adequacy/cash-flow testing and the reasonableness of the assumptions.
    - Consider the impact of historical approvals on the company's ability to obtain the rate increases presented in the projections. If concerns are identified in this area, obtain and review information on the company's plans to address these issues.
    - Compare the average percent of rate increases requested to the average approved.
    - Identify the amount of written premium change due to approved rate increases.
  - Regarding the adequacy of internal capital to support the LTCI business, compare the current total LTC reserves (active life and other), net of reinsurance, to the amount of internal capital the company has set aside for LTCI (e.g., internal capital per Own Risk and Solvency Assessment [ORSA] if applicable, or rating agency if higher than internal). If necessary, request information to gain an understanding of the degree of conservatism in such capital assumptions.

Impact of Changes in Valuation Bases of Reserves

~~***PROCEDURE #21:*** The analyst could r~~Review the insurer's description of the valuation standards used in calculating the additional contract reserves and consider whether the reserve bases, interest rates, and methods used appear reasonable. The insurer's description of the valuation standards used is required to be attached to the filed Annual Financial Statement.

If there was a change in the valuation basis of A&H policies during the year, the analyst should consider the following: 1) obtaining information regarding the reason for the change in the valuation basis; 2) determining whether the amount of the change in the actuarial reserve as a result of the change in the valuation basis is reasonable; and 3) determining whether the change in the valuation basis was approved by the domiciliary state insurance department, if required.

Assess the impact of changes in valuation bases on reserves.

Procedures / Data

- Note whether there has been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in capital and surplus. [Annual Financial Statement, Exhibit 5A]

Qualitative and Additional Review Considerations

- If there was a change in the valuation basis of the A&H policies during the year, consider performing the following:
  - Obtain information regarding the reason for the change in valuation basis and assess the change in the actuarial reserve.
  - Determine if changes in A&H reserve valuation bases received appropriate regulatory approval, if required.

Adequacy of Reserves on Captive (Non-Traditional) Reinsurance

PROCEDURE #22 assists the analyst in rReviewing reserve valuation of captive reinsurance transactions. Refer to the guidance in Chapter III.B.9.b. Strategic Risk Assessment Repository – Analyst Reference Guide, Procedure 9cc for an explanation of potential risks. Also, for affiliated transactions, refer to the guidance for Form D captive reinsurance transactions in Chapter V.C. Domestic and/or Non-Lead State Analysis for procedures that may have been conducted at the time the transaction was approved.

Qualitative and Additional Review Considerations

If business is ceded to a captive (non-traditional) reinsurer, consider the following procedures.

- Determine the percentage of gross premium written that is ceded to affiliated captive reinsurers (Schedule S, Part 3, Sections 1 and 2) (Utilize Reinsurance Dashboard).
- Review the information provided in the Form D application for compliance with reserve valuation standards for fixed annuities.
- Consider Handbook procedures similar to the procedures required for XXX/AXXX captive reinsurance (III.C. Special Analysis Procedures).
- Within the Actuarial Opinion Memorandum, require the insurer provide the results of cash flow testing and true-up of the statutory sufficiency of the reserve credit taken on gross reserves ceded to the affiliated reinsurer, including appropriate sensitivity tests (e.g., lapse, utilization, combined surrender and utilization, and credit defaults, etc.).
- Consider including confidential disclosure in the Insurer Profile Summary to other state insurance departments if the commissioner approved assets not meeting criteria A–C defined within the *Credit for Reinsurance Model Regulation* (#785) for Funds Withheld.

Additional Analysis and Follow-Up Procedures

Examination Findings direct the analyst to c

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

- If outstanding issues are identified perform follow-up procedures as necessary to address concerns.
- Request that the field examination staff request a valuation listing by plan and issue year and test a sample of the individual policy reserves for accuracy.

Inquire of the Insurer directs the analyst to c

Consider requesting additional information from the insurer if reserving risk concerns exist in a specific area. The list provided includes examples of types of information or explanations to be obtained that may assist in the analysis of reserving risk for specific topics where concerns have been identified, such as reserve methodologies, assumptions and oversight of reserve setting.

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

- If questions or concerns are noted, contact the insurer to request if the insurer initiated any internal changes that could impact the reserve estimates.
- Request of a copy of the insurer's business plan and review the insurer's plans to assess and mitigate reserve risks.
- Request information on who ultimately determines the level of reserves to be booked by the insurer and the board of directors' role in overseeing the reserving process.
- If filed on an insurance entity basis or if your state is the lead state, review the insurer's Corporate Governance Annual Disclosure (CGAD) filing to understand and assess the board of director's' role in overseeing the reserving process. If your state is not the lead state, rely on the information provided in the Group Profile Summary (GPS) or provided by the lead state, where the CGAD is filed on a group basis.

OWN RISK AND SOLVENCY ASSESSMENTOwn Risk and Solvency Assessment (ORSA) directs the analyst to o

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

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

- Review the ORSA Summary Report analysis conducted by the lead state for any reserving risks that require further monitoring or follow-up.
- Review the ORSA Summary Report analysis conducted by the lead state for any mitigating strategies for existing or prospective reserving risks.

HOLDING COMPANY ANALYSISHolding Company Analysis

directs the analyst to oObtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing reserving risks that could affect the insurer.

- Review the Holding Company analysis conducted by the lead state for any reserving risks impacting the insurer that require further monitoring or follow-up.
- Review the Holding Company Analysis conducted by the lead state for any mitigating strategies for existing or prospective reserving risks impacting the insurer.

Example Prospective Risk Considerations

The table provides the analyst with example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general description of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the reserving risk category.

DISCUSSION OF QUARTERLY RESERVING RISK ASSESSMENT

The quarterly reserving risk procedures described in the Quarterly Reserving Risk Assessment Repository are intended to identify significant changes in reserves that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.

Changes in Life Reserves and Reserve Adequacy

Procedures / Data

Determine changes in life reserves to assess any change in the adequacy of reserves.

- Change in reserve from the prior year-end where the aggregate reserve for life contracts exceeds 10% of capital and surplus.
- Change in any asset categories from the prior year-end. [Quarterly Financial Profile – "Mix of Cash & Invested Assets" section]
- Review, by line of business, the year-to-date direct premiums for the current and prior year quarter and note significant changes in direct premiums for any line of business from the prior year, same quarter. [Quarterly Financial Statement, Exhibit 1]

Changes in Accident and Health (A&H) Reserves and Reserve Adequacy

Procedures / Data
Determine changes in accident and health reserves to assess any change in the adequacy of reserves.

- Change in reserve from the prior year-end where the aggregate reserve for A&H contracts exceeds 10% of capital and surplus.
- Change in policy and contract claims from the prior year-end, where the A&H policy and contract claims exceeds 10% of capital and surplus.
- Change in benefits from the prior year, same quarter where the disability benefits and benefits under A&H contracts exceeds 10% of capital and surplus.
- Aggregate reserve for A&H contracts to capital and surplus ratio.
- Review, by line of business, the year-to-date direct premiums for the current and prior year quarter and note significant changes in direct premiums for any line of business from the prior year, same quarter. [Quarterly Financial Statement, Exhibit 1]

Changes in Annuity Reserves and Reserve Adequacy

Procedures / Data
Determine changes in annuity reserves to assess any change in the adequacy of reserves.

- Change in liability from the prior year-end where the liability for deposit-type contracts exceeds 3.5% of capital and surplus.
- Change in surrender benefits and other fund withdrawals change from the prior year, same quarter. [Quarterly Financial Statement, Summary of Operations]
- Change in any asset categories from the prior year-end. [Quarterly Financial Profile – "Mix of Cash & Invested Assets" section]
- Review, by line of business, the year-to-date direct premiums and deposit-type contract funds for the current and prior year and note whether direct premiums for any line of business or deposit-type contract funds have changed significantly from the prior year, same quarter. [Quarterly Financial Statement, Exhibit 1]

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

~~OVERVIEW OF~~ ACTUARIAL OPINION AND REGULATORY ASSET ADEQUACY ISSUES SUMMARY ASSESSMENT (RAAIS) OVERVIEW

Life insurers required to file an Annual Financial Statement are also required to file an SAO as a supplement to the Annual Financial Statement. The specific requirements for the SAO are described in the NAIC *Valuation Manual*, VM-30, Actuarial Opinion and Memorandum Requirements (AOMR). The SAO must be issued by an Appointed Actuary. The Appointed Actuary must be a qualified actuary appointed either directly by, or by the authority of, the board of directors through an executive officer of the company other than the qualified actuary. "Qualified

actuary" as used herein means a member in good standing of the American Academy of Actuaries, or an individual who has otherwise demonstrated his or her actuarial competence to the satisfaction of the domiciliary state insurance department. Requirements regarding the Appointed Actuary and Qualified Actuary must conform to those prescribed by the *Valuation Manual* authorized by Section 3B of the Standard Valuation Law as amended by the NAIC in December 2009. The Actuarial Opinion should include the general account and the separate accounts.

Life insurers are required to file a comprehensive SAO based on an asset adequacy analysis. The actuarial opinion is supported by an actuarial memorandum. The actuarial memorandum includes the results of the qualified actuary's asset adequacy analysis. While the SAO must be filed with the Annual Financial Statement, the actuarial memorandum is only provided to the regulator upon request. There is also a confidential executive summary, the RAAIS, filed with the insurance departments. In addition to an actuarial opinion, the insurer must also file a non-guaranteed elements opinion if policies containing non-guaranteed elements are currently being issued or are in-force. The specific requirements for the non-guaranteed elements opinion are described in the NAIC *Annual Financial Statement Instructions for Life, Accident and Health Insurance Companies*.

The SAO must follow the guidelines and standards for statements of actuarial opinion prescribed by the *Valuation Manual* authorized by Section 3B of the Standard Valuation Law as amended by the NAIC in December 2009. The SAO should consist of a paragraph identifying the qualified actuary, a scope section identifying the subjects on which an opinion is to be expressed and describing the scope of the qualified actuary's work, and an opinion paragraph expressing the qualified actuary's opinion with respect to such subjects. If there has been a material change in the actuarial assumptions from those previously employed, that change should be described in either the Annual Financial Statement or in a paragraph of the SAO. In addition, the scope paragraph should list those items and amounts to which the qualified actuary is expressing an opinion, including the following from the Annual Financial Statement: 1) aggregate reserves for life contracts (Exhibit 5); 2) aggregate reserves for A&H contracts (Exhibit 6); 3) deposit-type contracts (Exhibit 7); and 4) contract claims – liability end of current year (Exhibit 8, Part 1). If the actuary has not examined the underlying records but has relied upon listings and summaries of policies in force prepared by the company, the scope paragraph should include a sentence to this effect.

The Appointed Actuary must report to the board of directors or the Audit Committee each year on the items within the scope of the SAO. The minutes of the board of directors shall indicate that the Appointed Actuary has presented such information to the board of directors or the Audit Committee. A separate SAO is required for each company filing an Annual Statement. If the qualified actuary is unable to form an opinion, the actuary should issue a statement specifically stating the reason(s) why an opinion cannot be formed. If the qualified actuary's opinion is adverse or qualified, the actuary should issue an adverse or qualified actuarial opinion specifically stating the reason(s) for such an opinion. An adverse opinion is an actuarial opinion which the Appointed Actuary determines that the reserves and liabilities are not adequate.

DISCUSSION OF ACTUARIAL OPINION ASSESSMENT PROCEDURES

In most instances, proper review and analysis of the SAO will require a greater in-depth knowledge of actuarial science. In order to achieve this as a part of the financial review process, most opinions will be reviewed in detail by the Department's actuarial staff members. The review should encompass procedures discussed in the next section covering the Actuarial Opinion Assessment for the SAO. Although the analysis of the SAO, Actuarial Memorandum and RAAIS are often performed by the actuarial staff, analysts should have a basic understanding of interest rate risk and should consider reviewing the RAAIS and the New York 7, if available (see below for further discussion), or other stochastic testing results and discussing such results with the Department's actuary. When risks are identified in the RAAIS or actuarial memorandum, the analysts, ~~examiners~~examiners, and regulatory actuaries should communicate with each other the risk identified so that an overall understanding of the current and prospective risks of the insurer are documented and considered in the overall prioritization and profile of the insurer.

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However, if the Annual Financial Statement is received, a cursory review of the opinion should be performed to identify if any extraordinary item is detailed in the opinion. The primary goal of the Actuarial Opinion Assessment Procedures for the SAO is to determine if a SAO was to be filed and, if so, was it received and available for later review.

~~Every~~ All life insurers must file an SAO including an asset adequacy analysis unless granted an exemption of such analysis based on doing business only in one state.

An actuarial memorandum, which supports the findings expressed in the SAO, is available upon request by the regulator. The insurer will also file with the commissioner by March 15 a confidential RAAIS.

If the insurer presently issues or has in-force policies that contain non-guaranteed elements, then a Non-guaranteed Elements Actuarial Opinion must also be filed. Other opinions may be required~~—~~. For example, for business subject to an actuarial guideline—such as *Actuarial Guideline XXXV—The Application of the Commissioners Annuity Reserve Method to Equity Indexed Annuities* (AG 35) or XXXVI, which includes an opinion requirement, a compliant actuarial opinion must also be filed. The domestic insurance regulator should be familiar with all of the opinions each life insurer is required to submit. Reviewing the previous ~~year~~year's checklist is useful, but the state insurance regulator should be aware of new policy forms issued during the year that may add additional opinion requirements.

Asset Adequacy Analysis

Asset adequacy analysis is a process the appointed actuary uses to ascertain that the assets supporting a block of liabilities, along with future premium payments and investment income, are adequate under moderately adverse conditions to pay future expenses and policy obligations. This analysis may include cash flow testing, gross premium valuations, demonstrations of extreme conservatism, risk theory techniques, or loss ratio methods. Prior to 2001, requirements similar to the AOMR specified seven scenarios for cash flow testing (commonly referred to as the New York 7). Amendments adopted in 2001 removed those required scenarios and allowed the appointed actuary to determine the scenarios to use for cash flow testing.

The asset adequacy analysis is testing the adequacy of the reserves on a block of business as of a valuation date, not the solvency of the company. Typically, cash flow testing includes assets approximately equal to the reserves and therefore does not include assets equal to the surplus. In addition, future new business is not included in the cash flow testing.

The asset adequacy analysis typically includes approximately 95% of the total of life insurance reserves, annuity reserves and reserves for deposit-type contracts. This 95% threshold is included in *procedure #4,* but it is a recommendation, and the standard of materiality may vary among actuaries and among state regulators.

Actuarial Guideline 53:

Beginning with annual 2022, certain insurers will be required to document support for asset~~s~~ adequacy analysis for high-yielding complex assets pursuant to Actuarial Guideline 53 – Application of the Valuation Manual for Testing of Adequacy of Life Insurer Reserves (AG-53).

As noted in AG-53, "regulators have observed a lack of uniform practice in the implementation of asset adequacy analysis. The variety of practice in incorporating the risk of complex assets into testing does not provide regulators comfort as to reserve adequacy. Examples of complex assets are structured securities, including asset-backed securities and collateralized loan obligations, as well as assets originated by the company or an affiliated or contracted entity. An initial increase ~~of~~in this activity has been noted in support of general account annuity blocks; however, recent activity was noted in other life insurer blocks. AG-53 is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for asset adequacy analysis performed by life insurers."

This Guideline applies to a limited scope of life insurers, specifically those with:

A. Over $5 billion of general account actuarial reserves (from Exhibits 5, 6, 7, and 8 of the Annual Statement) and non-unitized separate account assets; or,
B. Over $100 million of general account actuarial reserves (from Exhibits 5, 6, 7, and 8 of the Annual Statement) and non-unitized separate account assets and over 5% of supporting assets (selected for asset adequacy analysis) in the category of Projected High Net Yield Assets, as defined in Section 3.F. of the AG-53.

The NAIC Life Actuarial (A) Task Force has developed a template for reporting of AG-53 documentation. The templates include reporting by asset classes, affiliated vs. non-affiliated, and initial assets vs. reinvestment assets. The template along with a narrative are submitted for the filing.[1]

The NAIC Valuation Analysis Working Group (VAWG) anticipates conducting reviews of AG-53 filings and can serve as a resource for state insurance departments for their own AG-53 reviews.

~~OVERVIEW OF~~ LIFE RESERVING RISK ASSESSMENT (INCLUDING PRINCIPLE-BASED RESERVING) OVERVIEW

Life insurance reserves represent the liability established by the insurance company to pay future policy benefits such as death benefits upon the death of the insured, endowment benefits upon the maturity of a life insurance policy and cash surrender benefits upon the surrender of the life insurance policy. Historically, the ~~company~~company's liability to pay future policy benefits has been determined by calculating a reserve based on a formula valuation methodology as described below. Life insurance products have evolved over time. Today, such products may be quite complex, offering multiple benefits and/or options to the policyowner or the insured or both the policyowner and the insured within a single contract such as death benefits, accelerated death benefits, secondary guarantees such as no lapse guarantees, policy loans, retirement income benefits such as guaranteed lifetime income benefits, and long-term care (LTC) benefits. The value of some of these complex benefits depends upon the current and future market value of the underlying assets. State insurance regulators have found it increasingly difficult to define or modify a formula-based valuation methodology to value all the options and/or benefits in a single contract. This complexity of current insurance products, along with the fact that the value of certain benefits depends upon the current and future market value of underlying assets, has led to the development of a principle-based valuation methodology that incorporates the value of both asset and liability cash flows. The principle-based valuation methodology is described below.

To implement the principle-based valuation methodology, amendments to the Standard Valuation Law were adopted in 2009, and a *Valuation Manual* was developed. The *Valuation Manual*, which is referred to in the amended Standard Valuation Law, provides reserve requirements for life, health and annuity products issued on and after the manual's operative date. Requirements include all of the details of the methodology for determining a principle-based reserve (PBR), as well as any changes to the formula-based valuation methodology that occurs on and after the operative date of the *Valuation Manual*. ~~The operative date of the *Valuation Manual* is Jan. 1 of the first calendar year following the first July 1 date in which the Standard Valuation Law as amended by the NAIC in 2009 has been enacted by at least 42 of the 55 jurisdictions representing NAIC membership and such jurisdictions represent greater than 75% of the direct premiums written as reported in the life, A&H annual statements; health annual statements; or fraternal annual statements submitted for 2008.~~

Unless a change in the *Valuation Manual* specifies a later effective date, changes to the *Valuation Manual* shall be effective Jan. 1 following the date when the change to the *Valuation Manual* has been adopted by the NAIC by an affirmative vote of at least three-fourths of the members of the NAIC voting but not less than a majority of the total membership and such members voting in the affirmative represent jurisdictions totaling greater than 75% of the direct premiums written as reported in the most recent life, A&H annual statements; health annual

[1] Given this is a new reporting requirement in 2022, additional analysis guidance in this area may be added to the Handbook in the future.

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statements; or fraternal annual statements. No state legislative adoption is needed to effect changes to the valuation manual.

The *Valuation Manual* defines the insurance contracts that are subject to a principle-based valuation (Section II). Unless otherwise specified in Section II, the principle-based valuation methodology will apply to life insurance contracts issued on and after the operative date of the *Valuation Manual*. However, a company may elect to defer the implementation of the principle-based valuation methodology to life insurance contracts issued during the first three years following the operative date of the *Valuation Manual*.

The Valuation Analysis (E) Working Group consisting of state insurance regulators with expertise in actuarial, financial analysis and examination experience reports to the Financial Condition (E) Committee and supports the states in the review of PBR to ensure consistent implementation and application of the methodology. The Working Group will also suggest necessary changes to the *Valuation Manual* to enhance clarification and interpretation of application of the principle-based valuation methodology.

The NAIC will acquire modeling software and develop actuarial staff expertise in modeling insurance cash flows to assist the Valuation Analysis (E) Working Group and the individual states in conducting analysis and examinations to verify the PBR and exclusion test calculations performed by the company.

As mentioned in the procedures, any questions or requests for assistance regarding PBR and for asset adequacy analysis may be made to the NAIC actuarial resources. Please see the NAIC website for the Valuation Analysis (E) Working Group for contact information regarding the use of NAIC actuarial resources and use of the Working Group if needed.

Formula-Based Valuation Methodology

Theoretically, the formula-based reserves represent the present value of future guaranteed benefits reduced by the present value of expected future net premiums. The insurance policy is a unilateral contract whereby the insured can cancel the agreement to pay premiums at any time. However, the insurer is “locked in” regardless of future experience and cannot forfeit on its guarantees as long as the premiums are paid. Life reserves are required in order to ensure that commitments made to policyholders and their beneficiaries will be met, even though the obligations may not be due for many years. Since the primary purpose of life reserves is to pay claims when they become due, life reserves must be adequate, and the funds must be safely invested.

The *Valuation Manual* prescribes the minimum standards to be used in determining the formula-based reserves as applicable in addition to PBR as discussed elsewhere in this document. Currently for most formula-based reserves, the manual refers to requirements in the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual). Insurers may establish life reserves, which equal or exceed these minimum standards. These minimum life reserve standards specify a: 1) valuation mortality table; 2) maximum valuation rate of interest; and 3) valuation method. The valuation method used to define minimum life reserves for statutory accounting purposes is referred to as the Commissioners Reserve Valuation Method (CRVM). The mortality rate assumptions are substantially higher than what the insurer can expect to realize from medically underwritten insurance policies. The interest rate assumptions are intended to be significantly lower than current money and capital market yields. Thus, the life reserves developed are generally conservative.

There are three general valuation methods under a formula-based valuation methodology used to value life reserves. The net level premium method does not provide for a first-year acquisition cost allowance in determining life reserves. Therefore, this method results in the most conservative, or highest, life reserve valuation of the three methods. The full preliminary term method does provide a first-year expense allowance and then assumes that the remaining premium stream is used to cover policy benefits. The CRVM is a form of the full preliminary method. This method allows for a lower life reserve valuation than the net level premium method in the earlier years of the policy term. The modified preliminary term method is a variation of the two methods described above and results in a reserve valuation between the net level premium and preliminary term methods.

As described below, the type of life insurance policy dictates the amount of the life reserve that must be established and the duration for maintaining the reserve. In addition, special situations arise which require unique reserving techniques. The following summarizes the major types of life insurance policies, and the related reserving implications under a formula-based valuation methodology:

1. **Ordinary Life Reserves**

   Under a whole life plan of insurance, the insurer is obligated to maintain a reserve until the death of the insured. Term life insurance provides coverage only for the period that is specified in the policy. Under a term insurance plan, the insurer must maintain a reserve, which reduces to zero upon expiration of the term period. Similar to term insurance, endowment life insurance provides coverage for a period specified in the policies. Unlike term insurance, the proceeds of endowment insurance are payable if the insured lives to the end of the period. Policies which permit flexible premium payments, are referred to as "universal life" policies and those with fixed premiums are referred to as "interest sensitive" policies. Universal life policies are accumulation type policies where the current account value is determined based upon the accumulation of premiums, less mortality charges and expense charges, plus a current interest rate credit. The account value less surrender charges is the cash value. Because of the unique features of universal life and interest sensitive types of policies, unique reserving requirements are specified for them in Appendix A-585, *Universal Life Insurance*, of the AP&P Manual. The minimum standard for universal life reserves ~~consider~~considers guarantees within the policy at the time of issue, present value of future guaranteed benefits, account value and cash value.

2. **Group Life Reserves**

   Most group life insurance is monthly renewable term insurance. For these policies, gross premiums are typically recalculated periodically, most often annually, using the age and sex census of the group along with experience adjustments. Therefore, the reserve is usually calculated as the unearned premiums or a percentage thereof to estimate the claim exposure. However, some group life insurance policies provide permanent or longer-term benefits analogous to individual coverages. In these cases, the reserving methods are similar to those employed for individual insurance, using appropriate mortality tables. Appendix A-820 does not specify a mortality table for group life insurance but leaves that to the discretion and approval of the domiciliary state.

3. **Industrial Life Reserves**

   Industrial life insurance is unique in that it involves higher unit premiums, smaller face amount policies and higher mortality expectations. The minimum standards for reserves are the same as the traditional life insurance except that a unique mortality table is used.

4. **Life Reserves Relating to Riders**

   Life insurance policies frequently include riders for additional benefits such as accidental death and disability and waiver of premium upon disability. The minimum valuation standards for reserves are the same as for the base life insurance except that specialized mortality and disability tables are used, and the net level premium valuation method is required.

5. **Miscellaneous Life Reserves**

   There are various other special situations involving life reserves. First, a deficiency reserve may be required in situations where the actual policy gross premium is less than the valuation net level premium. This situation occurs when pricing assumptions are used that are different from the minimum reserve valuation standards. This does not necessarily indicate that the policy is being sold at a loss by the insurer, but rather is a reflection of the highly conservative nature of the minimum reserve valuation standards. Second, there may be unusual situations where the cash surrender value of a life insurance policy is greater than the minimum reserve standard. In these situations, life reserves must be increased by the amount of this excess.

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6. **Minimum Aggregate Reserves**

   In the aggregate, policy reserves for all life insurance policies valued under a formula-based valuation methodology that are reported in the statutory financial statements must equal or exceed reserves calculated by using the assumption and methods that produce the minimum formula standard valuation.

Principle-Based Valuation Methodology

In general, under a principle-based valuation methodology, all of the liability cash flows emanating from the contract benefits provided in the product are determined for each period and compared with all of the asset cash flows for each period determined from the assets the insurance company has purchased or plans to purchase or sell to fund the liability cash flows. The resulting differences between the asset and liability cash flows for each period are valued under a range of likely or plausible economic scenarios. Economic scenarios may consist of interest rates or market returns or both depending on the nature of the asset and liability cash flows. A single economic scenario represents multiple consecutive periods (such as 30 or 40 years) of movements in the underlying interest rate or market rate returns. The length of the scenario period is determined by the length of the liabilities being valued. The economic scenarios are stochastically (randomly) generated using a prescribed economic scenario generator (ESG). The prescribed ESG can be found on the Society of Actuaries (SOA) website.

The reserve liability under a principle-based valuation methodology is determined as a function of the discounted value of the differences between the asset and liability cash flows for each period over the range of economic scenarios. The objective is to determine if there is a reasonable likelihood that assets are insufficient to cover the obligations of the company, and by what amount they may be insufficient. Under economic scenarios where assets are insufficient, the principle-based methodology determines all the amounts of the insufficiencies and discounts them back to the valuation date. The largest discounted value is known as the Greatest Present Value of Accumulated Deficiencies (GPVAD) for that scenario. The stochastic reserves may be set at a CTE (70) level (conditional tail expectation at the 70% level). The function CTE (70) means the average of the 30% (100% - 70%) worst (largest) GPVADs. So, for example, if a company randomly generates 1,000 economic scenarios, it would then determine the largest accumulated amount of deficiency for each of the 1,000 scenarios. The CTE (70) stochastic reserve (SR) level would be determined by taking the average of the 300 [1,000 x (100% - 70%)] worst GPVADs out of the 1,000 scenarios.

The principle-based valuation methodology developed for life insurance contracts defines three components of a PBR: 1) a net premium reserve (NPR); 2) a deterministic reserve (DR); and 3) an SR. The level of risk embedded in a life insurance contract will determine whether the PBR will consist of all three reserve components (NPR, DR, SR), only two reserve components (NPR, DR), or only one reserve component (NPR). The principle-based valuation methodology defines a stochastic exclusion test and a deterministic exclusion test, each of which are designed to measure the level of risk embedded in a life insurance contract. Life insurance contracts that pass an exclusion test are then exempt from the calculation of the associated PBR component. For example, all life insurance contracts that pass the stochastic exclusion test but fail the deterministic exclusion test must calculate the NPR and DR components. Life insurance contracts that pass both the stochastic and deterministic exclusion tests must only calculate the NPR component. For groups of policies other than variable life or universal life with a secondary guarantee (ULSG), a company may provide a certification by a qualified actuary that the group of policies is not subject to material interest rate risk or asset return volatility risk in lieu of performing the stochastic exclusion test. In addition, a company is not required to compute SR and DR on any of its ordinary life policies if it meets the requirements for a "Companywide Exemption" provided in Section II of the *Valuation Manual*. If the domestic commissioner does not reject a company's application for the companywide exemption pursuant to the *Valuation Manual*, Section II, then the company will compute reserves for its ordinary life policies per the requirements provided in VM-A and VM-C of the *Valuation Manual*.

Note that some states incorporated a "companywide exemption" in the Standard Valuation Law that may override Section II of the VM-20, Requirements for Principle-Based Reserves for Life Products. In such cases, the state's Standard Valuation Law will determine whether a company is not subject to computing the stochastic and

deterministic reserves. Note also, the insurance commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in a single state as defined in Section 15 of the amended Standard Valuation Law.

As part of the calculation process, the principle-based valuation methodology allows companies to aggregate or group policies with similar risk characteristics. For example, all term policies that provide only a death benefit and do not provide any cash surrender values may be grouped together by underwriting class. The exclusion tests are then applied on a group or aggregated basis and not a contract-by-contract basis. Also, the DR and the SR are calculated on thean aggregated or group basis. The NPR component is a fully prescribed formula-based reserve and can be applied on a contract-by-contract basis.

The annual statement blank contains a VM-20 Supplement. This supplement breaks out the PBR into its various components of NPR, DR and SR. State insurance regulators may request the assistance of NAIC modeling staff and or the Valuation Analysis (E) Working Group in verifying exclusion testing, as well as various components of the PBR on a smaller sample set of company contracts.

Actuarial Opinion and Asset Adequacy Analysis

Due to the complexity in determining life reserves, insurers must rely on actuaries to assist with valuation of these reserves. Insurers are required to annually obtain an opinion regarding the reasonableness of the reserves by a qualified actuary who is appointed by the company. The actuarial opinion requirements are provided in VM-30 of the *Valuation Manual*. These requirements also include requirements for asset adequacy analysis. As a result of the asset adequacy analysis conducted by the appointed actuary, the actuary may conclude that the insurer's assets are not adequate to cover future liabilities as valued by the calculated reserves. When this occurs, reserves must be increased by the estimated deficiency resulting from asset adequacy testing. Additional procedures regarding the SAO are found in Section III.B.8.b.iid.

ACCIDENT AND HEALTH RESERVING RISK ASSESSMENT ES OVERVIEW

The purpose of A&H insurance is to protect the insured against economic losses resulting from accident and/or sickness. There are many different types of A&H policies issued by insurers. The economic losses covered, and the types of benefits provided, vary with the different types of A&H policies. For example, a medical insurance policy may provide reimbursement for hospital, surgical, medical and drug expenses and a dental insurance policy may cover dental expenses. Another type of A&H insurance policy issued is disability insurance which provides monthly benefits for loss of income due to disability on either a short-term or long-term basis. A&H insurance is provided through individual policies, group policies and certain special types of policies such as credit disability insurance.

A&H reserves are complex and difficult to analyze because of the wide variety of types of coverage included in the A&H lines of business and the diversity of benefits which must be reserved for. A&H reserves are comprised of two separate liability line items in the Annual Financial Statement: 1) the aggregate reserve for A&H policies; and 2) the A&H policy and contract claims liability. These liabilities are discussed in more detail below.

1. **Aggregate Reserve for A&H Policies**

   The aggregate reserve for A&H policies consists of two different components: 1) policy reserves; and 2) claim reserves.

   a. **Policy Reserves**

      Policy reserves are required in recognition of the fact that premiums cover future liabilities as well as current claims and expenses. Policy reserves include unearned premium reserves, additional contract and actuarial reserves, reserves for future contingent benefits, and reserves for rate credits. The various types of policy reserves are discussed in more detail below.

Unearned premium reserves represent the amount of the premium applicable to coverage which extends beyond the valuation date (date of the statement). The unearned portion of the premium is generally computed on a pro rata basis.

Additional contract reserves are required for those policies with level premiums where the risk of loss increases with the age of the insured. For these policies, the insurer is required to set aside a portion of the current premium to pay claims that experience indicates will be incurred as the policy continues in force. These reserves are actuarially determined and are similar in concept to life reserves with the added requirement to consider morbidity assumptions as well as mortality and interest assumptions. The NAIC AP&P Manual prescribes the minimum standards used in determining the A&H policy reserves. Insurers may establish A&H policy reserves which equal or exceed these minimum standards. These minimum A&H policy reserve standards for most types of A&H insurance include: 1) a given morbidity table; 2) a maximum rate of interest; and 3) a valuation method. In no event, however, may the aggregate reserve for all policies be less than the unearned gross premiums under such policies. For financial statement purposes, the additional contract reserves represent the excess of the required A&H policy reserves over the unearned gross premiums on A&H policies. The insurer is required to attach to the Annual Financial Statement a description of the valuation standards used in calculating the additional contract reserves, specifying the reserve bases, interest ~~rates~~rates, and methods.

Determine if additional actuarial reserves are required as a result of actuarial cash flow testing and asset adequacy analysis.

If the A&H policy provides for future contingent benefits, a portion of the current premium must also be reserved for such coverage. For example, some A&H policies provide for deferred maternity benefits (which cover medical expenses incurred in childbirth for approximately nine months after the cessation of premium payments, even though the policy has been canceled, so long as conception occurred prior to the policy being canceled). An actuarially determined estimate of the costs associated with this future contingent benefit must be reserved for out of the current premium.

Some A&H policies provide for rate refunds based on policy year experience. For these policies, a reserve is required to be established for the rate credits based on the amount of the expected credit as of the valuation date. The reserve for rate credits is a difficult liability to establish because many policy years do not end on the valuation date (date of the statement) and subsequent experience may cause the rate credit to be greater or less than the liability established. However, the liability established must be reasonable under the circumstances and consistently calculated.

b. **Claim Reserves**

Claim reserves (sometimes referred to as disabled life reserves) are required for claims which involve continuing loss. The claim reserves represent the actuarially determined present value of future benefits or future covered benefits not yet due as of the valuation date (date of the statement) which are expected to arise under claims which have been incurred as of the statement date. However, although the liability for future covered benefits which are expected to arise under claims which have been incurred as of the statement date on medical insurance policies should be included in claim reserves according to *Statement of Statutory Accounting Principles* (*SSAP) No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*, some insurers include this liability in the A&H policy and contract claims liability which is discussed below.

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2. **A&H Policy and Contract Claims Liability**

   The A&H policy and contract claims liability includes: 1) due and unpaid claims; 2) claims in the course of settlement; and 3) incurred but not reported (IBNR) claims.

   a. **Due and Unpaid Claims**

      Due and unpaid claims are those which are complete except for the payment of the amount due. The amount of an insurer's due and unpaid claims is generally very small, and this liability is generally determined on an exact inventory basis of claims ready to be paid.

   b. **Claims in the Course of Settlement**

      Claims in the course of settlement include claims which have not been paid because all of the required information has not yet been received as of the statement date, resisted claims and the accrued portion (amount that is payable as of the statement date) of the next periodic payment on disability claims. The unaccrued portion of the next periodic payment on disability claims would be included in claim reserves discussed above. The liability for claims in the course of settlement, other than disability claims, may be determined based on estimates for each outstanding claim or the development of average claim factors or formulas based on historical experience.

   c. **IBNR Claims**

      IBNR claims are those claims which have occurred but have not yet been reported to the insurer. Since neither the number nor dollar amount of IBNR claims are known as of the statement date, the liability for IBNR claims is difficult to estimate. The liability for IBNR claims is generally estimated based on an actuarial analysis of past experience or on the development of lag studies using historical experience.

Due to the variety of types of A&H policies issued and the complexity of determining the aggregate reserve for A&H policies and the A&H policy and contract claims liability, most insurers rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some insurers do not use actuaries to actually set the A&H reserves, insurers are required to annually obtain an opinion regarding the reasonableness of the established A&H reserves by a qualified actuary. Therefore, qualified actuaries are involved in setting and/or reviewing the A&H reserve liabilities established for virtually all insurers.

ANNUITY RESERVING ASSESSMENT~~ES~~ 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.

The AP&P Manual prescribes the minimum standards to be used in determining reserves. Appendix A-820*, Minimum Life & Annuity Reserve Standards* of the AP&P Manual defines the minimum standards for all types of

policy reserves, including life & annuity policies. Insurers may establish annuity reserves, which equal or exceed these minimum standards. These minimum annuity reserve standards specify a: 1) given mortality table (if applicable); 2) maximum rate of interest; and 3) valuation method. The valuation method used to define minimum annuity reserves for statutory accounting purposes is referred to as the Commissioners Annuity Reserve Valuation Method (CARVM). The mortality rate assumptions, if applicable, are substantially lower than what the insurer can expect to realize from medically underwritten insurance policies. The interest rate assumptions are intended to be significantly lower than current money and capital market yields. Thus, the annuity reserves developed are generally conservative.

As described below, the type of annuity dictates the amount of the annuity reserve that must be established and the duration for maintaining the reserve. In addition, special situations arise that require unique reserving techniques. The following summarizes the major types of annuities and the related reserving implications:

1. **Deferred Annuities (Annual Premium and Single Premium)**

   All deferred annuities are reserved using the CARVM method. The reserve on any specific valuation date requires a calculation of the present value of future guaranteed benefits less the present value of future required net premiums for the current duration of the policy and for each future duration. For purposes of calculating this series of "excesses," premiums are only considered to be payable for the specific duration for which the excess is being calculated. The reserve is the greatest of these excesses. Reserves for guaranteed benefits must consider all contractual guarantees including cash values, death benefits, annuity income, etc. Cash values ~~are those~~are actually guaranteed under the policy provisions.

2. **Immediate Annuities**

   Immediate annuities are those that are in ~~a payout~~payout mode. Reserves are determined using the CARVM method, except that, in the case of supplemental contracts without life contingencies, mortality tables are not used.

3. **Guaranteed Interest Contracts**

   Guaranteed interest contracts (GICs) represent a type of funding vehicle used where group deferred annuities are involved. Under a basic GIC, the insurer accepts a single deposit from the plan sponsor (i.e., the employer) for a specified period of time, such as five years. Interest earned during the period may ~~be accumulated~~accumulate until the period expires, or the earned interest may be paid out annually. At the end of the period, the account balance, including any accumulated interest, is returned to the plan sponsor. Numerous variations of this basic guaranteed interest contract have been developed that: 1) allow the plan sponsor to make monthly contributions rather than the single deposit; and 2) provide that the principal and interest can be paid out in installments to make benefit payments to plan participants.

4. **Structured Settlements**

   Structured settlements are a form of immediate annuity generally established in connection with the settlement of a property/casualty claim wherein a predetermined future benefit stream is desired. Reserves are determined using the CARVM method with special actuarial guidelines that prescribe specialized mortality tables and govern the use of lump sum balloon payments.

5. **Variable Annuities**

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

Due to the complexity in determining annuity reserves, insurers must rely on actuaries to assist with valuation of these reserves. Insurers are required to annually obtain an opinion regarding the reasonableness of the reserves

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by a qualified actuary. In the aggregate, policy reserves for all annuity policies that are reported in the statutory financial statements must equal or exceed reserves calculated by using the assumptions and methods that produce the minimum standard valuation.

LONG-TERM CARE INSURANCE (LTCI) OVERVIEW

"Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital[2]. Historically, insurers that wrote LTCI encountered difficulties accurately projecting claims costs, lapse rates, investment returns, and other factors associated with LTCI, and subsequently many writers have experienced unprofitability in older (legacy) blocks of LTCI business. This has led many companies to request significant rate increases, modify product benefits or exit the product line altogether. Therefore, many insurers continue to experience significant solvency challenges related to this line of business, and state insurance regulators should continue to carefully evaluate and monitor the solvency position of all insurers with a material amount of LTCI business.

These same risks also affect reinsurers because the reinsurance contract may not arbitrarily allow for ceded premium increases. Additionally, in order to effectuate a true transfer of risk, the reinsurer may not have the ability to require the direct writer to request rate increases. As some insurers look for avenues to minimize or eliminate its risk from the LTCI block, they may look to new reinsurance opportunities or nontraditional buyers.

In addition, periods of economic downturn and low interest rates increase the risk that LTCI writers will be challenged to generate sufficient returns to support this line. In addition, declines in projected investment returns could have a significant impact on LTCI reserve assumptions.

Actuarial Guideline 51—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51)

Effective for reserves reported with the Dec. 31, 2017, financial statement, *Actuarial Guideline 51—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) now applies. The *Health Insurance Reserves Model Regulation* (#10) and the *Valuation Manual* VM-25, Health Insurance Reserves Minimum Reserve Requirements, contain requirements for the calculation of LTCI reserves. AG 51 requires companies with more than 10,000 LTCI enrollees to submit stand-alone LTCI asset adequacy analyses to the state. AG 51 is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to a company's LTCI block of contracts. AG 51 requires reporting to the department within the appointed actuary's actuarial memorandum required by VM-30 or in a special actuarial memorandum containing LTCI-specific information on the results of the analysis, assumptions on mortality, voluntary lapse, morbidity, investment returns and rate increase assumptions.

Factors Affecting LTCI Reserves and Rates

This following guidance provides additional information that may assist state insurance department staff in understanding the differences in premium rate review and approval, and valuation review of reserve adequacy assumptions in order to maintain or improve state insurance departments' current intra-departmental coordination/communication practices between the states' rate reviewers, valuation actuaries and analysts/ examiners.

Reserve Increase Factors

[2] Definition per *Long-term Care Insurance Model Act* (#640) Section 4.A.

1. **Background**

Ever since asset adequacy testing became a requirement for life insurers in the 1980s, actuaries have been required to analyze reserve adequacy assumptions on an annual basis and make the assumptions more conservative when experience or expectations become more adverse. If the result of the more conservative assumptions was inadequate reserves, companies have been required to establish higher reserves to ensure future claims could be paid in the more adverse environment.

In some cases, the chain of events is straightforward. For instance, for life insurance, if more people die at earlier ages than expected and the experience is highly credible, then the actuary increases mortality rates in the upcoming year-end filing, leading to higher reserves being established.

In other cases, the chain of events is less straightforward. For instance, it is expected that cash surrenders on deferred annuity products will increase if interest rates rise. However, most deferred annuities have been sold during a period of decreasing interest rates. Actuarial and regulatory practice require reserves to be adequate in moderately adverse conditions, even if those conditions have not been recently experienced. There is typically judgment by the company actuary and another layer of judgment by regulators in play in this type of complex situation. The *Standard Valuation Law* (#820), the *Valuation Manual* and the Actuarial Standards Board's (ASB's) Actuarial Standards of Practice (ASOPs) describe how these complex situations should be handled.

2. **Long-Term Care Insurance**

For LTCI blocks of business that experience higher morbidity than expected, this experience will likely lead to changes in expectations on future morbidity for both the observed block and other blocks.

With LTCI, some factors are likely to play out in a straightforward manner. A combination of higher life expectancy and lower lapses will lead to more people than expected reaching prime LTCI claims ages of 80 and above, which leads to companies holding higher reserves than originally anticipated. Similarly, all companies have experienced the decreasing interest rate environment, which has led to lower-than-expected investment returns and the need to hold higher reserves because investment income is relied upon to help pay claims.

Mortality, ~~lapse~~lapse, and interest rate factors become observable and can develop credibility during the premium-paying years prior to policy years when significant claims tend to occur.

3. **Morbidity Assumptions**

Morbidity, however, has tended to fall into the category of a complex factor. The three main aspects of LTCI morbidity are: 1) incidence, the percentage of people at a given age who start a claim; 2) average length of claim; and 3) utilization, which is less than 100% if, e.g., the daily nursing home cost is lower than the maximum daily benefit in the insurance policy.

There has not been uniform experience development in morbidity, except that length of claim has tended to increase, likely because cognitive (e.g., dementia and Alzheimer's disease) claims tend to be longer than average and incidence has been higher than expected, likely due to more people reaching the age when cognitive claims tend to occur.

Because of divergent experience among companies and because morbidity becomes observable and credible during the later claim-paying years, establishing and regulating LTCI morbidity assumptions has not been straightforward. However, as with other factors and other products, the handling of these situations is addressed in Model #820, *Valuation Manual* and ASOPs. Examples of these standards include:

- Model #820 Section 12A(3)(a): "Assumptions shall, to the extent that company data is not available, relevant or statistically credible, be established using other relevant, statistically credible experience."

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- Model #820 Section 12A(4): "Provide margins for uncertainty … such that the greater uncertainty, the larger the margin and resulting reserve."
- AG 51 (providing guidance on VM-30) Section 4.B.: "The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks. Material assumptions associated with the LTCI business shall be determined testing moderately adverse deviations in actuarial assumptions."
- *Acounting Practices and Procedures Manual* (AP&P Manual), Appendix A-010 paragraph 48.e (referenced in VM-30): "The total contract reserve established shall incorporate provisions for moderately adverse deviations."
- AP&P Manual, Appendix A-010 paragraph 51 (referenced in VM-30): "Annually, an appropriate review shall be made of the insurer's prospective contract liabilities … and appropriate increments … if such tests indicate that the basis of such reserves is no longer adequate."

The result is that whether credible experience exists or not, the company actuary needs to set assumptions underlying reserves, and the factors underlying the assumptions are often complex and frequently changing. Company and regulatory actuaries are experienced in working in this complex, changing environment with many life insurer products, such as variable annuities, indexed products and LTCI having product features and factors underlying reserves that are complex and changing.

4. **Rate Increases**

A unique aspect of LTCI products is being a long-term product with rate increases that require review by states. Besides states with the largest insurance departments, the actuaries reviewing LTCI reserves are often the same staff reviewing LTCI rate increases. For larger states, there is typically coordination or training to ensure the reserve and rate teams are on the same page regarding developments in, for example, life expectancy and morbidity. State insurance regulator experience in reviews of LTCI reserves and rate increase filings show that reserve increases and requests for rate increases are due to similar factors, including higher life expectancy, lower lapses, lower investment returns and worsened morbidity.

There has been additional regulatory attention on ensuring the companies asking for rate increases based on adversity of certain factors are holding reserves based on at least the same level of adversity in those factors. The questions used in many states' rate increase reviews require the company to explain the consistency between the rate increase filing assumptions and reserve adequacy assumptions.

To date, the most common complex, non-straightforward case is the applicability of a company's adverse morbidity experience of an older LTCI block to morbidity assumptions on a newer block. This complex dynamic comes into play when establishing reserve and rate increase assumptions.

The reserve assumption changes can occur with initiation by the company, through formal or informal agreement between regulators or companies, or by relying on Model #820 Section 11.6., which allows a commissioner to require a company to change reserve assumptions and adjust reserves.

Example:

A typical example of a chain of events would first involve a block issued in 1995 to 1998 to policyholders with issue ages ranging from 52 to 62. By 2019, enough policyholders have reached prime LTC claim ages of 80+. This experience is what drives reserve assumption changes. As policyholders enter ages in the upper 80s and 90s, additional experience will be attained that will predict future LTCI costs and result in further changes in reserve assumptions. The development of older-age morbidity experience is expected to generate volatility in LTCI reserves. For some companies, the older-age morbidity experience will likely be unfavorable, with increased reserves needed. For most other companies, the older-age morbidity experience will likely be as expected, leading to no significant, unforeseen reserve increases.

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Companies will be expected to apply lessons learned from older blocks of business to their newer blocks. Those lessons will likely differ by situation. For example, to the extent underwriting is different, the newer and older blocks may experience different morbidity trends.

5. **Rate Increase Factors**

   Factors affecting LTC reserves, including higher life expectancy, lower lapses, lower investment returns and changes in morbidity also potentially affect LTC rate increases.

   If a company's reserve adequacy testing is dependent upon assumption of future LTC rate increases, the state insurance department staff performing reserve valuation should evaluate that assumption for reasonableness. The company's rate increase assumptions and documentation should be consistent with the requirements specified in AG 51 related to rate increase plans. The state insurance department staff performing reserve valuation may wish to coordinate and communicate with the state's rate review staff to help evaluate the appropriateness and reasonableness of the company's future rate increase assumption.

6. **Intra-Department Communication and Coordination of Actuarial Review Work**

   While every state insurance department may be structured differently, many state insurance departments have the same staff members perform work on both LTCI reserve valuation analysis and rate increase reviews, while others have separate staff perform these functions. In the latter instance, department staff should be aware of or coordinate the intra-department review work related to each function.

   The following are suggested steps a state may consider ~~to ensure~~ensuring that actuarial assumptions associated with the rate increase request are consistent with the assumptions embedded in the asset adequacy testing.

- Inquire of the company's actuary or senior management regarding:
  - The relationship of the actuarial assumptions embedded in the rate filing versus those made for annual statement reporting.
  - Explanation if there is inconsistency between assumptions reported.
  - How AG 51 affects the company's rates and reserves.
  - Affirmation that the assumptions underlying the projections are consistent with the assumptions used in asset adequacy analysis.
  - A copy of the company's rate increase plan when rate increase filings disclose that future rate increase filings, beyond what is currently being requested, are planned.
- Consider reviews of different filings for consistency. For example:
  - Compare reserving assumptions to rate increase assumptions,
    - e.g., review the RAAIS and the Actuarial Opinion and Memorandum (AOM) to ensure that assumptions used for pricing and reserving are similar in nature.
  - Identify assumptions underlying the asset adequacy testing memorandum that appear to be an outlier and then compare against a subsequent rate increase filing.

Reserving Risk Assessment

Reserving Risk: Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.

The objective of Reserving Risk Assessment analysis is focused on reserve adequacy. The analysis of reserves relies heavily on the review of the Statement of Actuarial Opinion and other related filings. The following discussion of procedures provides suggested data, benchmarks and procedures that analysts can consider in their review. Aanalysts' risk-focused assessment of reserving risk should take into consideration the following areas (but be limited to):

- Reasonableness of assumptions and methodologies used by the Appointed Actuary to determine reserves
- Completeness and accuracy of the underlying data used by the Appointed Actuary in reserve calculations
- Accuracy of the Appointed Actuary's reserve calculations
- Relationship between the Appointed Actuary's reserve estimates and the company's carried amounts
- Appropriate reporting of reserves and consistency between amounts recorded in the Statement of Actuarial Opinion, Actuarial Opinion Summary (AOS), Actuarial Report and Annual Financial Statement
- Effect of discounting on the carried reserves
- Lines of business written by the insurer
- Reserve development
- Changes in ceded reinsurance program
- Collectability of ceded reinsurance
- Adequacy of assets to support policyholder benefits

OVERVIEW OF ACTUARIAL OPINION, ACTUARIAL REPORT, & ACTUARIAL OPINION SUMMARY

A. Actuarial Opinion

The Statement of Actuarial Opinion (Actuarial Opinion) provides a qualified actuary's opinion on the reasonableness of the insurer's reserves and gives insight into company-specific risk factors. The Actuarial Opinion can be valuable in determining whether the insurer requires further regulatory attention. The Actuarial Opinion is not independent from the Annual Financial Statement itself. Everything that follows in describing the Opinion should be expected to be consistent with all other elements of the Annual Financial Statement, including but not limited to the General Interrogatories, Notes to Financial Statements, MD&A, and Independent Auditors' Report. (Note that the Annual Financial Statement is also referred to as the Annual Statement within this reference guide.)

Exhibit A (Scope) and Exhibit B (Disclosures) are crucial elements of the Actuarial Opinion. Exhibit A details the specific areas the actuary examined, such as loss and loss adjustment expense reserves, premium reserves, and other relevant reserve items. Exhibit B includes the Appointed Actuary's identification, qualifications, opinion type, materiality standard, risk assessment, reserve discounting, and other disclosures.

Annual Statement Instructions – Actuarial Opinion

Section 1 of tThe *Annual Statement Instructions* (Instructions) identifies the insurer's responsibilities regarding the appointment of a qualified actuary, notification to regulators, regulatory requirements for a change in actuary, requesting an exemption from filing the Actuarial Opinion, and reporting requirements for insurers that participate in an intercompany pooling arrangement. Most of this is straightforward; therefore, the following is a summary of what is included within each section.

Actuarial Report

The Actuarial Report is a confidential document separate from the Actuarial Opinion. It serves as a formal means of communicating the Appointed Actuary's professional conclusions and recommendations to the state regulatory authority and the Board of Directors. Additionally, it documents the methods and procedures used, ensures that all parties involved understand the significance of the Actuary's opinion, and provides a record of the underlying analysis.

To be considered a "Qualified Actuary" as defined in the NAIC Statement of Actuarial Opinion, an actuary must satisfy specified qualification standards, retain an Accepted Actuarial Designation, and maintain membership in a professional actuarial association that requires adherence to the same Code of Professional Conduct promulgated by the American Academy of Actuaries and participation in the Actuarial Board for Counseling and Discipline. With respect to filing exemptions, it should be noted that a commissioner is not obligated to grant an exemption merely due to the presence of one or more conditions. Consideration of an exemption request should include the size and uncertainty in the reserves, both the direct and assumed as well as the net.

Section 1C applies only to insurers that participate in intercompany pooling agreements. Exhibits A and B for each company in the pool should reflect the company's share of the pool and should reconcile to values filed with the Annual Statement.

For companies whose pool participation is 0%, (i.e., no reported Schedule P data), the Appointed Actuary is directed to write an Actuarial Opinion that reads similar to that of the lead company. Exhibits A and B of the lead company should be filed as an addendum to the Actuarial Opinions of the 0% pool companies. This will allow for proper data submission for each company in the pool while providing additional meaningful data to analysts. The Instructions require specific answers for the Exhibit B questions regarding materiality and the risk of material adverse deviation (RMAD).

Note the distinction between pooling with a 100% lead company with no retrocession and ceding 100% via a quota share agreement. These affiliate agreements must be approved by the regulator as either an intercompany pooling arrangement or a quota share reinsurance agreement. The proper financial reporting is dependent on the approved filings, regardless of how company management regards its operating platform.

The remainder of the Instructions provides guidance to company management and its Appointed Actuary (as these terms are defined in the Instructions) regarding regulatory expectations around the reported information.

Section 2 states that the Actuarial Opinion should contain four clearly designated sections: Identification, Scope, Opinion, and Relevant Comments. While illustrative language is presented in the Instructions, specific language is not required, provided the Appointed Actuary clearly conveys the information.

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

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

Section 4 requires the Appointed Actuary to disclose the name and affiliation of the person(s) upon whom the Appointed Actuary relied for the data used in the reserve analysis. This reliance is expected to be based on an individual(s) from the company who has both authority and responsibility for relevant data and data systems. An Appointed Actuary employed by the company may choose to accept responsibility for the data without identifying reliance on another company person. If someone from the regulated insurance entity is not named here, analysts should request that the insurer provide a clarifying amendment.

Section 5 (Opinion) requires the Appointed Actuary to explicitly state his or her opinion using one of five opinion types. The illustrative language provided in the Instructions is based on the most commonly rendered opinion — that the carried reserves are reasonable. Should any other type of opinion be presented, the Actuarial Opinion calls for immediate further attention by the state insurance regulator to determine the need for follow-up action?

Section 6 (Relevant Comments) identifies specific areas on which the Appointed Actuary is required to comment. The purpose of this requirement is to provide the regulator with information that numbers alone

~~cannot convey. The most important relevant comment relates to the RMAD. The Appointed Actuary should provide explanation of the major risk factors affecting the company. The Appointed Actuary must also identify the materiality standard and the basis for establishing it. The Appointed Actuary must then explicitly state whether or not he or she reasonably believes that there are significant risks and uncertainties that could result in material adverse deviation.~~

~~Appointed Actuaries often choose a materiality standard as a percentage of surplus or reserves, but other standards may also be appropriate. The standard chosen quantifies the amount of adverse deviation that the Appointed Actuary judges to be material. The standard may vary based on the solvency position of the insurer. The materiality section of the Preamble to the *Accounting Practices and Procedures Manual* (AP&P Manual) contains excellent guidance regarding the selection of a materiality threshold. Based on this guidance, an Appointed Actuary for two companies with comparable business and comparable reserves could select different materiality standards. For example, an insurer with a risk-based capital (RBC) ratio of 205% could possibly need only a small change in reserves to put it in Company Action Level, so the Appointed Actuary's chosen materiality standard for this insurer may be lower than for a similar insurer with an RBC ratio of 600%.~~

~~If the company is subject to RBC reporting requirements, the results of the Bright Line Indicator test should be reviewed in conjunction with the Appointed Actuary's RMAD statement: If the insurer triggers the Bright Line Indicator test, meaning that 10% of the insurer's net loss and loss adjustment expense (LAE) reserves is greater than the difference between the Total Adjusted Capital and Company Action Level Capital, and the Appointed Actuary opines that there is not a RMAD, the Appointed Actuary should be asked to explain this opinion.~~

~~A similar comparison could be made between 10% of the insurer's net reserves and the size of its underwriting or operating income. It should be noted that the RMAD might increase with more volatile exposures such as asbestos and environmental, excess casualty, or other commercial lines.~~

~~Collectively the Relevant Comments should reveal exposures, transactions, historical developments, processes, and uncertainty that contribute to the Appointed Actuary's opinion. Some of the comments call for judgment on the part of the Appointed Actuary. The disclosures in Exhibit B are required to ensure that the Appointed Actuary acknowledges consideration of certain items in reaching his or her opinion.~~

~~**Section 7 (Actuarial Report)** provides guidance for both the Appointed Actuary (regarding required content of the report) and for the regulator (regarding what to expect from the report). State insurance regulators place a high level of trust in the work of a qualified actuary. State insurance regulators rely upon the Appointed Actuary's work to evaluate balance sheet entries—most notably, the loss and LAE reserves that represent management's best estimates; these estimates can be highly uncertain. State insurance regulators' trust in Appointed Actuaries is only justified if the Appointed Actuary can readily provide support for the opinion provided. That support should be available in the Actuarial Report.~~

~~**Section 8 (Signature)** is self-explanatory. The Appointed Actuary must sign and date both the Actuarial Opinion and the Actuarial Report.~~

~~**Section 9 (Error Correction)** addresses required actions if an Appointed Actuary determines that the Actuarial Opinion submitted to the domiciliary commissioner was in error. If the insurer or its Appointed Actuary notifies the domiciliary commissioner that the Actuarial Opinion was in error, analysts should immediately determine if additional regulatory action is needed.~~

~~**Section 10 (Exhibits)** relates to the data Exhibits A (Scope) and B (Disclosures).~~

~~B.~~ Actuarial Opinion Summary

The Actuarial Opinion Summary (AOS) is a confidential document that ~~provides~~offers valuable insight into an Appointed Actuary's ~~conclusion regarding~~assessment of the reasonableness of ~~the~~ carried reserves. While n~~N~~early all Actuarial Opinions ~~state~~ conclude that ~~the~~ carried reserves are reasonable~~.~~, t~~T~~he AOS provides quantitative information ~~to more clearly show~~that helps analysts ~~how~~ understand the ~~Appointed Actuary reached that conclusion~~basis for this conclusion. ~~With~~ By examining the additional information ~~provided~~ in the AOS, analysts can ~~make a judgment regarding the need fo~~determine whether further regulatory attention is warranted.

Annual Statement Instructions – Actuarial Opinion Summary Supplement

As with the Actuarial Opinion, the *Annual Statement Instructions* for the AOS are directed to the insurer.

Section 1 of the AOS Supplement identifies the specific responsibilities of the insurer regarding this document. Analysts should first determine if the domiciliary state requires the AOS. If so, the AOS should be reviewed in tandem with the Actuarial Opinion and factored into the decision on further regulatory attention.

Section 2 restates regulatory expectations that the AOS be consistent with professional standards that guide a "qualified actuary" as defined in the Actuarial Opinion Instructions.

Section 3 relates to exemption considerations for filing the AOS, which are the same for filing the Actuarial Opinion.

Section 4 addresses confidentiality. As noted above, analysts should understand the state's requirements for submission of the AOS.

Section 5 provides guidance to the company and its Appointed Actuary regarding the specific content that is expected in the AOS. This is the quantitative information that analysts should focus on in order to develop a recommendation for further regulatory action.

Parts A, B, C and D of Section 5 call for a comparison that can be presented in a simple table. Regardless of how the information is presented, the intention is to translate for the regulator the qualitative/subjective opinion regarding "reasonableness" into a quantitative/objective financial comparison.

Parts A and B require the Appointed Actuary to compare his/her point estimate and/or range of estimates (whatever is calculated), to the carried loss and LAE reserves. The Appointed Actuary must compare these estimates on both a net and gross of reinsurance basis. The carried amounts should agree with the amounts presented in Exhibit A of the Actuarial Opinion and the Annual Statement. Analysts should note that the amounts provided in the AOS are commonly presented as combined loss and LAE amounts (Exhibit A of the Actuarial Opinion, lines 1 and 2 for net and lines 3 and 4 for direct and assumed). If the amounts do not agree, this could be an indication of weak controls within the reserving or financial reporting process of the company. Discrepancies that are not adequately explained by the Appointed Actuary require follow up.

If the Appointed Actuary issues a "reasonable" opinion, the comparisons in the AOS will likely be described by one of the following three situations. The tables in these illustrations show both point and range estimates by the Appointed Actuary. The Appointed Actuary is not required to calculate both, but regulators expect Appointed Actuaries to report whatever is calculated. A small percentage of Appointed Actuaries calculate a range only.

Situation 1: Appointed Actuary's Point Estimate or Range Midpoint = Carried Reserves

	Net Loss + LAE Reserves			Direct & Assumed Loss + LAE Reserves		
	Low	Point	High	Low	Point	High
B. Appointed Actuary's Estimates	17,000	20,000	23,000	21,500	25,000	28,000
C. Company Carried Reserves		20,000			25,000	
D. Difference	3,000	0	(3,000)	3,500	0	(3,000)

The example above is simple and can represent a situation in which the company relies completely on the Appointed Actuary by carrying his or her estimate. In this case, there is no difference between the Appointed Actuary's estimate and the carried amount. Further action is generally not necessary.

There may be small variations from this scenario in which the Appointed Actuary's estimate is "close to" the company's carried reserves. Analysts need to determine "How close is close enough?". Regulatory emphasis is on financial solvency. Therefore, an initial consideration might be the impact on surplus of management's decision to carry an amount different from the Appointed Actuary's estimate. Further action is generally not necessary unless the analyst is concerned that carried reserves are far enough below the Appointed Actuary's estimate as to not obviously be "close enough."

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Situation 2: Appointed Actuary's Point Estimate or Range Midpoint < Carried Reserves

	Net Loss + LAE Reserves			Direct & Assumed Loss + LAE Reserves		
	Low	Point	High	Low	Point	High
B. Appointed Actuary's Point Estimates	17,000	20,000	23,000	21,500	25,000	28,000
C. Company Carried Reserves		21,000			26,500	
D. Difference	4,000	1,000	(2,000)	5,000	1,500	(1,500)

In this case, the company is carrying a reserve amount greater than the Appointed Actuary's point estimate and in the higher end of the Appointed Actuary's range. From a solvency perspective, surplus is more conservatively stated. Further action is generally not necessary.

Situation 3: Appointed Actuary's Point Estimate or Range Midpoint > Carried Reserves

	Net Loss + LAE Reserves			Direct & Assumed Loss + LAE Reserves		
	Low	Point	High	Low	Point	High
B. Appointed Actuary's Point Estimates	17,000	20,000	23,000	21,500	25,000	28,000
C. Company Carried Reserves		17,100			22,000	
D. Difference	100	(3,000)	(5,900)	500	(3,000)	(6,000)

When the carried reserves are less than the Appointed Actuary's point estimate or range midpoint, the question of "How close is close enough?" becomes more relevant. This is a more challenging situation for analysts to evaluate. Analysts should focus on the difference between the carried reserves and the point estimate or range midpoint. If the Appointed Actuary has issued a "reasonable" opinion, analysts should consider the following factors:

- The difference as a percent of surplus
- The difference as a percent of carried loss and LAE reserves
- The company's RBC position

At this point, analysts might cconsider an alternate question: "If the company had carried the Appointed Actuary's higher estimate and surplus was comparably reduced, would my evaluation of the company's financial condition change to a less favorable one?". If the answer to that question is "yes," then analysts should consider requesting management's rationale and documentation to support the lower carried reserve amount(s). In addition, analysts might require the company to have its Appointed Actuary provide additional information regarding the range of estimates, if calculated. The Appointed Actuary's description of the range should also be documented in the Actuarial Report supporting the Actuarial Opinion.

As a rule of thumb, it is concerning if carried reserves are more than 5% (of surplus) below the Appointed Actuary's point estimate or range midpoint, even if the reserves still lie within the Appointed Actuary's range. The 5% (of surplus) is a common examiner materiality starting selection for financial examinations.

Next, consider the AOS in the context of RMAD as addressed in the Actuarial Opinion. If a range is provided, is the materiality standard less than the difference between the carried reserves and the high end of the Appointed Actuary's range? This means that reserves would still lie within the Appointed Actuary's range of reasonable reserve estimates if carried reserves developed adversely by an amount the Appointed Actuary considers to be material. In this situation, state insurance regulators generally expect the Appointed Actuary to conclude that there is a significant risk of material adverse deviation. If the Appointed Actuary concludes that there is not a significant RMAD in this situation, analysts should document any comments or concerns and consider following up with the Appointed Actuary.

Most opinions issued are "Reasonable," which means that the carried reserve amounts are within the Appointed Actuary's range of reasonable reserve estimates. Only a handful of opinions fall into the other categories as defined in the Instructions (Deficient or Inadequate, Redundant or Excessive, Qualified, or No Opinion). These types of opinions likely require further action by analysts. The Considerations section identifies several actions that could be taken, particularly with regard to a Qualified Opinion or No Opinion.

~~A Deficient or Inadequate Opinion, while rare, presents a challenge for analysts. This type of opinion means that the carried reserves are less than the minimum amount the Appointed Actuary considers to be reasonable. As with Situation #3 above, analysts should evaluate the materiality of the deficiency in light of surplus, the company's RBC position, net income, and other factors. Analysts should review all options listed in the Considerations section. In this situation, the regulator may wish to initiate a target examination or engage an independent actuary to evaluate the reasonability of the carried reserves so that the implied deficiency can be evaluated.~~

~~Regardless of analysts' concerns, it is important to remember that the carried reserves are the responsibility of management. The Appointed Actuary may or may not be part of management. In nearly all cases, analysts should direct initial questions to company management for rationale and documentation of decisions regarding the carried reserves.~~

~~Part E of Section 5 addresses what the Casualty Actuarial and Statistical (C) Task Force calls "persistent adverse development." When the company experiences one-year adverse development in excess of 5% of the prior year's surplus as measured by Schedule P – Part 2 Summary in at least three of the past five calendar years, the Appointed Actuary must provide an explicit description of the reserve elements or management decisions that were the major contributors. The one-year adverse development ratio can be found in the Five-Year Historical Data exhibit of the Annual Statement.~~

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

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

~~Analysts should also consider the following situations:~~

~~Situation A: Prior AOSs indicate that the company relies on the Appointed Actuary's estimates. If persistent adverse development occurs, analysts might infer that the Appointed Actuary's methods and assumptions have a bias towards underestimation.~~

~~Situation B: Prior AOSs indicate that the company regularly carries amounts lower than the actuarial point estimate or low in the Appointed Actuary's range. If persistent adverse development occurs, analysts might infer that management takes a more optimistic view of its liabilities, regardless of what the Appointed Actuary calculates.~~

~~**Section 6** of the AOS Instructions is regarding the AOS for a pooled company, which includes the same information provided in the Actuarial Opinion Instructions.~~

~~**Section 7** indicates that net and gross reserve values in the AOS should reconcile to the corresponding values in the Annual Statement.~~

~~**Section 8** outlines the notification requirements of the Appointed Actuary if an AOS submitted to the domiciliary commissioner contained errors.~~

~~**Section 9** is a legal disclaimer that no Appointed Actuary shall be liable for any statement made in connection with the AOS if such statements were made in a good faith effort.~~

~~**Considerations**~~

The Actuarial Opinion and AOS may contain broad general caveats. These include generalizations about the unpredictability of future jury awards, coverage expansions, etc. They are not to be confused with disclosures about company-specific sources of uncertainty, such as new lines of business or territories, new claims/underwriting/marketing/systems initiatives, etc. These specific disclosures should be viewed as areas for formal investigation through an examination or informal investigation via correspondence or conversation.

Initial Steps

The Statement of Actuarial Opinion Worksheet (SAO Worksheet) provides guidance for a reviewing analyst. The SAO Worksheet should be supplemented with comments and questions as needed. Both the Actuarial Opinion and the AOS should be reviewed and considered together before any action is taken. At the completion of the SAO Worksheet, analysts should conclude what, if any, further action is needed.

a. Consult with the regulatory P/C actuary, if available

If the insurance department has a regulatory P/C actuary on staff, analysts may consult with him or her for any questions or concerns.

b. Contact the insurer

Analysts may need to contact the insurer for additional information, particularly if the materiality standard is large relative to surplus or if the insurer's RBC is likely to fall below the Company Action Level. Some of the items that may need clarification are a concern over reinsurance collectability, a change in discounting procedures, or other items noted in the Relevant Comments section of the Actuarial Opinion as having the potential to result in material adverse deviation. Typically, items of a general nature, such as the risk from a change in the legal or regulatory environment, would not require further investigation.

The Relevant Comments section may note a concern with collectability of reinsurance. Contracts with reinsurers that are not financially strong, reinsurance coverage obtained under a program that is no longer offered or reinsurance coverage on unusual risks could increase the uncertainty regarding reinsurance collectability. Also, a change in reinsurance contract language, a change in reinsurers or writing a new program in a new line or class of business may affect the uncertainty concerning reinsurance collectability if the insurer does not have a good understanding of the primary coverage written and the reinsurance coverage obtained.

If an insurer has recently implemented loss reserve discounting or if the discount rate used to determine the reserves has changed, analysts should ascertain the impact on the reserve estimates arising from these changes. Analysts should consider the magnitude of the impact in relation to the materiality standard and the potential effect on RBC levels.

Analysts may need to contact the insurer when the insurer has provided coverage for certain classes of business where liabilities are especially uncertain. Asbestos, environmental, pollution and other mass tort liabilities are particularly difficult to estimate and are often determined by models that examine the risk profile of the company's policyholders, particularly when the insurer's loss history has limited predictive power. The results from these models often have a wide range in estimates for loss and LAE reserves and, therefore, a high degree of uncertainty. Construction defect claims have a 10-year reporting period in some states, making their liabilities particularly difficult to estimate. Analysts should consider submitting a request for additional information from the insurer if an RMAD from these types of claims is identified.

The Appointed Actuary must include comments on the factors that led to any exceptional values for Insurance Regulatory Information System (IRIS) ratios #11, #12 or #13 in the Actuarial Opinion. An explanation that identifies risk elements that are part of the insurer's ongoing operations rather than a one-time occurrence would merit further investigation by analysts. It is generally not sufficient to explain an exceptional value by simply stating the insurer has strengthened reserves. Detail regarding lines of business, accident years, or changes in operations should be requested if the Appointed Actuary has not provided that explanation for the specific IRIS ratio.

c. Obtain a copy of the Actuarial Report

If there are particular items identified as significant in the Relevant Comments section or there is significant risk of the insurer falling below the RBC Company Action Level, a review of the Actuarial Report supporting the Actuarial Opinion can give analysts insight into the nature and severity of the risks identified. If one or more portions of the carried reserves are excluded from the Actuarial Opinion, the Actuarial Report may give analysts information on the relative amount of any excluded items and the reasons why those items were excluded from the Actuarial Opinion.

If the analyst requests the Actuarial Report, the analyst might start by reviewing the narrative component. The narrative, often referred to as the executive summary, should contain the summary exhibits and the

~~Appointed Actuary's point estimate and/or range. The technical component should contain the loss development triangles and factors, support for ultimate loss selections, and required data reconciliations. Normally, the technical component would be requested for a full-scope examination or limited-scope examination that includes a risk-focused review of the carried reserves, since such a review would often include a review of the Appointed Actuary's report.~~

~~If the Relevant Comment paragraphs mention the use of retroactive reinsurance or financial reinsurance, analysts need to understand how these agreements may affect the insurer's financial position. The Actuarial Report may include information about these arrangements.~~

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

~~d. Consult with the Appointed Actuary~~

~~Analysts may contact the Appointed Actuary regarding any issues noted in the Actuarial Opinion or the AOS, regardless of where the Appointed Actuary is employed. However, analysts should consider informing company management before contacting the Appointed Actuary and copying company management on communications with the Appointed Actuary. In particular, companies with an external Appointed Actuary may request that they be notified before the Department of Insurance contacts its Appointed Actuary.~~

~~**Next Steps**~~

~~a. Engage an independent actuary to review the insurer's reserves~~

~~For items that were not quantified in the Actuarial Opinion or any liability items for which there is significant concern, analysts may recommend engaging an independent actuary to provide a review of the carried reserves in question. This independent review can also be valuable if there is a significant difference between management's view and the Appointed Actuary's view concerning a material item identified in the Actuarial Report.~~

~~b. Meet with the insurer's management~~

~~Analysts may recommend meeting with the insurer's management when there are items in the Actuarial Report that need clarification or require the insurer to take further action. Further actions could include developing a business plan, setting up interim reporting, developing a corrective action plan, or providing additional information about the underlying factors contributing to the risk in the insurer's Annual Statement. Any concerns with company financial data or reconciling various data sources should be investigated with the insurer's management. Concerns about a company's exposure due to policy coverage terms or lack of available data should be investigated as warranted.~~

~~c. Refer the insurer to the examination section for a target examination~~

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

~~DISCUSSION OF THE~~ STATEMENT OF ACTUARIAL OPINION WORKSHEET (P/C AND TITLE)

~~Using the Worksheet~~

The Statement of Actuarial Opinion Worksheet (SAO Worksheet) is intended to provide procedures for reviewing the Actuarial Opinion, AOS and Actuarial Report for compliance and assessment of risks. In many states, the Actuarial Opinion, AOS and Actuarial Report are reviewed by actuarial staff. Whether the reviews are performed by the analyst or the actuary, the SAO Worksheet provides for the results of the reviews to be documented and communicated to the analyst.

The SAO Worksheet should be supplemented with comments and questions as needed. Both the Actuarial Opinion and the AOS should be reviewed and considered together before any action is taken. At the completion of the SAO Worksheet, analysts should conclude what, if any, further action is needed.

a. Consult with the regulatory P/C actuary, if available

If the insurance department has a regulatory P/C actuary on staff, analysts may consult with him or her for any questions or concerns.

b. Contact the insurer

Analysts may need to contact the insurer for additional information, particularly if the materiality standard is large relative to surplus or if the insurer's RBC is likely to fall below the Company Action Level. Some of the items that may need clarification are a concern over reinsurance collectability, a change in discounting procedures, or other items noted in the Relevant Comments section of the Actuarial Opinion as having the potential to result in material adverse deviation. Typically, items of a general nature, such as the risk from a change in the legal or regulatory environment, would not require further investigation.

The Relevant Comments section may note a concern with collectability of reinsurance. Contracts with reinsurers that are not financially strong, reinsurance coverage obtained under a program that is no longer offered or reinsurance coverage on unusual risks could increase the uncertainty regarding reinsurance collectability. Also, a change in reinsurance contract language, a change in reinsurers or writing a new program in a new line or class of business may affect the uncertainty concerning reinsurance collectability if the insurer does not have a good understanding of the primary coverage written and the reinsurance coverage obtained.

If an insurer has recently implemented loss reserve discounting or if the discount rate used to determine the reserves has changed, analysts should ascertain the impact on the reserve estimates arising from these changes. Analysts should consider the magnitude of the impact in relation to the materiality standard and the potential effect on RBC levels.
Analysts may need to contact the insurer when the insurer has provided coverage for certain classes of business where liabilities are especially uncertain. Asbestos, environmental, pollution and other mass tort liabilities are particularly difficult to estimate and are often determined by models that examine the risk profile of the company's policyholders, particularly when the insurer's loss history has limited predictive power. The results from these models often have a wide range in estimates for loss and LAE reserves and, therefore, a high degree of uncertainty. Construction defect claims have a 10-year reporting period in some states, making their liabilities particularly difficult to estimate. Analysts should consider submitting a request for additional information from the insurer if an RMAD from these types of claims is identified.

The Appointed Actuary must include comments on the factors that led to any exceptional values for Insurance Regulatory Information System (IRIS) ratios #11, #12 or #13 in the Actuarial Opinion. An explanation that identifies risk elements that are part of the insurer's ongoing operations rather than a one-time occurrence would merit further investigation by analysts. It is generally not sufficient to

explain an exceptional value by simply stating the insurer has strengthened reserves. Detail regarding lines of business, accident years, or changes in operations should be requested if the Appointed Actuary has not provided that explanation for the specific IRIS ratio.

c. Obtain a copy of the Actuarial Report

If there are particular items identified as significant in the Relevant Comments section or there is significant risk of the insurer falling below the RBC Company Action Level, a review of the Actuarial Report supporting the Actuarial Opinion can give analysts insight into the nature and severity of the risks identified. If one or more portions of the carried reserves are excluded from the Actuarial Opinion, the Actuarial Report may give analysts information on the relative amount of any excluded items and the reasons why those items were excluded from the Actuarial Opinion.

If the analyst requests the Actuarial Report, the analyst might start by reviewing the narrative component. The narrative, often referred to as the executive summary, should contain the summary exhibits and the Appointed Actuary's point estimate and/or range. The technical component should contain the loss development triangles and factors, support for ultimate loss selections, and required data reconciliations. Normally, the technical component would be requested for a full-scope examination or limited-scope examination that includes a risk-focused review of the carried reserves, since such a review would often include a review of the Appointed Actuary's report.

If the Relevant Comment paragraphs mention the use of retroactive reinsurance or financial reinsurance, analysts need to understand how these agreements may affect the insurer's financial position. The Actuarial Report may include information about these arrangements.

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

d. Consult with the Appointed Actuary

Analysts may contact the Appointed Actuary regarding any issues noted in the Actuarial Opinion or the AOS, regardless of where the Appointed Actuary is employed. However, analysts should consider informing company management before contacting the Appointed Actuary and copying company management on communications with the Appointed Actuary. In particular, companies with an external Appointed Actuary may request that they be notified before the Department of Insurance contacts its Appointed Actuary.

e. Engage an independent actuary to review the insurer's reserves

For items that were not quantified in the Actuarial Opinion or any liability items for which there is significant concern, analysts may recommend engaging an independent actuary to provide a review of the carried reserves in question. This independent review can also be valuable if there is a significant difference between management's view and the Appointed Actuary's view concerning a material item identified in the Actuarial Report.

f. Meet with the insurer's management

Analysts may recommend meeting with the insurer's management when there are items in the Actuarial Report that need clarification or require the insurer to take further action. Further actions could include developing a business plan, setting up interim reporting, developing a corrective action plan, or providing additional information about the underlying factors contributing to the risk in the insurer's Annual Statement. Any concerns with company financial data or reconciling various data sources should

be investigated with the insurer's management. Concerns about a company's exposure due to policy coverage terms or lack of available data should be investigated as warranted.

g. Refer the insurer to the examination section for a target examination
Analysts may recommend a target examination if, after obtaining further information, there is still concern about the financial position of the insurer. The target examination should determine if the insurer is taking proper steps to mitigate the potential adverse impact arising from the risks identified in the Actuarial Opinion.~~***ANALYSIS DOCUMENTATION:*** Results of the analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.~~

Insurer Exemption from Filing an Actuarial Opinion~~—~~

Procedure #1. Determine whether the insurer is exempt from filing the Actuarial Opinion. Insurers may be exempt from filing an Actuarial Opinion under the following circumstances:

- *Small Companies*: Insurers with total direct and assumed written premiums and loss reserves below $1,000,000 for the preceding calendar year.
- *Insurers Under Supervision or Conservatorship*: Unless directed by the domiciliary commissioner, insurers under supervision or conservatorship are exempt.
- *Nature of Business*: Insurers may apply for an exemption based on the nature of their business.
- *Financial Hardship*: Insurers may apply for an exemption due to financial hardship. This is presumed to exist if the projected cost of the Actuarial Opinion exceeds the lesser of 1% of capital and surplus or 3% of premiums.

The commissioner has discretion to grant or deny exemptions, even if one or more of these conditions are met.

~~General and~~ Actuary Identification, Qualifications, Relationship to the Company, and Date of Appointment

Procedure ~~s #1,~~ #2 ~~and #3~~. ~~assist analysts in d~~Determin~~ing~~e whether~~: 1) the insurer is exempt from filing the Actuarial Opinion; 2) if not, whether~~ the Actuarial Opinion was prepared by a Qualified Actuary who was appointed by the insurer's board of directors prior to Dec. 31 of the calendar year for which the opinion was rendered; To be considered a "Qualified Actuary" as defined in the NAIC Statement of Actuarial Opinion, an actuary must satisfy specified qualification standards, retain an Accepted Actuarial Designation, and maintain membership in a professional actuarial association that requires adherence to the same Code of Professional Conduct promulgated by the American Academy of Actuaries and participation in the Actuarial Board for Counseling and Discipline.

Intercompany Pooling Arrangement Disclosures

Procedure ~~and #~~3~~)~~. Determine whether the Appointed Actuary made the required disclosures if the insurer is a member of an intercompany pooling arrangement (pool). Pool members' financial results may need to be evaluated differently than those of insurers that operate independently. Exhibits A and B for each company in the pool should reflect the company's share of the pool and should reconcile to values filed with the Annual Statement.

For companies whose pool participation is 0%, (i.e., no reported Schedule P data), the Appointed Actuary is directed to write an Actuarial Opinion that reads similar to that of the lead company. Exhibits A and B of the lead company should be filed as an addendum to the Actuarial Opinions of the 0% pool companies. This will allow for

proper data submission for each company in the pool while providing additional meaningful data to analysts. The Instructions require specific answers for the Exhibit B questions regarding materiality and the risk of material adverse deviation (RMAD).

Note the distinction between pooling with a 100% lead company with no retrocession and ceding 100% via a quota share agreement. These affiliate agreements must be approved by the regulator as either an intercompany pooling arrangement or a quota share reinsurance agreement. The proper financial reporting is dependent on the approved filings, regardless of how company management regards its operating platform.~~The remainder of the Instructions provides guidance to company management and its Appointed Actuary (as these terms are defined in the Instructions) regarding regulatory expectations around the reported information.~~

~~Actuarial Opinion -~~ Scope

Procedure #4. ~~assists analysts in d~~Determine~~ing~~ whether the Appointed Actuary included the appropriate loss reserves, LAE reserves, and (if appropriate) other loss and premium reserves within the scope of the opinion and whether the reserve amounts included in Exhibits A and B of the Actuarial Opinion agree with the amounts reported in the Annual Statement. If the reserve amounts included in the Actuarial Opinion do not agree with the amounts per the Annual Statement, analysts should: 1) comment on the reasons for the differences; 2) consider the impact of the differences on the analyst's conclusions about the Annual Statement; and 3) consider the need to perform additional analysis on the Annual Statement.

Procedure #5. ~~assists analysts in d~~Determine~~ing~~ whether the Appointed Actuary relied on an officer of the company for data preparation. The individual(s) relied upon should have both authority and responsibility for relevant data and data systems. A company Appointed Actuary may choose to accept responsibility for the data without identifying reliance on another company person. If someone from the regulated insurance entity is not named here, analysts should request that the insurer provide a clarifying amendment.

The Appointed Actuary is also directed to state whether the data used in forming the Appointed Actuary's opinion was reconciled to Schedule P – Part 1 of the insurer's Annual Statement. (Schedule P – Part 1 is then required to be tested by the independent certified public accountant (CPA) as a part of the audit of the insurer.)

~~Actuarial Opinion -~~ Opinion

Procedures #6 and #7. ~~assist analysts in d~~Determine~~ing~~ whether the Actuarial Opinion states that the reserves meet the requirements of the insurance laws of the state of domicile, are computed in accordance with accepted loss reserving standards and principles and make a reasonable provision for all unpaid loss and LAE obligations of the insurer under the terms of its policies and agreements. ~~**Section 5 (Opinion)** requires t~~The Appointed Actuary ~~to~~ must explicitly state his or her opinion using one of five opinion types. ~~The illustrative language provided in the Instructions is based on the most commonly rendered opinion—that the carried reserves are reasonable. Should a~~Any ~~other type of~~ opinion ~~be presented, the Actuarial Opinion calls~~that is not 'Reasonable' should be flagged for immediate ~~further~~ attention by the state insurance regulator to determine the need for follow-up action~~?~~.

If unearned premium reserves or other reserve items are included within the scope of the Appointed Actuary's opinion, this section of the Actuarial Opinion will also provide the Appointed Actuary's conclusion on the reasonableness of these reserves.

If the Actuarial Opinion deviates from the above statements or if a material portion of the insurer's reserves is excluded from the scope of the Actuarial Opinion, analysts should: 1) comment on the deviations or exclusions; 2) consider the impact on the analyst's conclusions about the Annual Statement; and 3) consider the need to perform additional analysis on the Annual Statement.

Actuarial Opinion – Relevant Comments and Exhibit B Disclosures

Procedure #8. assists analysts in dDetermineing whether the actuary commented on various topics and issues in Exhibit B of the Actuarial Opinion (including the materiality standard, anticipated salvage and subrogation, discounting, asbestos and environmental reserves, extended claims made reserves, etc.) as required by the *Annual Statement Instructions Property/Casualty*. The Actuarial Opinion should also indicate if any of the reserving IRIS ratios produce exceptional values and discuss any exceptional values.

The most important relevant comment relates to the Risk of Material Adverse Deviation (RMAD). The Appointed Actuary should provide explanation of the major risk factors affecting the company. The Appointed Actuary must also identify the materiality standard and the basis for establishing it. The Appointed Actuary must then explicitly state whether or not he or she reasonably believes that there are significant risks and uncertainties that could result in material adverse deviation.

Appointed Actuaries often choose a materiality standard as a percentage of surplus or reserves, but other standards may also be appropriate. The standard chosen quantifies the amount of adverse deviation that the Appointed Actuary judges to be material. The standard may vary based on the solvency position of the insurer. The materiality section of the Preamble to the *Accounting Practices and Procedures Manual* (AP&P Manual) contains excellent guidance regarding the selection of a materiality threshold. Based on this guidance, an Appointed Actuary for two companies with comparable business and comparable reserves could select different materiality standards. For example, an insurer with a risk-based capital (RBC) ratio of 205% could possibly need only a small change in reserves to put it in Company Action Level, so the Appointed Actuary's chosen materiality standard for this insurer may be lower than for a similar insurer with an RBC ratio of 600%.

If the company is subject to RBC reporting requirements, the results of the Bright Line Indicator test should be reviewed in conjunction with the Appointed Actuary's RMAD statement: If the insurer triggers the Bright Line Indicator test, meaning that 10% of the insurer's net loss and loss adjustment expense (LAE) reserves is greater than the difference between the Total Adjusted Capital and Company Action Level Capital, and the Appointed Actuary opines that there is not a RMAD, the Appointed Actuary should be asked to explain this opinion.
Bright Line Indicator: This test is only applicable if the Company is subject to RBC. This indicator is triggered if 10% of the insurer's net reserves (Liabilities, Surplus and Other Funds page, sum of losses and LAE) is greater than the difference between the Total Adjusted Capital (Five-Year Historical Data page) and Company Action Level RBC (twice the Authorized Control Level RBC amount in the Five Year Historical Data page). If the Bright Line Indicator is triggered and the Appointed Actuary opines that there is not a significant risk of material adverse deviation, analysts should request commentary from the Appointed Actuary. A special report on the Bright Line Indicator is located on StateNet under the Financial Analysis link.

A similar comparison could be made between 10% of the insurer's net reserves and the size of its underwriting or operating income. It should be noted that the RMAD might increase with more volatile exposures such as asbestos and environmental, excess casualty, or other commercial lines.

Collectively the Relevant Comments should reveal exposures, transactions, historical developments, processes, and uncertainty that contribute to the Appointed Actuary's opinion. Some of the comments call for judgment on the part of the Appointed Actuary. The disclosures in Exhibit B are required to ensure that the Appointed Actuary acknowledges consideration of certain items in reaching his or her opinion.

-The Actuarial Opinion should also indicate if any of the reserving IRIS ratios produce exceptional values and discuss any exceptional values.

~~Actuarial Opinion – Assurance That an~~ Actuarial Report ~~Has Been~~ Prepared, Supports Actuarial Opinion, ~~Signature~~Signed, and Contains ~~Requirements~~ Required ~~for Actuarial Report~~Elements

***Procedure #9*.** ~~assists analysts in d~~Determin~~ing~~e whether the Appointed Actuary indicates that an Actuarial Report has been prepared which supports the findings expressed in the Actuarial Opinion. In some cases, analysts may consider obtaining a copy of the Actuarial Report. The Actuarial Report is a confidential document that describes the sources of data, material assumptions, and methods used, and supports the Appointed Actuary's opinion. The Actuarial Report generally includes relevant loss and LAE data triangles and discusses significant issues that affected the Appointed Actuary's interpretation of the data. Examples of significant issues that may be discussed by the Appointed Actuary include changes in the following: management of the insurer, claims payment philosophy, the claims reporting process, computer systems, mix of business, contract limits or provisions, and reinsurance. While the Actuarial Report should not be filed with the Actuarial Opinion, the Actuarial Report is required to be retained by the insurer for a period of seven years and available for regulatory examination. The Instructions dictate certain elements that must be included in the Actuarial Report. In addition, the Actuarial Report must be signed and dated by the Appointed Actuary and must be consistent with the documentation and disclosure requirements of Actuarial Standard of Practice (ASOP) No. 41 – *Actuarial Communications*.

Actuarial Opinion Summary

~~The AOS is a confidential document that compares the Appointed Actuary's estimates to the company's carried reserves. The AOS procedures guide analysts through reviewing this document. The procedures should be supplemented with comments and questions as needed.~~

***Procedure #10*.** ~~v~~Verif~~ies~~y the regulatory requirements for filing the AOS and the company's compliance with the requirement.

***Procedure #11*.** ~~v~~Verif~~ies~~y that the AOS discloses required pooling information if the insurer is a member of an intercompany pooling arrangement.

***Procedure #12*.** ~~v~~Verif~~ies~~y that the AOS contains the required comparisons and that the amounts in the AOS reconcile with those in the Actuarial Opinion, Actuarial Report and Annual Financial Statement. Inconsistencies in reported values may indicate weak controls within the company.

***Procedure #13*.** ~~v~~Verif~~ies~~y that the Appointed Actuary's opinion implied by the comparisons in the AOS is consistent with the type of opinion rendered in the Actuarial Opinion. Analysts should note concerns regarding carried reserves that appear significantly low relative to the Appointed Actuary's estimate(s). ~~See the above discussion for guidance on evaluating the comparison between the Appointed Actuary's estimates and the company's carried reserves.~~

Parts A, B, C and D of Section 5 of the AOS call for a comparison that can be presented in a simple table. Regardless of how the information is presented, the intention is to translate for the regulator the qualitative/subjective opinion regarding "reasonableness" into a quantitative/objective financial comparison.

Parts A and B require the Appointed Actuary to compare his/her point estimate and/or range of estimates (whatever is calculated), to the carried loss and LAE reserves. The Appointed Actuary must compare these estimates on both a net and gross of reinsurance basis. The carried amounts should agree with the amounts presented in Exhibit A of the Actuarial Opinion and the Annual Statement. Analysts should note that the amounts provided in the AOS are commonly presented as combined loss and LAE amounts (Exhibit A of the Actuarial Opinion, lines 1 and 2 for net and lines 3 and 4 for direct and assumed). If the amounts do not agree, this could be an indication of weak controls within the reserving or financial reporting process of the company. Discrepancies that are not adequately explained by the Appointed Actuary require follow up.

If the Appointed Actuary issues a "reasonable" opinion, the comparisons in the AOS will likely be described by one of the following three situations. The tables in these illustrations show both point and range estimates by the Appointed Actuary. The Appointed Actuary is not required to calculate both, but regulators expect Appointed Actuaries to report whatever is calculated. A small percentage of Appointed Actuaries calculate a range only.

Situation 1: Appointed Actuary's Point Estimate or Range Midpoint = Carried Reserves

	Net Loss + LAE Reserves			Direct & Assumed Loss + LAE Reserves		
	Low	Point	High	Low	Point	High
B. Appointed Actuary's Estimates	17,000	20,000	23,000	21,500	25,000	28,000
C. Company Carried Reserves		20,000			25,000	
D. Difference	3,000	0	(3,000)	3,500	0	(3,000)

The example above is simple and can represent a situation in which the company relies completely on the Appointed Actuary by carrying his or her estimate. In this case, there is no difference between the Appointed Actuary's estimate and the carried amount. Further action is generally not necessary.

There may be small variations from this scenario in which the Appointed Actuary's estimate is "close to" the company's carried reserves. Analysts need to determine "How close is close enough?". Regulatory emphasis is on financial solvency. Therefore, an initial consideration might be the impact on surplus of management's decision to carry an amount different from the Appointed Actuary's estimate. Further action is generally not necessary unless the analyst is concerned that carried reserves are far enough below the Appointed Actuary's estimate as to not obviously be "close enough."

Situation 2: Appointed Actuary's Point Estimate or Range Midpoint < Carried Reserves

	Net Loss + LAE Reserves			Direct & Assumed Loss + LAE Reserves		
	Low	Point	High	Low	Point	High
B. Appointed Actuary's Point Estimates	17,000	20,000	23,000	21,500	25,000	28,000
C. Company Carried Reserves		21,000			26,500	
D. Difference	4,000	1,000	(2,000)	5,000	1,500	(1,500)

In this case, the company is carrying a reserve amount greater than the Appointed Actuary's point estimate and in the higher end of the Appointed Actuary's range. From a solvency perspective, surplus is more conservatively stated. Further action is generally not necessary.

Situation 3: Appointed Actuary's Point Estimate or Range Midpoint > Carried Reserves

	Net Loss + LAE Reserves			Direct & Assumed Loss + LAE Reserves		
	Low	Point	High	Low	Point	High
B. Appointed Actuary's Point Estimates	17,000	20,000	23,000	21,500	25,000	28,000
C. Company Carried Reserves		17,100			22,000	
D. Difference	100	(3,000)	(5,900)	500	(3,000)	(6,000)

When the carried reserves are less than the Appointed Actuary's point estimate or range midpoint, the question of "How close is close enough?" becomes more relevant. This is a more challenging situation for analysts to evaluate. Analysts should focus on the difference between the carried reserves and the point estimate or range midpoint. If the Appointed Actuary has issued a "reasonable" opinion, analysts should consider the following factors:

- The difference as a percent of surplus
- The difference as a percent of carried loss and LAE reserves
- The company's RBC position

At this point, consider an alternate question: "If the company had carried the Appointed Actuary's higher estimate and surplus was comparably reduced, would my evaluation of the company's financial condition change to a less favorable one?". If the answer to that question is "yes," then consider requesting management's rationale and documentation to support the lower carried reserve amount(s). In addition, analysts might require the company to have its Appointed Actuary provide additional information regarding the range of estimates, if calculated. The Appointed Actuary's description of the range should also be documented in the Actuarial Report supporting the Actuarial Opinion.

As a rule of thumb, it is concerning if carried reserves are more than 5% (of surplus) below the Appointed Actuary's point estimate or range midpoint, even if the reserves still lie within the Appointed Actuary's range. The 5% (of surplus) is a common examiner materiality starting selection for financial examinations.

Next, consider the AOS in the context of RMAD as addressed in the Actuarial Opinion. If a range is provided, is the materiality standard less than the difference between the carried reserves and the high end of the Appointed Actuary's range? This means that reserves would still lie within the Appointed Actuary's range of reasonable reserve estimates if carried reserves developed adversely by an amount the Appointed Actuary considers to be material. In this situation, state insurance regulators generally expect the Appointed Actuary to conclude that there is a significant risk of material adverse deviation. If the Appointed Actuary concludes that there is not a significant RMAD in this situation, analysts should document any comments or concerns and consider following up with the Appointed Actuary.

Most opinions issued are "Reasonable," which means that the carried reserve amounts are within the Appointed Actuary's range of reasonable reserve estimates. Only a handful of opinions fall into the other categories as defined in the Instructions (Deficient or Inadequate, Redundant or Excessive, Qualified, or No Opinion). These types of opinions likely require further action by analysts. The Considerations section identifies several actions that could be taken, particularly with regard to a Qualified Opinion or No Opinion.

A Deficient or Inadequate Opinion, while rare, presents a challenge for analysts. This type of opinion means that the carried reserves are less than the minimum amount the Appointed Actuary considers to be reasonable. As with Situation #3 above, analysts should evaluate the materiality of the deficiency in light of surplus, the company's RBC position, net income, and other factors. Analysts should review all options listed in the Considerations section. In this situation, the regulator may wish to initiate a target examination or engage an independent actuary to evaluate the reasonability of the carried reserves so that the implied deficiency can be evaluated.

Regardless of analysts' concerns, it is important to remember that the carried reserves are the responsibility of management. The Appointed Actuary may or may not be part of management. In nearly all cases, analysts should direct initial questions to company management for rationale and documentation of decisions regarding the carried reserves.

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Procedure #14. ~~v~~Verif~~ies~~y compliance with the AOS reporting requirement regarding persistent adverse development. Analysts should note concerns regarding the nature of historical adverse development.~~ See the above discussion for guidance on evaluating the comments provided by the Appointed Actuary.~~

Part E of Section 5 addresses what the Casualty Actuarial and Statistical (C) Task Force calls “persistent adverse development.” When the company experiences one-year adverse development in excess of 5% of the prior year’s surplus as measured by Schedule P – Part 2 Summary in at least three of the past five calendar years, the Appointed Actuary must provide an explicit description of the reserve elements or management decisions that were the major contributors. The one-year adverse development ratio can be found in the Five-Year Historical Data exhibit of the Annual Statement.

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

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

Analysts should also consider the following situations:

- *Situation A*: Prior AOSs indicate that the company relies on the Appointed Actuary’s estimates. If persistent adverse development occurs, analysts might infer that the Appointed Actuary’s methods and assumptions have a bias towards underestimation.
- *Situation B*: Prior AOSs indicate that the company regularly carries amounts lower than the actuarial point estimate or low in the Appointed Actuary’s range. If persistent adverse development occurs, analysts might infer that management takes a more optimistic view of its liabilities, regardless of what the Appointed Actuary calculates.

~~OVERVIEW OF~~ PROPERTY/CASUALTY RESERVING RISK ASSESSMENT OVERVIEW

The single largest liability reported by most P/C insurers is the liability for unpaid losses (commonly known as loss reserves). Loss reserves are ~~based on~~ estimates rather than ~~payments~~definitive amounts, ~~so they cannot be precisely determined in advance~~as they are based on projections of future claim payments.

The underlying goal ~~in~~ of loss reserve estimation~~ng~~ ~~reserves is for unpaid losses~~is to accurately reflect the outstanding liability, net of reinsurance, for all losses that have occurred and not been paid as of the financial statement date. ~~Except for claims-made~~While most policies recognize ~~,~~losses ~~are recognized as~~when they occur, ~~not as they are reported~~claims-made policies create a unique dynamic. ~~Typically, claims-made policies only cover losses that are reported during the policy period or renewal term.~~ Under these policies, ~~a~~ losses ~~is~~ are recognized when ~~it is~~they are reported to the insurer, ~~rather than~~not when ~~it~~ they occur~~s, and the report date is substituted for the incurred date for the loss~~. This distinction impacts the timing of loss recognition and reserve estimation.

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

In addition to unpaid losses, ~~an~~ insurers must also establish reserves for loss adjustment expenses (LAE). ~~the~~ LAE represents the estimated future costs ~~of~~ associated with settling ~~the~~ unpaid losses, ~~otherwise known as LAE. The reserve for LAE is an estimate of all expenses that will be incurred in connection with the settlement of unpaid losses, which~~ including~~es~~ claims adjustment expenses, legal fees, court costs, investigation fees, claims processing, and payment expenses. LAE is classified as either "defense and cost containment (DCC) expense" or "adjusting and other expense." DCC expenses are correlated with the loss amounts and include defense, litigation, and medical cost containment expenses. Adjusting and other expenses are correlated with the number of claim counts and include all LAE other than DCC expenses, such as fees of adjusters and attorney fees incurred in the determination of coverage. The reserve for LAE should be the insurer's best estimate of the LAE that will be paid ~~in order~~ to settle both reported and IBNR unpaid claims.

Due to the complexity of reserving for unpaid losses and LAE, most insurers rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some insurers ~~do~~ may not ~~use~~ employ actuaries ~~to~~ for reserve estimation~~e their reserves~~, they are nonetheless required to obtain an annual opinion from a qualified actuary regarding the reasonableness of their carried reserves.

~~Since~~ As these liabilities ~~must be~~necessitate estimation~~ed~~, they are ~~generally~~ inherently considered a high-risk area for P/C insurers. The reasonableness of an insurer's ~~liabilities~~ reserves for unpaid losses and LAE must be closely monitored on an ongoing basis. A deficiency in these liabilities directly ~~affects~~ impacts surplus, which, in turn, affects the insurer's overall financial solvency. Therefore, the primary ~~concern~~ focus of analysts ~~in the~~ reviewing ~~of~~ unpaid losses and LAE is ~~whether the~~to assess whether the insurer's established 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 ANNUAL RESERVING RISK REPOSITORY~~GENERAL GUIDANCE

~~The Annual Reserving Risk Repository is 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.~~

~~**Using the Repository**~~

~~The~~ To assess r~~R~~eserving r~~R~~isk ~~Repository is a list of possible~~consider the quantitative and qualitative data, benchmarks, and procedures ~~that the analyst or actuary may use in the review of reserving risk~~in this chapter. It's important to note that this is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the state department based on the nature and scope of the risk.

The placement of procedures, metrics, and data within reserving risk is based on "best fit". Analysts should ~~use their~~exercise professional judgement ~~in~~when categorizing risks ~~when~~and documenting financial determinations ~~of the analysis.~~

In conducting ~~your~~the analysis, utilize available tools in iSite+, such as financial profile reports, dashboards, loss

reserves tool (projection and development triangles), and Annual Filings such as the Statement of Actuarial Opinion. Additionally, consider external resources such as rating agency reports, industry reports, and publicly available insurer information.

Analysts are not expected to respond document everyt to all procedures, data point, and or benchmark results listed in the repository. Rather, analysts and supervisors should use leverage their expertise, knowledge of the insurer, and professional judgment to tailor the analysis to the specific risks of the insurer and document completion the applicable details within of the analysis. ResultsThe results of the reserving risk analysis should be documented in Section III: Risk Assessment of the insurer. This dDocumentation of the risk assessment analysis should be sufficiently robust to explain the risks, and the strengths, and weaknesses of the insurer.

The repository is not an all-inclusive list of possible procedures. The department should consider the nature and scope of the risk when analyzing risks for which no procedure is described.
In using procedures in the repository, aAnalysts should review the resultscomplete their reserving risk assessment in conjunction with:

- -A review of the Supervisory Plan and Insurer Profile Summary and the prior period analysis.
- Communication with the company.
- -Communication and coordination with other internal departments. is a critical step in the overall risk assessment process and is crucial to the review of certain procedures in the repository.

The placement of the following data and procedures in the reserving risk repository is based on "best fit." Analysts should use their professional judgment in categorizing risks when documenting results of the analysis. Analysts should also recognize that examiners or company management may classify a risk differently from what is outlined in this repository. Key insurance operations/activities or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with reserves. For example, reserves are also addressed in the Actuarial Opinion Risk Assessment Repository.

ANALYSIS DOCUMENTATION: Results of the reserving risk analysis should be documented in Section III: Risk Assessment of the insurer.

QUANTITATIVE AND QUALITATIVE DATA AND PROCEDURESANNUAL RESERVING RISK ASSESSMENT

Understated Loss and LAE Reserves

PROCEDURE #1 Understated Loss and LAE Reserves

asks analysts to iIncorporate any concerns noted in the review of the Actuarial Opinion into the review of the insurer's reserves. Issues noted in the review of the Actuarial Opinion may be relevant to aspects of reserve risk identified in other procedures.

Determine whether anSignificance of Potential uUnderstatement of lLoss and LAE rReserves would be significant.

PROCEDURE #2 assists analysts in dDetermineing whether an understatement in loss and LAE reserves would be significant to the insurer. The ratio of loss and LAE reserves to surplus is a leverage ratio that indicates the margin of error an insurer has in estimating its reserves. For an insurer with a reserve leverage ratio of 300%, a 33% understatement of its reserves would eliminate its entire surplus. In addition to the reserve leverage ratio, analysts should consider the nature of the insurer's business. An insurer that writes primarily short-tail property lines might not be a concern, even if its leverage ratio is greater than 300%. The risk of significant understatement of its reserves is less than that of an insurer that writes primarily long-tail liability lines, such as medical professional liability.

Procedures/Data

- Ratio of ~~L~~loss and LAE reserves to surplus
- Ratio of net premiums written ~~NPW~~ (long-tail) to total ~~NPW~~net premiums written
- Increase in ratio of ~~NPW~~net premiums written (long-tail) to total ~~NPW~~net premiums written from ~~PYE~~the prior year
- Review the shift in business mix from short-tail property lines to long-tail liability lines within the past five years.

~~Review r~~Reserve ~~d~~Development ~~to assess whether losses and LAE appear to have been adequately reserved.~~

~~PROCEDURE #3~~ ~~assists analysts in d~~Determin~~ing~~e 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, or the two-year reserve development to second prior year-end surplus result is consistently worse than the one-year reserve development to prior year-end surplus, the insurer has been understating its reserves.

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

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

~~Analysts may A~~Aalso consider performing a review, by line of business, of items including: one-year and two-year development in net incurred losses and DCC expenses per the Annual Financial Statement, Schedule P – Part 2 to determine which lines of business are developing adversely, and incurred loss and LAE ratios per the Annual Financial Statement, Schedule P – Part 1 to determine any unusual fluctuations between years.

~~Analysts may a~~Also consider a review of cumulative paid net losses and DCC by line of business in the Annual Financial Statement, Schedule P – Part 3 to determine whether there were any unusual fluctuations or aberrations in payment patterns between accident years or within an accident year. The review of the Annual Financial Statement, Schedule P Interrogatories, #7.1 is used to determine if there are any other factors that the insurer indicated should be considered in the analysis of the adequacy of unpaid losses and LAE. If there are still concerns regarding the adequacy of unpaid losses and LAE as a result of other steps performed, analysts should consider performing a loss reserve analysis on the more volatile long-tail liability lines of business using the Loss Reserves Estimation Tool (or other loss reserve analysis software) to project loss reserves based on incurred and paid claims per the Annual Financial Statement, Schedule P. However, ~~analysts 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, ~~analysts should c~~Consider having an actuary review the analysis performed.

Procedures/Data

- One-year reserve development to PYE surplus ratio ~~(~~[IRIS #11]
- Two-year reserve development to second PYE surplus ratio [IRIS #12]
- Adverse or unusual trend in
  - One-year reserve development
  - Two-year reserve development
- Estimated current reserve deficiency to surplus ratio [IRIS #13]

Additional Review Considerations

- Review, by line of business, the one-year and two-year development in incurred net losses and defense and cost containment expenses by accident year reflected in Annual Financial Statement, Schedule P – Part 2, or review the loss reserve development section in the Financial Profile Report.
  - Note any unusual development. Consider the significance of the lines of business producing unusual development in relation to the insurer's total book of business.
  - Determine if any internal changes have been initiated that may impact the reserve estimates (e.g., accelerating claim payments).
- Review, by line of business, the cumulative net paid losses and defense and cost containment expenses by accident year in Annual Financial Statement, Schedule P – Part 3 and comment on any unusual fluctuations or aberrations in loss and expense payment patterns between accident years or within an accident year.
- Review the Annual Financial Statement, Schedule P Interrogatories, #7.1 for information on significant events or changes in coverage, retention, or accounting changes.
- Perform loss reserve analysis on the more volatile long-tail liability lines of business using the Loss Reserves Estimation tool or other loss reserve analysis software to project loss reserves based on incurred claims data in Annual Financial Statement, Schedule P – Part 2 less Part 4, and paid claims data in Annual Financial Statement, Schedule P – Part 3. Compare the projected reserves to the reserves established by the insurer.
- If significant concerns regarding reserve development are identified, request the assistance of a department or consulting actuary in reviewing and assessing the adequacy of the reserves carried by the insurer.

Exposure to ~~Assess a~~Asbestos and ~~/e~~Environmental ~~reserves. Review the Actuarial Opinion; Annual Financial Statement, Notes to Financial Statements, Note #33, and survival ratios.~~Claims

~~***PROCEDURE #4*** provides metrics for a~~Assess~~ing~~ the insurer's exposure to asbestos and environmental (A&E) liabilities.

~~Asbestos and environmental~~A&E liabilities pose unique challenges for insurers due to their complex nature and potential long-term consequences. ~~are particularly difficult to estimate. Many years may pass between exposure and the realization of adverse effects; in insurance terms, there may be a long~~These liabilities often involve a significant lag between ~~the occurrence~~exposure, the manifestation of adverse effects, ~~-~~and the reporting of a loss, making accurate estimation difficult. Legal decisions, ~~-may change the value of outstanding claims and lead to new claim filings. Different~~varying court~~s~~ interpretations, and ~~may interpret policy language differently, and questions may arise on which~~ policy coverages ~~a claim~~disputes can further complicate matters.

To assess~~If~~ the insurer's ~~has significant~~ exposure to ~~asbestos or environmental~~A&E claims, ~~analysts may want to~~ review the Notes to Financial Statements – Note #33. ~~-to gain~~This note provides valuable information ~~on~~ into the nature of the liabilities. However, it is important to note that Note #33 does not account for any A&E exposures assumed or ceded under retroactive reinsurance agreements.

Procedures/Data

- Exposure to ~~asbestos and environmental~~A&E liabilit~~y~~ies
- Ratio of ~~N~~net ~~asbestos and environmental~~A&E loss and LAE reserves to surplus
- Increase in net ~~asbestos and environmental~~A&E loss and LAE reserves over prior year, where current year change in reserves is material to surplus

- A&E survival ratio

Additional Review Considerations

If significant exposure to ~~asbestos and environmental (~~A&E~~)~~ reserves is identified, analysts may further assess the exposure by reviewing the following sources of information:

- The Actuarial Opinion:
  - Determine if the Appointed Actuary mentions A&E exposure as a risk factor or potential source of material adverse deviation and if A&E exposure is material.
- Annual Financial Statement, Notes to Financial Statement, Note #33:
  - Determine if there have been material changes in A&E reserves over time. Note #33 provides both qualitative and quantitative information on an insurer's exposure to asbestos and environmental liabilities, including:
    - Whether the insurer has potential exposure to asbestos or environmental claims.
    - The lines of business for which there is potential exposure and the nature of the exposure.
    - Loss and LAE payments during the year for the most recent five calendar years.
    - Loss and LAE reserves at the end of the year for the most recent five calendar years.
    - The amount of bulk and IBNR reserves within the most recent year-end's reserves.
    - The amount of LAE reserves within the most recent year-end's reserves.

~~Note #33 does not include the effects of any asbestos and environmental exposures assumed or ceded under retroactive reinsurance agreements.~~

- A&E survival ratios in the Financial Profile Report.
  - Determine if material changes have occurred over time.
    - A survival ratio is calculated as the carried reserves divided by the average paid losses. The ratios in the Financial Profile Report combine asbestos and environmental exposures and use the most recent three years in the average of paid losses. The ratio gives the number of years the insurer's reserves will last if future average payments equal the current average payments. All else equal, a higher survival ratio indicated greater reserve adequacy. When compared to industry averages, the survival ratio for an insurer serves as one metric of the insurer's reserve adequacy.
    - Survival ratios may be distorted by unusual one-off transactions such as large settlements or loss portfolio transfers. The survival ratio in the Financial Profile Report do not include the effects of any asbestos and environmental exposure assumed or ceded under retroactive reinsurance agreements.
- Actuarial Report, i~~d~~f requested:
  - Determine if the report provides information on the insurer's exposure to A&E losses and the Appointed Actuary's reserving methodology.

After review of the information above a meeting with company management may be warranted, particularly given the uniqueness of A&E exposures and variation in companies' reporting and reserving practices for A&E losses and LAE.

~~**Exposure to Discounted Losses and LAE Reserves**~~

Exposure to Discounted Loss and LAE Reserves

~~*PROCEDURE #5* assists analysts in d~~Determin~~ing~~e whether unpaid losses and LAE have been discounted and, if so, whether concerns exist regarding the amount of the discount or the interest rate used.

While Ppresent value discounting of P/C loss reserves is generally not an accepted under statutory accounting practice principles, there are exceptions. in the case ofFor example, fixed and determinable payments, such as those resulting from workers' compensation tabular indemnity reserves and long-term disability claims, can be discounted. However, some state insurance departments permit insurers to discount other types of business on a non-tabular basis.
All Any discounting, other than tabular discounting on the types of claimsas specified in *Statement of Statutory Accounting Principles* (SSAP) *No. 65—Property and Casualty Contracts*, must be approved byrequires approval from the domiciliary state insurance department and must be disclosed in the Schedule P Interrogatories of the Annual Financial Statement. Annual Financial Statement, Schedule P – Part 1 is required to be completed gross of non-tabular discounting, and Schedule P – Part 2 and 4 are required to be completed gross of all discounting.

If loss reserves are discounted, the Annual Financial Statement, Underwriting and Investment Exhibit, Part 2A, is completed net of the discount,. Additionally, and disclosure of discounting is required in the Annual Financial Statement, Notes to Financial Statements – Note #32 must disclose the discounting, including the discount rates used and . This disclosure includes a discussion of the discount rates used and the basis for using those ratesthe underlying rationale. In addition, if the rates used to discount prior accident years' reserves have changed from the previous Annual Financial Statement, the insurer is required to disclose the amount of discounted current reserves (excluding the current accident year) at current interest rate assumptions, the amount of discounted current reserves (excluding the current accident year) at previous interest rate assumptions, and the change in discounted reserves due to the change in interest rate assumptions.

Analysts may also considershould carefully reviewing the information in Note #32 in more detail and compareing the interest rates used to discount reserves to the insurer's investment yield. Analysts may also consider comparing the maturities of the insurer's investment portfolio and the estimated timing of future payments on unpaid claims.

Procedures/Data
- Determine the ratio of time value of money discount on unpaid losses and LAE to surplus

Additional Review Considerations
- Review the Annual Financial Statement, Notes to Financial Statements, Note #32, consider the following:
  - The lines of business with discounted reserves
  - The interest rates used to discount reserves, including the basis indicated for using those rates
  - The amount of discount in relation to surplus
  - If the interest rates used to discount the prior accident years' reserves have changed from the previous Annual Financial Statement, document the change in discounted reserves due to the change in interest rate assumptions and the effect on surplus
- Determine whether the interest rates used to discount reserves appear to be reasonable considering the insurer's investment yield and the insurer's comments in Note #32 regarding the basis for the interest rates used.
- If the insurer is using discounting procedures that depart from the guidance in *Statement of Statutory Accounting Principles* (SSAP) *No. 65—Property and Casualty Contracts*, ensure that the insurer received a permitted practice to do so. (The insurer may describe permitted practices in the Annual Financial Statement, Notes to Financial Statements, Note #1. The NAIC's iSite+ also has a Permitted Practices for Accounting report for each insurer in the Financial Analysis/Examination report category.)

~~**Exposure to Salvage and Subrogation**~~

Exposure to Salvage and Subrogation

~~***PROCEDURE #6*** assists analysts in d~~Determin~~ing~~e whether unpaid losses and LAE are reduced for anticipated salvage and subrogation recoveries and, if so, whether concerns exist regarding the consideration of estimated salvage and subrogation in establishing unpaid losses and LAE.

Salvage ~~is~~ refers to the proceeds ~~received by~~ an insurer receives from the sale of property on which the insurer has paid a total loss to the insured. For example, when an insurer pays the insured the full value of a wrecked automobile, ~~the insurer~~it takes ~~title to the automobile. The insurer~~ownership and then sells the damaged automobile, ~~and~~ us~~e~~ings the proceeds to reduce its ultimate loss on the claim.

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 it has paid ~~by the insurer under the terms of a policy~~. For example, ~~when an insurer~~in an auto accident where the insurer pays ~~its~~ a not-at-fault insured, ~~for an auto collision loss, the insurer~~it may subrogate against the ~~third party responsible for the accident and collect the~~at-fault part to recoup the amount paid~~,~~ or a portion thereof. Subrogation recoverables are treated as a reduction of ultimate losses paid.

Because of the difficulty in determining an estimate of anticipated salvage and subrogation on unpaid losses, ~~it is~~they are generally recognized in the Annual Financial Statement only after ~~it has~~they have been reduced to cash or its equivalent. However, if loss and LAE reserves reported in the Annual Financial Statement are net of anticipated salvage and subrogation, the estimated amount ~~of such anticipated salvage and subrogation~~ must be disclosed in Schedule P.

Analysts should ~~Analysts may also c~~Consider review~~ing~~ the Annual Financial Statement, Schedule P – Part 1 to determine which lines of business have anticipated salvage and subrogation recoverables. ~~For the more significant lines of business, analysts might compare the ratio of anticipated salvage and subrogation to unpaid losses and LAE (gross of anticipated salvage and subrogation) to the ratio of salvage and subrogation received to claims paid (gross of salvage and subrogation received) to help determine the reasonableness of the anticipated salvage and subrogation.~~

Procedures/Data

- Determine the anticipated salvage and subrogation to surplus ratio

Additional Review Considerations

- Review the Annual Financial Statement, Schedule P – Part 1 to determine which lines of business have unpaid losses and LAE that have been reduced due to consideration of anticipated salvage and subrogation.
- For the more significant lines of business, review Annual Financial Statement, Schedule P – Part 1 and compare the ratio of anticipated salvage and subrogation to unpaid losses and LAE (gross of anticipated salvage and subrogation) to the ratio of salvage and subrogation received to claims paid (gross of salvage and subrogation received) to determine the reasonableness of anticipated salvage and subrogation.

ADDITIONAL ANALYSIS ~~AND FOLLOW-UP~~ PROCEDURES APPLICABLE TO RESERVING RISK

Examination Findings

~~directs analysts to r~~Review the recent examination report, summary review memorandum and communication with the examination staff to identify if any reserving risk issues were discovered during the examination.

Inquire of the Insurer

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

- Request a copy of the qualified actuary's actuarial report and review the actuary's comments regarding the analysis performed and conclusions reached.
    - If additional questions or concerns are noted after reviewing the report, contact the appointed actuary to discuss the nature and scope of the reserve valuation procedures performed.
- Request a copy of the insurer's business plan, and review the insurer's plans to assess and mitigate reserve risks.
- Request information regarding any significant changes in reserve methodologies and assumptions, underwriting practices, case reserving, or claims handling practices with the potential to affect reserve setting.
- Request information on who ultimately determines the insurer's carried reserves and the Board of Director's role in overseeing the reserving process.
- If filed on an insurance entity basis or if your state is the lead state, review the insurer's Corporate Governance Annual Disclosure (CGAD) filing to understand and assess the board of directors' role in overseeing the reserving process. If your state is not the lead state, rely on the information provided in the Group Profile Summary (GPS) or provided by the lead state, where the CGAD is filed on a group basis.

Own Risk and Solvency Assessment (ORSA)

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

- Determine if the ORSA Summary Report analysis conducted by the lead state indicated any reserving risks that require further monitoring or follow-up.
- Determine if the ORSA Summary Report analysis conducted by the Lead State indicated any mitigating strategies for existing or prospective reserving risks.

Holding Company Analysis

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

- Determine if the Holding Company analysis conducted by the lead state indicated any reserving risks impacting the insurer that require further monitoring or follow-up?
- Determine if the Holding Company analysis conducted by the lead state indicated any mitigating strategies for existing or prospective reserving risks impacting the insurer?

Example Prospective Risk Considerations

The table provides analysts with suggested risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general description of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the reserving risk category.

DISCUSSION OF QUARTERLY PROCEDURESRISK ASSESSMENT

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

Change in Losses and LAE

Determine whether ~~Significant~~the changes~~s~~ in unpaid losses and LAE since the prior year-end or incurred losses and LAE since the prior year-to-date was significant.

Procedures / Data

- Change in loss reserves
- Change in LAE reserves

~~Significant changes in incurred losses and LAE since the prior year period~~

- Change in net losses incurred
- Change in ~~N~~net LAE incurred

Reserve Development

~~Whether there has been significant~~Evaluate the materiality of ~~-~~adverse development ~~on~~ in ~~the liabilities for~~ unpaid losses and LAE established ~~at~~ as of the prior year-end.

Procedures / Data

- ~~r~~Ratio of loss and LAE reserves to surplus
- ~~c~~Change in loss and LAE reserves to surplus ratio from prior year-end
- Review the year-to-date reserve development of prior year-end's loss and LAE reserves.
    - Ratio of year-to-date reserve development of prior year-end total loss and LAE reserves to prior year-end surplus

~~Significant changes pertaining to loss reserve discounting~~**Exposure to Discounted Unpaid Losses and LAE**

Evaluate if there have been notable changes in the discounting of loss reserves since the prior year.

Procedure

- Review Note #32 of the Quarterly Financial Statement's Notes to Financial Statements to identify any changes in the discounting of loss reserves. If such changes exist, provide an explanation of the changes and assess the materiality.

~~For additional guidance on inidividual procedure steps, please see the corresponding annual procedures dicussed above.~~

Strategic Risk Assessment

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

The objective of Strategic Risk Assessment analysis is to focused primarily on risks inherent in the company's business strategy and plans. As such, risks in this area are often prospective in nature and may require additional investigation and information requests to understand and assess their potential impact. For example, analysts may require an up-to-date business plan from the insurer to assess emerging risk exposures and prospective risks that could prevent the insurer from meeting its strategic goals. In addition, information presented in the Enterprise Risk Report (Form F) and Own Risk and Solvency Assessment (ORSA) Summary Report (if available) which the lead state reviews and documents risks, may assist analysts in identifying and assessing the insurer's exposure to strategic risks.

The following discussion of procedures provides suggested data, benchmarks and procedures analysts can consider in his/her review. In analyzing strategic risk, analysts may analyze a wide range of risk exposures related to the insurer's business plan and overall strategy. An analyst's risk-focused assessment of strategic risk should take into consideration the following areas (but not be limited to):

- Industry and market factors
- Risk management and governance challenges
- Changes in officers and directors
- Recent and pending merger and acquisition activity
- The insurer's strategic planning process
- Significant recent or pending changes in business plan and strategy
- Underwriting strategy and plans
- Investment strategy and use of investment advisors
- Reinsurance strategy, including adequacy of coverage
- Affiliate relationships and transactions
- Capital planning and adequacy

Discussion of Annual ProceduresGENERAL GUIDANCE

Using the Repository

To assessThe Sstrategic Rrisk Repository is aconsider the list of possible quantitative and qualitative procedures, including specific data elements, metrics and benchmarks in this chapterand procedures from which analysts may select to use in his/her review of strategic risk.

The placement of the following data and procedures, metrics and data with-in the Strategic Risk Repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with strategic risk.

In conducting your analysis, utilize available tools in iSite+ such as financial profile reports, dashboards, investment snapshots, jumpstart reports, and other industry aggregated analysis. Consider also external tools

such as rating agency reports, industry reports, and publicly available insurer information.

Analysts are not expected to ~~respond~~document every ~~to all~~ procedure~~s~~, data or benchmark result~~s listed in the repository~~. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document ~~completion~~the applicable details within ~~of~~ the analysis. ~~The repository is not an all-inclusive list of possible procedures. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.~~

~~In using procedures in the repository, a~~Analysts should ~~review the results in~~ complete their credit risk assessment in conjunction with:

- A review of the Supervisory Plan, Insurer Profile Summary and the prior period analysis.
- Communication and/or coordination with other internal departments. ~~are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures in the repository.~~
- ~~Analysts should also consider t~~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 placement of the following data and procedures in the Strategic Risk Repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories. Therefore, analysts may need to review other repositories in conjunction with strategic risk.~~

~~***ANALYSIS DOCUMENTATION:*** Results of strategic risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.~~
The following is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

ANNUAL STRATEGIC RISK ASSESSMENT~~Quantitative and Qualitative Data and Procedures~~

~~**News, Press Releases and Industry Reports**~~

Impact of News, Press Releases and Industry Reports on Insurer Stategy

~~***PROCEDURE #1*** directs analysts to i~~Identify and assess concerns from news, press releases or industry reports with the potential to affect the insurer or insurance group. The intent ~~of this procedure i~~is for analysts to identify issues that could affect an insurer's ability to effectively implement its strategy. For example, if the insurer's strategy is focused on a particular line of business that is facing challenging economic conditions, analysts may be able to identify this concern through NAIC Industry Snapshots and Reports or NAIC Risk Alerts. Another example might be a news release or press release from the company indicating shifts or changes in strategy that could affect the insurer's financial condition. If concerns exist with respect to a potentially damaging report issued on the insurer or group, analysts should inquire about the overall financial impact on the insurer and the steps the insurer plans to implement to mitigate the circumstances.

Procedures

- Review any insurance, marketplace or economic industry reports, news releases, press releases, and emerging issues to identify if any issues have the potential to negatively impact the insurer's strategy.

- Examples: NAIC "Insurance Industry Snapshots" and "Insurance Industry Analysis Reports"; NAIC Capital Markets Bureau reports, rating agency reports, insurance news sources, NAIC Risk Alerts, etc.
- Review movements and trends in the insurer's or group's stock price and trading volume to assist in identifying and assessing strategic risk.

Additional Review Considerations

- If concerns exist regarding a recent industry report, news release, stock movement or emerging issue, determine if the news or industry issue has the potential to impact the insurer's strategy, operations or financial solvency.
- Perform additional non-routine procedures where applicable (e.g., survey or questionnaire, stress testing, etc.).
- Inquire of the Insurer:
  - The financial impact to the insurer and/or group's operations and surplus
  - Disclosures of financial impact to the public and agent distribution force
  - The insurer's efforts to mitigate any impact of the risk. For ORSA filers, this may be identified in the ORSA Summary Report for certain risks.
  - Policies and procedures in place to mitigate adverse publicity
  - Revised business plan

~~Risk Management and Governance~~

Insufficient Risk Management and Governance Practices

~~***PROCEDURE #2*** directs analysts to d~~Determine whether the risk management practices of the insurer are sufficient to provide for the establishment, implementation and oversight of an effective business strategy. Weaknesses or immaturity in the insurer's risk management practices may limit its ability to identify, track, assess and manage significant strategic risks. In completing this procedure, analysts must first determine whether the insurer is subject to ORSA requirements. If the insurer is subject to ORSA requirements, analysts are directed to obtain and review work performed by the lead state to evaluate the insurer's risk management framework.

For insurers that are not subject to ORSA reporting requirements, analysts may need to gather additional information regarding the insurer's risk management processes in order to assess their impact on strategic risk. ~~Analysts may be able to leverage work recently completed by financial examiners in this area by requesting Exhibit M and/or C-Level interview results to gain an understanding of risk management practices in place. As part of the examination, several key areas are considered when reviewing the risk management function, including those outlined in procedure 2c. Where applicable, analysts should review and follow up on work performed by the examiner, including any comments or recommendations.~~

~~If the information is not available or not sufficient, analysts may need to inquire regarding the insurer's internal risk management practices to obtain an understanding and evaluate the impact of such practices on the insurer's business strategy.~~ A review of the entity's risk-management function should be conducted through discussions with senior management and the board of directors, and through gaining an understanding of the risk-management function including inspection of relevant risk management documentation. An effective risk-management function is essential in providing effective corporate governance over financial solvency.

Procedures

- If the insurer or insurance group is subject to Own Risk and Solvency Assessment (ORSA) requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead

state as discussed in Section VI.F Own Risk and Solvency Assessment (ORSA) of the Handbook. Document any concerns regarding the insurer's risk management practices and effects on the insurer's ability to establish, implement and oversee an effective business strategy.

- If the insurer or insurance group is not subject to ORSA requirements:
  - Communicate with the examiner or obtain the recent examination work papers, including Exhibit M and C-Level interview results, to gain an understanding of the insurer's enterprise risk management (ERM) program.
  - Inquire as to whether the company prepares an ERM assessment or similar risk assessment program. If "yes," request a copy. If not, request an explanation or lead a discussion on how the insurer identifies risks.
  - Evaluate the impact of such ERM practices on the insurer's business strategy.
- Review information provided on the company's ERM assessment or similar risk assessment program and/or follow-up on the work performed by the examiners regarding assessment of risk management, and evaluate any changes in the following or other areas:
  - The risk management culture demonstrated throughout the organization.
  - The importance of risk management to the organization.
  - How risk tolerances and "appetites" are defined and communicated throughout the organization.
  - How existing risks are identified, tracked, assessed and mitigated.
  - How emerging and/or prospective risks are identified, tracked, assessed and managed.
  - How the organization uses the risk information to determine capital needs.
  - Whether internal models are utilized and regularly updated to ensure appropriate risk management decisions.
  - How responsibilities for risk-management functions are delegated and monitored.
  - The level of involvement of the board of directors in the risk management function.
  - How risk management processes and results are incorporated into ongoing strategic planning and decision making.

Additional Review Considerations

- If not already included in ORSA or other ERM filings, inquire of the insurer:
  - Risk management policies and procedures
  - Risk monitoring and reporting tools
  - The impact of significant changes in board and executive leadership on the insurer's strategy and business plans
  - Information on significant recent or pending changes to organizational structure or operations

Change in Strategic Direction / Lack of Experienced Leadership

PROCEDURE #3 directs analysts to eEvaluate the effects of changes in officers, directors or organizational structure on the strategic direction of the insurer. The followingis procedures isare Thise procedure is intendedintentdedhere is to assist analysts in assessing the potential impact on strategic risk from changes in directors, senior management, and organizational structure or operations. At times it is impossible to avoid director and management turnover. Whether the change is a result of retirement or term limits, performance, promotion, or termination, the end result is a new individual being placed in a position that could affect the strategy of the insurer. For example, new management may institute change in future business plans that could have a significant impact on the insurer or group (e.g., new types of business, new geographic areas of writings, staff changes, or new affiliations). The lack of experienced leadership at the board and senior management level may make it difficult to set, maintain and achieve strategic goals. Changes in organizational structure and operations may have a similar impact and should be considered and evaluated for their potential to affect the insurer's ability to achieve its business strategy.

Procedures

- Review the changes in officers, directors or trustees and any concerns noted during a review of biographical affidavits.
  - Ascertain whether new directors and officers have the required knowledge, experience and training to perform their duties.
  - Determine whether the new board of director members are sufficiently independent from management and adequately engaged in performing their duties.
  - Determine whether new directors and officers ever been officers, directors, trustees, key employees or controlling stockholders of an insurance company that, while they occupied any such position or served in any such capacity with respect to it. If yes to any the following, explain:
    - Been placed in supervision, conservation, rehabilitation or liquidation;
    - Been enjoined from, or ordered to cease and desist from, violating any securities or insurance law or regulation;
    - Suffered the suspension or revocation of their certificate of authority or license to do business in any state.
  - Evaluate and summarize the insurer's policies and procedures regarding performance of background checks on new management.
- If a significant amount of turnover and/or changes in key positions (i.e., chairman of the board of directors, chief executive officer [CEO]) are identified, gain an understanding of and evaluate the impact of such changes on the insurer's strategic direction. Consider requesting updated business plans, holding in-person meetings, conducting conference calls, or taking other steps to understand and address significant changes.
- Identify any changes in the organization's structure. Request the reasons for the changes and the impact on future business plans and strategy from the insurer.
- Determine whether there have been any significant operational or business changes that have resulted in significant changes to staffing levels, consolidations of operations with affiliates, outsourcing of key functions, or placing blocks of business into run-off (closed) blocks.

Mergers and Acquisitions

Lack of Due Diligence in Mergers and Acquisitions

Integration Challenges

PROCEDURE #4 directs analysts to cConsider how recent and pending merger and acquisition activity may affect the current and prospective solvency position of the insurer. Merger and acquisition activities have the potential to move the company into new lines of business and new geographical areas, and may result in significant staffing turnover and integration activities. Failure to adequately conduct due diligence in evaluating the financial condition and compatibility of merger and acquisition candidates may lead to strategic difficulties. The insurer may experience problems in integrating people, culture, systems and business plans as a result of business combinations and merger/ acquisition activity. All of these elements have the potential to significantly affect the business strategy of the insurer. In addition, analysts should be mindful of the fact that mergers and acquisitions do not always yield the desired results. As such, follow-uppost-acquisition procedures comparing projections to actual results and evaluating the effectiveness of system integration and cost-cutting measures may help identify prospective risks and concerns that merit ongoing monitoring.

Procedures

- Determine whether the insurer has been a party to a merger or consolidation as indicated in General Interrogatories, Part 1, #5.1 of the Annual Financial Statement.

Additional Review Considerations

- If the insurer has been a party to a merger or consolidation, note any observations or concerns, ensure Form A or additional filings have been approved, and assess if the insurer is meeting the expectations set forth in the Form A business plan, consider the following additional procedures (as necessary):
  - If regulatory approval of the merger or acquisition was subject to ongoing conditions or restrictions, verify compliance with those requirements.
  - Compare actual results to pre- and post-transaction projections to determine whether results are meeting expectations. If not, gain an understanding of why projections have not been achieved and the company's planned actions to address issues.
  - Request and review information regarding the integration of the new business into the company's processes and systems (systems transition plan), the insurer's process and controls over integration, as well as the steps taken to ensure that adequate cybersecurity precautions are taken during the integration process.
  - Gain an understanding of and consider the impact of planned cost-cutting activities, including the nature and magnitude of cuts and their potential impact on risk exposures.
- Inquire as to whether the company is actively investigating or pursuing merger and acquisition opportunities. If "yes," consider the following additional procedures (as necessary):
  - Obtain an understanding of and consider the company's motivation for pursuing acquisition opportunities (e.g., gain market share, increase producer fees/commissions, diversification, etc.) and how that motivation may affect strategic planning and prospective risk exposures.
  - Gain an understanding of and evaluate the company's processes to perform due diligence when investigating mergers and acquisitions.

~~Business Plans~~

Lack of Strategic Business Planning

Overly Aggressive or Overly Optimistic Business Strategies

~~***PROCEDURE #5*** directs analysts to e~~Evaluate the effectiveness of the insurer's business/strategic planning process and whether the current plan adequately addresses the significant solvency risks facing the insurer. ~~After obtaining and reviewing a current business plan from the insurer, analysts should determine whether any changes have been made in the business goals or philosophies.~~ Analysts should consider the overall planning process (e.g., who is involved, how frequently it occurs, etc.) and how the overall initiatives are determined. In addition, analysts may consider discussing with the insurer any assumptions used in establishing the goals. ~~Analysts should assess whether the current management team has the expertise to attain the goals of the business plan.~~ Through communication with the insurer, analysts should document any detailed explanations regarding variances in projected financial results and the insurer's intended plan to address variances. If analysts determine the goals of the business plan previously provided are not attainable and/or projections are unreasonable, a revised business plan may be requested.

Special consideration should be given to startup insurers that project rapid growth and significant underwriting and net losses. In many cases, startups rely heavily on the parent company's capital contributions to finance operations until the insurer can achieve profitability. The analyst should evaluate the reasonableness of the insurer's business plan and projections and determine whether the plan is attainable.

Procedures

- Review previous business plans and financial projections filed with the state insurance department, Determine the following:
  - Whether significant changes in business plan or philosophy have occurred.
  - Assess if initiatives outlined in the business plan have been accomplished.
  - Compare actual with projected financial results and determine whether actual results are consistent with management's expectations.

- Request an explanation for the variance including an explanation of whether management believes it has achieved its goals for the period and if any noted risks or challenges were not considered in the business plan.
- Describe any events, transactions, market conditions and/or strategic management decisions that have occurred (or are planned) that may cause a significant positive or negative variance from projections, including new product development or enhancements, changes in sales volume, product mix, or geographical locations.
- Determine whether there are internal and/or external prospective risks that have the potential to impact the overall business plan.

- If based on the review of the previously provided plan, it appears no longer current or relevant, as appropriate, request a revised business plan. Review the updated strategic business plan, noting any areas of concern and, if necessary, request additional explanations from the insurer.
  - Whether the new business plan reflects significant changes in the strategic goals or philosophies compared to the prior plan.
  - Describe the insurer's strategic and annual planning process.
  - Describe the board of directors' involvement in developing and implementing the business plan.
  - Assess the insurer's ability to attain the expectations of the business plan and projections and determine whether the business plan reflects changes that appear unrealistic for the current market environment, financial position of the insurer or other circumstances. If so, evaluate the following:
    - Reasonableness of underwriting assumptions
    - Current and anticipated interest rate and economic environment
    - Growth objectives
    - Stability of capital and ability to access additional capital, if needed
    - Quality and sources of earnings (trends and stability)
    - Dividends and dividend payout policy
- For startup insurers that project rapid growth and material losses, consider the following:
  - Obtain a five-year business plan and assess the insurer's current and projected capital adequacy relative to its growth plans.
  - If future growth is to be funded by capital contributions from the parent, assess the parent's ability to meet future funding expectations.
  - Determine whether growth and capital financing expectations are sustainable until the insurer becomes profitable.

Additional Review Considerations

- If concerns exist regarding the business plan, further inquire of the insurer:
  - Information on strategic planning processes and board approval
  - Investment policies and strategy documentation
  - Derivative use plan and information on hedging strategies
  - Investment management agreements
  - Information on reinsurance program structure
  - Significant reinsurance contracts and agreements
  - Reinsurance intermediary agreements
  - Strategies for limiting the financial impact of a pandemic event on the company's solvency position (Health)

Overly Aggressive Investment Strategy
Lack of Investment Expertise and Oversight

PROCEDURE #6 directs analysts to assess Determine whether the insurer's investment strategies and holdings are appropriate to support its ongoing business plan and strategy. Analysts should review tool results (e.g., financial profile, investment snapshot, etc.) to get a basic understanding of the insurer's investment holdings/strategy and any changes noted. If changes or concerns are noted, analysts may need to request a copy of the insurer's formal adopted investment plan. This should be evaluated to determine if the plan appears to result in investments that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs and to determine whether the insurer appears to be adhering to its plan. The plan should also specify investment guidelines for the company to follow in asset allocation addressing quality, maturity/duration and diversification (by issuer, industry, geographic location, etc.). If concerns are identified regarding the insurer's investment plan or strategy, analysts should consider requesting a portfolio analysis from the NAIC's Capital Markets Bureau or use other investment expertise to address the issues.

Analysts may perform additional procedures if there are concerns regarding the level of investment in derivative instruments. Analysts 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, analysts 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 *Accounting Practices and Procedures Manual* (AP&P Manual) have been met. Analysts 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.

Procedures

- Review the asset section of the Financial Profile Report to identify material shifts in investment percentages between asset categories, which may indicate the insurer has increased its investment risk exposure.
- Request a copy of the insurer's investment plan that discusses investment objectives and strategy, with specific guidelines as to quality, maturity, and diversification of investments and:
  - Evaluate whether the investment plan appears to result in investments and practices that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs.
  - Review the guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity and geographic location.
  - Determine who is authorized to purchase and sell investments and what approvals are required for investment transactions.
  - Evaluate the involvement of the board of directors and senior management in overseeing the investment strategies of the insurer.
  - Consider the level of knowledge and expertise of asset managers used by the insurer in making investment decisions, and evaluate the level of oversight provided to any third-party asset managers.
  - Determine whether the insurer appears to be adhering to the investment plan.
- If the insurer allocates a significant amount of its portfolio to structured securities, request information from the insurer regarding its background and expertise in structured securities of its investment advisers (in-house and/or contractual) and its analytical systems capabilities. Determine whether the advisers and systems are adequate to allow the insurer to continuously monitor its structured securities investments.
- If the insurer's investment plans and strategies include the use of derivatives for hedging purposes, request and review a comprehensive description of the insurer's hedge program in order to gain an understanding of how derivative instruments are used to hedge against the risk of a change in value, yield, price, cash flow,

quantity or degree of exposure with respect to assets, liabilities or future cash flows that the insurer has acquired or incurred or anticipates acquiring or incurring and:

- Evaluate whether the hedge program appears to result in hedges that are appropriate for the insurer based on its assets, liabilities and cash flow risks, and are consistent with the insurer's overall strategy.
- Note anything unusual or any variances from the insurer's current hedging program description.
- Determine whether the insurer appears to be adhering to the description of the hedge program.
- For significant derivative instruments that are open at year-end, analysts should consider requesting and reviewing:
  - aA description of the methodology used by the insurer to verify the continued effectiveness of the hedge provided,
  - a A description of the methodology to determine the fair value of the derivative instrument, and
  - Aa description of the determination of the derivative instrument's book/adjusted carrying value, to determine whether the requirements of the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) have been met. Analysts might also
- cConsider having the insurer's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.

- If concerns related to the investment strategy or portfolio are identified, consider requesting and reviewing a preliminary portfolio analysis from the NAIC's Capital Markets Bureau.

Reinsurance Strategy

Adequaqcy of the Reinsurance Strategy

Reinsurance Cost and Availability

PROCEDURE #7 relates to the reinsurance levels maintained by tDetermine whether the insurer has established and maintained whether they are adequateappropriate levels of reinsurance to support the insurer's business plan and strategy., in consideration of its capital and surplus position and risk exposure. As risks related to reinsurance strategy may vary somewhat according to business type, the procedures in this area include both considerations applicable to all business types and those specifically associated with Property/Casualty (P/C), Life and Health business.

In general, to assess the adequacy of the reinsurance program in place, analysts should evaluate the insurer's leverage position (on both a gross and net basis), as well as identify risk concentrations that could expose the insurer to significant loss events. An in-depth understanding of the insurer's lines of business and business strategy is most likely to result in the identification of risk concentrations, and a number of tools and reports can be beneficial in supporting and supplementing that understanding. Many of the most relevant tools and metrics are highlighted in the procedure, such as Schedule T premium data, risk-based capital (RBC) RCAT disclosures, disclosures in the Annual Financial Statement and various tool results and ratios (e.g., Largest Net Amount Insured in a One Risk to Surplus). In addition, information provided in ORSA reporting and rating agency reports (i.e., A.M. Best Supplemental Ratings Questionnaire – Reinsurance Section) may provide additional information on risk concentrations and exposures.

If concerns related to the insurer's leverage position and significant risk concentrations/exposures are identified, analysts should evaluate the adequacy of the insurer's reinsurance program to mitigate those exposures. In so doing, analysts should use information in the Annual Financial Statement and other available information (e.g., actuarial opinion, Management's Discussion and Analysis (MD&A), Form B, business plan, reinsurance contracts filed with the department, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy, including adequate protection for large losses. After reviewing information on reinsurance included in the business plan and the various regulatory filings available, analysts should request and review additional information as necessary to gain an adequate understanding of the

insurer's reinsurance strategy and program structure. In so doing, analysts should evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, reinstatement provisions, or use of non-traditional reinsurance etc.) on the insurer's business plan and strategy.

In addition to considerations regarding the insurer's current reinsurance program and its adequacy, analysts may want to evaluate the longer-term sustainability of the insurer's reinsurance strategy. This is particularly true for entities that are subject to significant catastrophic risk exposures with the potential to be impacted by climate change. The analyst may find information provided in the NAIC's Climate Risk Disclosure Survey, ORSA Summary Reports, and/or U.S. Securities and Exchange Commission (SEC) 10-K and 10-Q filings valuable in identifying and assessing risks in this area.

Procedures/Data – P/C

- Leverage ratios
  - Gross premium written to surplus [IRIS #1]
  - Net premium written (NPW) to surplus [IRIS #2]
- Net retention
- Gross premium written (liability lines) to surplus
- Net premium written (liability lines) to surplus
- NPW (long-tail) to total NPW
- Change in NPW (long-tail) to total NPW from prior year
- Largest net amount insured in any one risk (excluding WC) to surplus
- Ceded loss ratio

Additional Review Considerations – P/C

- If the insurer or insurance group is subject to ORSA requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk and Solvency Assessment (ORSA) of the Handbook. Document any concerns and conclusions reached regarding the insurer's reinsurance strategy and program structure.
- Obtain a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section to identify any risks or concerns.
- Review and compare the insurer's ceded loss ratio to its overall loss ratio to evaluate the effectiveness and sufficiency of reinsurance coverage.
- Briefly scan the individual reinsurers and related financial data provided in the Annual Financial Statement and:
  - Identify any significant changes in the primary reinsurers during the year compared to the prior year.
  - Determine if there are any significant new reinsurers known to engage in financial reinsurance or surplus relief transactions that may trigger concerns as to transfer of risk with respect to this specific insurer.
  - Determine if there are specific situations noted or overall trends that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies.
  - Determine if there are any unusual items noted, such as significant amounts of reinsurance with alien reinsurers.
  - If concerns are identified, contact the company to discuss and evaluate the effect on the company's business plan and strategy.
- After reviewing information on reinsurance included in the business plan and the various regulatory filings available to analysts, request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. Evaluate the impact of any

significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, etc.) on the insurer's business plan and strategy.

- Review the Annual Financial Statement and other available information (e.g., actuarial opinion, Management's Discussion and Analysis (MD&A), Form B, business plan, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy, including adequate protection for large losses.
- Request the Department Actuary review the available information regarding the reinsurance program to identify any concerns.
- Consider the following specific procedures related to the Annual Financial Statement, General Interrogatories, Part 2:
  - Determine whether any concerns exist regarding the provision the company has made to protect itself from any excessive loss in the event of a catastrophe under a workers' compensation contract issued without limit of loss. [General Interrogatory #6.1].
  - Determine whether any concerns exist regarding the provision the company has made to protect itself from an excessive loss arising from the types and concentrations of insured exposures composing its probable maximum property insurance loss. [General Interrogatory #6.3].
  - Determine whether any reinsurance contract considered in the calculation of the largest net aggregate risk amount include an aggregate limit of recovery without also including a reinstatement provision. [General Interrogatory #13.2].
  - Ascertain whether the number of reinsurance contracts considered in the calculation of the largest net aggregate risk amount are cause for concern. [General Interrogatory #13.3].
- Review the insurer's gross and net writings leverage positions to assist in evaluating the adequacy of the insurer's reinsurance strategy. Consider the following specific procedures in this area:
  - Compare the gross writings leverage ratio and the net premium written to surplus ratio to the industry averages to determine any significant deviations from the industry averages.
  - If the insurer is a member of an affiliated group of insurers, compute the gross premium written to surplus ratio and the net premium written to surplus ratio on a consolidated basis to determine if the affiliated group of insurers appears to be excessively leveraged.
  - Obtain an explanation from the insurer for unusual results for P/C IRIS ratios #1 and #2.
- Review, for each line of business included in the Annual Financial Statement, Schedule P, the trends in accident year loss ratios, on both a gross and net basis, for indications of deteriorating underwriting results that may warrant reinsurance consideration.
- Review the Annual Financial Statement, Schedule T and determine whether there appears to be large geographic concentrations of premiums in areas especially prone to catastrophic events. If so, consider requesting and reviewing information from the insurer regarding its catastrophic reinsurance coverage to evaluate its sufficiency.
- Review information provided by the insurer in the RCAT (PR027) section of its risk-based capital (RBC) filing to identify and assess the insurer's current exposure to catastrophic events at modeled worst year in 50, 100, 250, and 500 levels on both a gross (direct and assumed) and net basis (after reinsurance). Evaluate the adequacy of the company's catastrophic reinsurance coverage at various modeled loss levels, including the potential impact on capital and surplus and RBC position.
- Review information provided in the insurer's response to the NAIC's Climate Risk and Disclosure Survey (if available) on its exposure to physical losses impacted by climate change, as well as its potential impact on reinsurance decision-making.
  - Determine whether any of the company's responses require further investigation and inquiry.
- Review relevant information provided in the Own Risk and Solvency Assessment (ORSA) Summary Report and/or U.S. Securities and Exchange Commission (SEC) 10-K or 10-Q filings (if available) discussing the insurer's exposure to physical losses impacted by climate change, as well as its potential impact on reinsurance decision making.

- Utilize the information gathered and/or request additional information as necessary to evaluate and assess the adequacy of the insurer's catastrophic reinsurance coverage to limit its exposure to large loss events and/or the attritional costs of multiple smaller events.
    - Gain an understanding of and evaluate the company's process to incorporate catastrophe modeling results into its reinsurance decision-making processes (e.g., retention levels, coverage limits, exclusions, reinstatement provisions, or use of nontraditional reinsurance).
    - Gain an understanding of and evaluate the potential impact of climate change on the company's reinsurance decision-making processes.

Procedures/Data – Life, A&H

- Leverage ratios:
    - A&H: Gross A&H premium written to capital and surplus
    - A&H: Net A&H premium to capital and surplus
- Net retention
- Ceded loss ratio

Additional Review Considerations – Life, A&H

- If the insurer or insurance group is subject to ORSA requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk and Solvency Assessment (ORSA) of the Handbook. Document any concerns and conclusions reached regarding the insurer's reinsurance strategy and program structure.
- Obtain a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section to identify any risks or concerns.
- Review and compare the insurer's ceded loss ratio to its overall loss ratio to evaluate the effectiveness and sufficiency of reinsurance coverage.
- Briefly scan the individual reinsurers and related financial data provided in the Annual Financial Statement and:
    - Identify any significant changes in the primary reinsurers during the year compared to the prior year.
    - Determine if there are any significant new reinsurers known to engage in financial reinsurance or surplus relief transactions that may trigger concerns as to transfer of risk with respect to this specific insurer.
    - Determine if there are specific situations noted or overall trends that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies.
    - Determine if there are any unusual items noted, such as significant amounts of reinsurance with alien reinsurers.
    - If concerns are identified, contact the company to discuss and evaluate the effect on the company's business plan and strategy.
- After reviewing information on reinsurance included in the business plan and the various regulatory filings available to analysts, request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. Evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, etc.) on the insurer's business plan and strategy.
- Review the Annual Financial Statement and other available information (e.g., actuarial opinion, Management's Discussion and Analysis (MD&A), Form B, business plan, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy, including adequate protection for large losses.
    - Request the Department Actuary review the available information regarding the reinsurance program to identify any concerns.

  - Consider the insurer's surplus level and leverage position in evaluating the adequacy of reinsurance.
- Review, for each line of business included in the Annual Financial Statement, Analysis of Operations by Lines of Business, the trends in loss ratios for indications of deteriorating underwriting results that may warrant reinsurance consideration.

Procedures/Data - Health

- Leverage ratios:
  - Premium & risk revenue to capital and surplus
- Net retention
- Ceded loss ratio
- Ascertain whether the insurer reported they do not have stop-loss reinsurance as indicated on General Interrogatories, Part 2, #5.1 and #5.2 of the annual financial Statement

Additional Review Considerations – Health

- If the insurer or insurance group is subject to ORSA requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk and Solvency Assessment (ORSA) of the Handbook. Document any concerns and conclusions reached regarding the insurer's reinsurance strategy and program structure.
- Obtain a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section to identify any risks or concerns.
- Review and compare the insurer's ceded loss ratio to its overall loss ratio to evaluate the effectiveness and sufficiency of reinsurance coverage.
- Briefly scan the individual reinsurers and related financial data provided in the Annual Financial Statement and:
  - Identify any significant changes in the primary reinsurers during the year compared to the prior year.
  - Determine if there are any significant new reinsurers known to engage in financial reinsurance or surplus relief transactions that may trigger concerns as to transfer of risk with respect to this specific insurer.
  - Determine if there are specific situations noted or overall trends that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies.
  - Determine if there are any unusual items noted, such as significant amounts of reinsurance with alien reinsurers.
  - If concerns are identified, contact the company to discuss and evaluate the effect on the company's business plan and strategy.
- After reviewing information on reinsurance included in the business plan and the various regulatory filings available to analysts, request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. Evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, etc.) on the insurer's business plan and strategy.
- Review the Annual Financial Statement and other available information (e.g., actuarial opinion, Management's Discussion and Analysis (MD&A), Form B, business plan, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy, including adequate protection for large losses.
  - Request the Department Actuary review the available information regarding the reinsurance program to identify any concerns.
  - If the insurer reported that they do not have stop-loss reinsurance, review the insurer's maximum retained risk in Annual Financial Statement, General Interrogatories, Part 2, #5.3. Determine whether any concerns exist regarding the health entity's level of maximum retained risk.

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- Review, for each line of business included in the Annual Financial Statement, Analysis of Operations by Lines of Business, the trends in loss ratios for indications of deteriorating underwriting results that may warrant reinsurance consideration.

Affiliated Reinsurance Concerns

~~***PROCEDURE #8*** asks analysts to d~~Determine how changes in affiliate relationships may affect the insurer's business plans and strategy. This procedure focuses largely on affiliate reinsurance relationships and transactions (both ceded and assumed) and their impact on business strategy. As risks related to affiliated reinsurance may vary somewhat according to business type,~~ the procedures in ~~ this area include both considerations applicable to all business types and those specifically associated with P/C, Life and Health business. Reinsurance transactions and relationships with affiliates may fail to transfer risk, contain inequitable or unprofitable provisions and/or mask true financial performance. ~~These procedures are generally included to provide information to analysts on new reinsurance transactions with affiliates or significant shifts in the results of ongoing affiliated reinsurance arrangements.~~

It is important to note that a group of affiliated insurance companies may use reinsurance as a mechanism to diversify the portfolios of individual companies and to allocate premiums, assets, liabilities, and surplus among affiliates. Intercompany pooling, where each company reinsures a fixed proportion of business written by pool members, is a standard practice among companies under common management. From an economic standpoint, reinsurance transactions between affiliated insurance companies do not reduce risk for the group but instead shift risk among affiliates. Reinsurance between affiliated companies presents opportunities for manipulation and potential abuse. In a group of affiliated insurers, intercompany reinsurance may serve to obscure one insurer's financial condition by shifting loss reserves from one affiliate to another or improperly supporting or subsidizing one affiliate at the expense of another.

As the placement of risks within a group due can have a drastic effect on an insurer's strategy, analysts should identify and assess risks in this area. In addition, as affiliated reinsurance contracts are typically subject to department review and approval, significant concerns over risk concentrations and/or the reasonableness/equity of terms in significant affiliated reinsurance contracts should be identified and addressed with the insurer as necessary. Such discussions may occur during both the initial department review of the contract (Form D filing) and/or on an ongoing basis as necessary, as the results of affiliated reinsurance arrangements indicate a need to reassess the reasonableness of contracts.

Procedures/Data – P/C

- Premiums assumed from affiliates to gross premiums ratio
    - Change from prior year
    - Change over past five years
- Premiums ceded to affiliates to gross premiums ratio
    - Change from prior year
    - Change over past five years
- Total reinsurance recoverables from affiliates to surplus ratio
    - Change from prior year
    - Change over past five years

Additional Review Considerations – P/C

- Obtain and review the underlying agreements that support the transaction(s) in question. Critically assess the substance of the transaction in terms of the following criteria:
    - The transaction must be economic-based and at arm's length

- The transaction must result in transfer of risk and represent a consummated or permanent act
- Any assets transferred to an affiliate must be transferred at fair value in an economic-based transaction
- In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approval

- Determine whether there are any changes in intercompany pooling agreements during the year. [Annual Financial Statement, Notes to Financial Statements, Note #10 and Note #26]
- Determine whether there are any premium portfolio transfers involving affiliates. [Annual Financial Statement, Schedule F – Part 2]

Procedures/Data – Life, A&H

- Premiums assumed from affiliates to gross premiums ratio
  - Change from prior year
  - Change over past five years
- Premiums ceded to affiliates to gross premiums ratio
  - Change from prior year
  - Change over past five years
- Total reinsurance recoverables from affiliates to capital and surplus ratio
  - Change from prior year
  - Change over past five years

Additional Review Considerations– Life, A&H

- Obtain and review the underlying agreements that support the transaction(s) in question. Critically assess the substance of the transaction in terms of the following criteria:
  - The transaction must be economic-based and at arm's length
  - The transaction must result in transfer of risk and represent a consummated or permanent act
  - Any assets transferred to an affiliate must be transferred at fair value in an economic-based transaction
  - In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approval
- Ascertain whether any of the reinsurers, listed in Annual Financial Statement, Schedule S as non-affiliated, are owned in excess of 10% or controlled, either directly or indirectly, by the insurer or any representative, officer, trustee, or director of the insurer [Annual Financial Statement, Notes to Financial Statement, Note #23, Schedule S – Part 3 – Section 1]. If yes, review Annual Financial Statement, Schedule S – Part 2 and Schedule S – Part 3 – Section 2 to determine if any unusual items are noted regarding the nature or magnitude of these non-affiliated relationships.
- Determine whether any policies issued by the insurer have been reinsured with an alien insurer owned or controlled, directly or indirectly, by the insured, a beneficiary, a creditor of the insured, or any other person not primarily engaged in the insurance business [Annual Financial Statement, Notes to Financial Statements, Note #23, Schedule S – Part 3 – Section 1].

Procedures/Data – Health

- Premiums assumed from affiliates to gross premiums [Health]
  - Change from prior year
  - Change over past five years
- Premiums ceded to affiliates to gross premiums [Health]
  - Change from prior year
  - Change over past five years
- Total reinsurance recoverables from affiliates to surplus [Health]
  - Change from prior year

- Change over past five years

Additional Review Considerations - Health

- Obtain and review the underlying agreements that support the transaction(s) in question. Critically assess the substance of the transaction in terms of the following criteria:
  - The transaction must be economic-based and at arm's length
  - The transaction must result in transfer of risk and represent a consummated or permanent act
  - Any assets transferred to an affiliate must be transferred at fair value in an economic-based transaction
  - In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approval

Concerns with Reinsurance Contracts

PROCEDURE #9 asks analysts to dDetermine how any significant or unusual third-party reinsurance transactions, including loss portfolio transfers and commutations, as well as relationships with reinsurance intermediaries may affect the insurer's business plan and strategy. As risks related to unusual reinsurance transactions may vary somewhat according to business type, the procedures in this area includes both considerations applicable to all business types and those specifically associated with P/C, Life and Health business. The insurer may participate in significant third-party reinsurance contracts that distort its surplus position, mask true financial performance, or raise questions related to risk-transfer and ongoing obligations.

Various metrics are provided in procedures #9a – #9j for P/C, Life and Health to assist analysts in identifying risks related to large or unusual reinsurance transactions or reinsurance arrangements that may require additional review and scrutiny.

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PROCEDURES #9R AND #9T (ALL BUSINESS TYPES), as well as many of the procedures from #9k – #9q and #9y – #9bb (P/C-specific), are directed at i**Risk Transfer:** Identifying and assessing 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.

Types of Reinsurance: Analysts should be particularly alert to certain types of unusual reinsurance transactions where risk transfer issues may be more prevalent and/or where the transaction involves the transfer of a large block of business, such as bulk reinsurance (Life/Health), assumption reinsurance (Life/Health), surplus relief transactions (all business types), commutations (P/C) and loss portfolio transfers (P/C).

Bulk reinsurance (Life/Health) is when an insurer cedes all or part of a block of insurance business. Such bulk cessions may or may not be in the ordinary course of business and may or may not require prior regulatory approval. Under an indemnity reinsurance arrangement, the ceding insurer remains liable to the policyholders

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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, statutory accounting principles do not allow a credit to surplus until the risk has been transferred.

Assumption reinsurance agreements (Life/Health) occur when the insurer transfers, with the consent of the policyholder, responsibility for policyholder obligations to another insurer. These types of transactions are of concern to the policyholder, particularly where the assuming company has a weaker financial position than the ceding insurer. They may also indicate financial difficulties of the ceding insurer and may be motivated by pressure to generate surplus.

A commutation (P/C) is a transaction that results in the complete and final settlement and discharge of all present and future obligations between parties to a reinsurance agreement. With regard to commutation agreements, the present value of the reinsurer's estimated ultimate losses is paid by the reinsurer to the ceding insurer. The ceding insurer immediately establishes the ultimate loss reserve liability, and the cash received as a negative paid loss, thus creating a reduction in surplus equal to the difference between the ultimate and present value of the loss reserve. The reasons for commutations differ from insurer to insurer, however, some of the key reasons include:

- Exit of Business**:** The cedant may strategically exit a specific line of business or the reinsurer may withdraw from the reinsurance marketplace.
- Perceived Financial Instability: The cedant or reinsurer may have concerns regarding the other party's solvency. Commutation in this case would reduce credit risk, provide immediate cash infusions to cedant and/or allow the reinsurer to avoid future issues with the assigned liquidator.
- Disputes: The cedant and reinsurer may have significantly different evaluations of ultimate loss costs, claims resolution, or contract provisions and would prefer a single negotiation over commutation than continued disputes over issues.
- Underwriting Risk: The reinsurer may wish to eliminate underwriting and pricing risks relating to the cedants underwriting practices. Or, the reinsurer may determine that the price of the commutation is less than carried reserves and the commutation improves the reinsurer's underwriting results.

Commutations require a thorough financial and actuarial review of the business being commuted. The cedant will need to have a clear understanding of the book of business to ensure that it receives adequate settlement from the reinsurer to pay all future claims and expenses and not lose the original value of the reinsurance and commutation agreements.

A loss portfolio transfer (P/C), or LPT, is an agreement that is applied retroactively, in which the ceding company transfers a portfolio of losses (i.e., loss reserves) to another company along with consideration for assuming such loss reserves. LPTs are complicated transactions, and it is often difficult to distinguish between those that provide indemnification through transfer of risk and those that are merely financing arrangements. LPT agreements are normally executed because it is the objective of the ceding company to record, as a credit to surplus, the difference between the loss reserves transferred and the consideration paid. However, statutory accounting practices do not allow such a credit to surplus until the risk has been transferred and the liability of the ceding company has been terminated.

Additional procedures assist analysts in evaluating the significant or unusual reinsurance transactions identified. Analysts should analyze these types of transactions closely to determine whether a transfer of risk has been consummated. Even when transfer of risk has been consummated, analysts should evaluate the impact of the transaction on future financial performance of the insurer.

Reinsurance Intermediaries:*PROCEDURES #9U, #9V AND #9W (ALL BUSINESS TYPES),* relate to Determine whether any significant and/or unusual reinsurance intermediary or reinsurance assumed agreements exist. While some major professional reinsurers are direct marketers, intermediaries (e.g., brokers, managers, or managing general agents) may arrange reinsurance agreements between a ceding company and a reinsurer in exchange for commissions or fees. A reinsurance broker negotiates agreements for a ceding company but does not have the authority to bind the insurer to a reinsurance agreement. On the other hand, a reinsurance manager acts as the agent for a reinsurer and has the authority to bind a reinsurer to an agreement. Finally, a managing general agent may have authority both to underwrite primary insurance and to bind reinsurance agreements on that business for the ceding company. An intermediary has an incentive to place reinsurance with sound reinsurers when its commission is tied to the success of the business being reinsured. However, when commissions are based on volume of business, reinsurance placed through an intermediary may be subject to conflicts of interest and potential abuse. To generate more income, a managing general agent may cede business to reinsurers who later are unable or unwilling to pay losses, or a reinsurance manager may assume poor, underpriced risks. The intermediary bears no financial risk in the event of underpriced or poor underwriting or placement with a troubled reinsurer. But poor performance by an intermediary can affect both ceding companies and reinsurers.

PROCEDURE #9X (ALL BUSINESS TYPES) assists analysts in d**Reinsurance Fronting**: Determineing 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.

P/C Reinsurance

Procedures/Data – P/C

- Surplus aid to policyholders' surplus [IRIS #4]
- Ratio of assumed premiums written from non-affiliates to total gross premiums written
- Assumed loss ratio compared to gross loss ratio where the assumed premiums written are materials to gross premiums written
- Ratio of ceded premiums written to gross premiums written for any significant line of business, defined as a line of business where gross premium is material to total gross premium written
- Ceded commissions to ceded premiums written as percentage of expense ratio
- Determine whether the company reinsured any risk under a quota share reinsurance contract that would limit the reinsurers' losses below the stated quota share percentage. [Annual Financial Statement, General Interrogatories, Part 2, #7.1]
- Determine whether the reporting entity ceded any risk under any reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which, during the period covered by the statement: (1) it recorded a positive or negative underwriting result greater than 5% of current year-end surplus as regards to policyholders, or it reported calendar-year written premium ceded or year-end loss and loss expense reserves ceded greater than 5% of current year-end surplus as regards policyholders, (2) it accounted for the contract as reinsurance and not as a deposit, and (3) the contract(s) contain(s) one or more of the following [Annual Financial Statement, General Interrogatories, Part 2, #9.1]:
  - A contract term longer than two years, and the contract is non-cancelable by the reporting entity during the contract term;
  - A limited or conditional cancellation provision under which cancellation triggers an obligation by the reporting entity, or an affiliate of the reporting entity, to enter into a new reinsurance contract with the reinsurer, or an affiliate of the reinsurer;
  - Aggregate stop loss reinsurance coverage;
  - An unconditional or unilateral right by either party (or both parties) to commute the reinsurance contract, whether conditional or not, except for such provisions which are only triggered by a decline in the credit status of the other party;
  - A provision permitting reporting of losses, or payment of losses, less frequently than on a quarterly basis (unless there is no activity during the period); or
  - Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.
- Determine whether the reporting entity, during the period covered by the statement, ceded any risk under a reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which it recorded a positive or negative underwriting result greater than 5% of prior year-end surplus as regards policyholders, or for which it reported calendar-year written premium ceded or year-end loss and loss expense reserves ceded greater than 5% of prior year-end surplus as regards policyholders, excluding cessions to approved pooling arrangements or to captive insurance companies that are directly or indirectly controlling, controlled by, or under common control with (1) one or more unaffiliated policyholders of the reporting entity, or (2) an association of which one or more unaffiliated policyholders of the reporting entity is a member where [Annual Financial Statement, General Interrogatories, Part 2, #9.2]:
  - The written premium ceded to the reinsurer by the reporting entity or its affiliates represents 50% or more of the entire direct and assumed premium written by the reinsurer based on its most recently available financial statement; or
  - 25% or more of the written premium ceded to the reinsurer has been retroceded back to the reporting entity or its affiliates in a separate reinsurance contract.
- Except for transactions meeting the requirements of paragraph 36 of SSAP No. 62R, Property and Casualty Reinsurance, determine whether the reporting entity ceded any risk under a reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement and either accounted for that contract as reinsurance (either prospective or retroactive) under statutory accounting principles (SAP) and as a deposit under generally accepted accounting principles

(GAAP), or accounted for that contract as reinsurance under GAAP and as a deposit under SAP. [Annual Financial Statement, General Interrogatories, Part 2, #9.4]
- Ascertain whether there were any agreements to release reinsurers from liability during the year. If yes, explain. [Annual Financial Statement, General Interrogatories, Part 2, #8.1]
- If the insurer assumed risks from another company during the period covered by the financial statement, determine whether the company failed to establish a reserve equal to that which the original company would have been required to establish had it retained the risks. If yes, provide an explanation. [Annual Financial Statement, General Interrogatories, Part 2, #10]
- Ascertain whether the insurer guaranteed any policies issued by another company and determine how many are now in force. If yes, provide an explanation. [Annual Financial Statement, General Interrogatories, Part 2, #11.1]

Additional Review Considerations – P/C
- Review the Annual Financial Statement, including the reinsurance schedules and related footnotes, as well as other regulatory filings (e.g., actuarial opinion, MD&A, Form B, etc.) to determine whether any significant and/or unusual reinsurance transactions were completed during the year. Such transactions may include portfolio transfer transactions; commutation agreements; surplus relief or financial reinsurance; bulk or assumption reinsurance; or material non-renewal, cancellation or revisions of ceded reinsurance agreements or changes in the primary reinsurers.
  - Did the insurer enter into any assumption reinsurance agreements whereby the responsibility for the insurer's policyholder obligations passes to an assuming insurer?
  - Are there any concerns expressed in the actuarial opinion relating to surplus relief reinsurance, loss portfolio transfers or financial reinsurance, etc.?
- If concerns exist relating to significant and/or unusual reinsurance transactions, consider the following additional procedures:
  - Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief or financial reinsurance agreements.
  - Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements.
  - Determine whether transfer of risk criteria have been met.
  - Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly "mirrored"
  - Determine whether proper policyholder consents received before the assumption reinsurance transfer was consummated.
  - Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.
- Determine whether the insurer reported during the year, in accordance with the *NAIC Disclosure of Material Transactions Model Act* (#285), any material non-renewals, cancellations, or revisions of ceded reinsurance agreements.
  - If yes, obtain and review supporting documentation of such material transactions.
  - Determine if, in the analyst's opinion, additional procedures are considered necessary.
- Obtain and review underlying documents relating to the use of the reinsurance intermediary or reinsurance assumed. Determine whether agreements are at arm's length and have economic substance.
- Determine whether the requirements of the *NAIC Reinsurance Intermediary Model Act* (#790) have been met. If not, list the requirements that the insurer has not met.
- Determine whether the requirements of the *NAIC Managing General Agents Act* (#225) have been met. If not, draft a list of the requirements that the insurer has not met.
- If the insurer is engaged in reinsurance for fronting purposes:

   - Determine whether the requirements of the state's statutes and regulations regarding fronting disclosure have been met.
   - Review the types of reinsurance being used and the specific products involved.
   - Perform procedures to evaluate collectability (see Credit Risk)
- Ascertain whether there were any portfolio transfer transactions consummated that, individually or in the aggregate, resulted in an increase in surplus greater than 5%.
- Review the Annual Financial Statement, Notes to Financial Statements, Note #23E:
   - Determine whether there were any commutation agreements consummated that, individually or in the aggregate, resulted in a significant change in surplus (+/-5%).
   - Determine whether there is a trend of annual commutations and if a trend is identified, obtain a detailed rationale for the transactions.
   - If annual trending of commutations is noted, determine any favorable/unfavorable financial impact on the insurer.
- Review the Annual Financial Statement, Schedule F, Part 3, Note A (footnote disclosure of the five highest commission rates relating to reinsurance treaties). Determine whether any of the commission rates are greater than 40%.
- If the insurer utilizes financial reinsurance:
   - Review a summary of the reinsurance contract terms.
   - Review the discussion of management's principal objectives for entering into the reinsurance contract, as well as the economic purpose achieved.
   - Review the aggregate financial impact gross of all ceded reinsurance contracts on the balance sheet and statement of income.
   - Determine whether the reinsurance contract has been accounted for properly, and note any special accounting treatment, including any difference in treatment between GAAP and SAP.

Life/A&H Reinsurance

Procedures/Data – Life/A&H

- Surplus relief of >10% [IRIS #8].
- Ratio of total assumed premiums written to gross premiums.
- Ratio of total assumed premiums written to gross premiums written for any significant line of business, defined as a line of business where gross premium is material to total gross premium written.
- Ratio of assumed premiums written from non-affiliates to total gross premiums written.
- Determine whether any agent, general agent, or broker control a substantial part of new or renewal business. [Annual Financial Statement, General Interrogatories, Part 1, #4.11 and #4.12].
- Ratio of ceded premiums written to gross premiums written for any significant line of business, where a line of business's gross premium is material of total gross premium written.

Additional Review Considerations – Life/A&H

- Review the Annual Financial Statement, including the reinsurance schedules and related footnotes, as well as other regulatory filings (e.g., actuarial opinion, MD&A, Form B, etc.) to determine whether any significant and/or unusual reinsurance transactions were completed during the year. Such transactions may include portfolio transfer transactions; commutation agreements; surplus relief or financial reinsurance; bulk or assumption reinsurance; or material non-renewal, cancellation or revisions of ceded reinsurance agreements or changes in the primary reinsurers.
   - Determine whether the insurer entered into any assumption reinsurance agreements whereby the responsibility for the insurer's policyholder obligations passes to an assuming insurer.
   - Ascertain whether there are any concerns expressed in the actuarial opinion relating to surplus relief reinsurance, loss portfolio transfers or financial reinsurance, etc.

- If concerns exist relating to significant and/or unusual reinsurance transactions, consider the following additional procedures:
  - Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief or financial reinsurance agreements.
  - Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements.
  - Determine whether transfer of risk criteria have been met.
  - Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly "mirrored"
  - Determine whether proper policyholder consents received before the assumption reinsurance transfer was consummated.
  - Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.
- Determine whether the insurer reported during the year, in accordance with the *NAIC Disclosure of Material Transactions Model Act* (#285), any material non-renewals, cancellations, or revisions of ceded reinsurance agreements.
  - If yes, obtain and review supporting documentation of such material transactions.
  - Determine if, in the analyst's opinion, additional procedures are considered necessary.
- Obtain and review underlying documents relating to the use of the reinsurance intermediary or reinsurance assumed. Determine whether agreements are at arm's length and have economic substance.
- Determine whether the requirements of the *NAIC Reinsurance Intermediary Model Act* (#790) have been met. If not, list the requirements that the insurer has not met.
- Determine whether the requirements of the *NAIC Managing General Agents Act* (#225) have been met. If not, draft a list of the requirements that the insurer has not met.
- If the insurer is engaged in reinsurance for fronting purposes:
  - Determine whether the requirements of the state's statutes and regulations regarding fronting disclosure have been met.
  - Review the types of reinsurance being used and the specific products involved.
  - Perform procedures to evaluate collectability (see Credit Risk)

Life Principles Based Reserving: While state insurance departments have enacted principals-based reserving laws that are effective Jan. 1, 2020, some life insurers continue to establish reinsurance agreements to cede longevity risks (e.g., fixed annuities with guaranteed lifetime withdrawal benefits (GLWBs) and other products such as variable annuities and long-term care insurance to non-U.S. affiliates or U.S. captive insurance companies. State insurance regulators should review this reinsurance activity through the Form D approval process, if affiliated, and through the annual solvency analysis process when new transactions are identified in the annual statement. A potential area of concern would be if such transactions result in an unlevel playing field between insurers, or if the state insurance regulator regime of the captive's jurisdiction results in reduced policyholder protection and regulatory arbitrage. Specifically,

- Where a captive affiliate is domiciled in an international jurisdiction, the regulatory regime of that jurisdiction may not have the same conservatism as the U.S. statutory framework. For example, it may not require asset adequacy analysis which may create material differences in reserves, or it may not require capital charges for longevity risk.
- With regard to appropriate documentation of the agreement, some ceding insurers may not fully document their assessment of the reinsurance within the Actuarial Opinion and Memorandum (i.e., gross reserve cash flow testing) or require a true-up of the reserve credit.

- If transactions are not at arms-length, it may result in questionable invested assets and activities within funds withheld/modified coinsurance (MODCO) trust agreements. For example, assets in the trust agreement may include non-investment grade assets, mortgage loans, complex and non-rated BA assets, securities lending, etc., which may also indirectly impact the ceding insurer's RBC calculation.

Additional Review Considerations

- If the insurer cedes gross premium to captive (non-traditional) reinsurers, utilize the information in Form D for affiliated captive transactions and other annual reporting i.e. annual statement, actuarial reporting, and if necessary, ask the company, to gain an understanding of the purpose of the use of captive (non-traditional) reinsurance to better assess the insurer's overall reinsurance strategy.

Health Reinsurance

Procedures/Data – Health

- Ratio of ceded premiums written to gross premiums written

Additional Review Considerations - Health

- Review the Annual Financial Statement, including the reinsurance schedules and related footnotes, as well as other regulatory filings (e.g., actuarial opinion, MD&A, Form B, etc.) to determine whether any significant and/or unusual reinsurance transactions were completed during the year. Such transactions may include portfolio transfer transactions; commutation agreements; surplus relief or financial reinsurance; bulk or assumption reinsurance; or material non-renewal, cancellation or revisions of ceded reinsurance agreements or changes in the primary reinsurers.
    - Determine whether the insurer entered into any assumption reinsurance agreements whereby the responsibility for the insurer's policyholder obligations passes to an assuming insurer.
    - Ascertain whether there are any concerns expressed in the actuarial opinion relating to surplus relief reinsurance, loss portfolio transfers or financial reinsurance, etc.
- If concerns exist relating to significant and/or unusual reinsurance transactions, consider the following additional procedures:
    - Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief or financial reinsurance agreements.
    - Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements.
    - Determine whether transfer of risk criteria have been met.
    - Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly "mirrored"
    - Determine whether proper policyholder consents received before the assumption reinsurance transfer was consummated.
    - Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.
- Determine whether the insurer reported during the year, in accordance with the *NAIC Disclosure of Material Transactions Model Act* (#285), any material non-renewals, cancellations, or revisions of ceded reinsurance agreements.
    - If yes, obtain and review supporting documentation of such material transactions.
    - Determine if, in the analyst's opinion, additional procedures are considered necessary.
- Obtain and review underlying documents relating to the use of the reinsurance intermediary or reinsurance assumed. Determine whether agreements are at arm's length and have economic substance.

- Determine whether the requirements of the *NAIC Reinsurance Intermediary Model Act* (#790) have been met. If not, list the requirements that the insurer has not met.
- Determine whether the requirements of the *NAIC Managing General Agents Act* (#225) have been met. If not, draft a list of the requirements that the insurer has not met.
- If the insurer is engaged in reinsurance for fronting purposes:
    - Determine whether the requirements of the state's statutes and regulations regarding fronting disclosure have been met.
    - Review the types of reinsurance being used and the specific products involved.
    - Perform procedures to evaluate collectability (see Credit Risk)

~~***PROCEDURE 9cc.***~~

~~**Capital Adequacy**~~

Capital Adequacy Management – Concerns with RBC Position

~~***PROCEDURE #10***~~ ~~addresses~~ **Risk-Based Capital:** Evaluate the adequacy of the insurer's risk-based capital (RBC) position in light of its business/strategic plans and risk exposures. The various metrics and considerations outlined under this procedure address the causes of significant changes in the RBC ratio, as well as follow-up procedures that may be necessary to investigate and address the issues identified. Some examples that may cause the RBC ratio to fall into an RBC Action Level include, but are not limited to, increased writings, heightened investment risk, catastrophic loss events, or an unexpected surplus decline. Th~~is~~e~~ procedure~~ also identifies insurers with an RBC ratio below 300% that have recorded significant increases or decreases from the prior year. Additionally, the procedure identifies insurers that have recorded RBC ratio declines over two successive years and a broader trend (e.g., five or more years decline) and the insurer's plans to mitigate. If a downward trend is identified, analysts should review the insurer's projections and document its plan to improve the capital position.

~~***PROCEDURE #10C***~~ ~~assists analysts in **d**~~**Total Adjusted Capital:** Determin~~ing~~e if the change in the insurer's RBC ratio was due to Total Adjusted Capital. Total Adjusted Capital is computed by subtracting the value of any reserving discounts from policyholders' surplus and adjusting for asset valuation reserve (AVR) and half of any dividend liability of the insurer's life insurance affiliates in addition to applying credit for capital notes. ~~Procedure #10d assists analysts in d~~Otherwise, determin~~ing~~e if the change in the insurer's RBC ratio was due to the Authorized Control Level.

~~***PROCEDURE #10E***~~ ~~assists analysts in **d**~~**RBC Trend Test**: Determin~~ing~~e whether the insurer triggered the RBC Trend Test. For P/C insurers, the RBC Trend Test is triggered when an insurer has an RBC ratio between 200% and 300% and a combined ratio greater than 120%. For life insurers, the RBC Trend Test is triggered when an insurer has an RBC ratio between 200% and 250% (or 300%) 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% could be place in a Company Action Level if the state has adopted the RBC trend test. For Health insurers, the RBC Trend test is triggered when a health entity has an RBC ratio that falls below 300% (the Trend Test level) and has a combined ratio greater than 105%.

After considering the reasons for triggering the trend test and their potential impact on the solvency of the insurer, analysts should determine whether the state should place the insurer in RBC Company Action Level to deal with the violation and the underlying issues.~~If the insurer has triggered the trend test, procedure #10j recommends reviewing and documenting the reasons.~~

PROCEDURE #10K directs analysts to obtain a copy of the insurer's RBC plan if the insurer has triggered an RBC Action Event. If applicable in your state, analysts may participate in the review and approval process of the RBC plan. The RBC plan is a comprehensive financial plan that:

1) 1) Identifies the conditions in the insurer that contribute to the Company Action Level event;
2) 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) 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) 4) Identifies the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions;
5) 5) Identifies the quality of and problems associated with the insurer's business including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance in each case, if any.

Analysts reviewing the plan should take the following steps:

- Verify the accuracy of all historical information provided
- Review the plan's assumptions for reasonableness
- Estimate the impact of the proposed corrective actions on financial result, and review the projected experience in the plan for reasonableness
- Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results
- Identify any internal or external problems not considered in the plan that may affect future financial results. Examples of such problems include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company's product designs; or 3) the loss of key marketing personnel.

Analysts should also monitor, on a periodic basis, the insurer's progress in achieving the initiatives included in the RBC plan and the impact of those initiatives on Total Adjusted Capital and the risk factors in the Authorized Control Level RBC. The goal of any RBC plan is the improvement of the underlying causes that led to an RBC Action Level, and an improvement in subsequent RBC ratio results that will remove the insurer from Action Level status.

Procedures/Data
- RBC ratio.
- Significant change in RBC ratio from prior year.
- Change in Total Adjusted Capital from prior year.
- Change in Authorized Control Level from prior year.
- Ascertain whether the RBC trend test has been triggered.
- Determine whether there has been a decrease in RBC over the last two years.

Additional Review Considerations
- If there has been a downward trend in RBC over the last two years, document the cause(s) of the decline. If a broader trend (e.g., five or more years decline) has been noted, document how the insurer plans to mitigate this continued decline.

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- If the insurer reported an increase in Total Adjusted Capital due to special surplus or capital infusions, etc., document the source and plan for continued support.
- Review the RBC risk component(s) and document the underlying causes of any significant changes.
- If the insurer triggered the RBC Trend Test, review and document the reason(s).
- If the insurer has triggered an RBC Action Level event and if authorized by state statute, obtain and review a copy of the insurer's RBC plan and monitor the overall progress.
- Analysts reviewing theIf reviewing an RBC plan should take the following steps:
  - Verify the accuracy of all historical information provided
  - Review the plan's assumptions for reasonableness
  - Estimate the impact of the proposed corrective actions on financial result, and review the projected experience in the plan for reasonableness
  - Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results
  - Identify any internal or external problems not considered in the plan that may affect future financial results. Examples of such problems include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company's product designs; or 3) the loss of key marketing personnel.
- If the insurer has an RBC plan, monitor, on a periodic basis, the insurer's progress in achieving the initiatives included in the RBC plan and the impact of those initiatives on Total Adjusted Capital and the risk factors in the Authorized Control Level RBC.
-

Adequacy of Capital and Surplus

PROCEDURE #11 addresses Evaluate the adequacy of the insurer's overall capital and surplus position in light of its business/strategic plans and risk exposures. The RBC ratio is designed to calculate a minimum threshold of capital and surplus based on each insurer's unique mix of asset risk, credit risk, off-balance sheet risk, business risk, and underwriting (premium and loss) risk. A measure of surplus adequacy that is commonly considered is the ratio of surplus to assets. Gross change in surplus and change in adjusted surplus (P/C IRIS ratio #7 and #8) and net/gross change in capital and surplus (Life IRIS ratio #1 and #2), measure the improvement or deterioration in the insurer's financial condition from the prior year. Even insignificant increases in the change in surplus ratio may indicate instability or mask financial problems attributable to fundamental changes in the insurer.

PROCEDURES #11M is designed to assist analysts in identifying dividend payments or declarations to determine if any necessary approvals were obtained. Other metrics (see #11j, #11k, #11n and #11o) are designed to assist analysts in identifying significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds, as well as other activities during the year related to capital and surplus notes.

Procedures/Data – P/C

- Surplus to assets ratio
  - Compare to industry averages
- Change in adjusted policyholders' surplus [IRIS #8]
- Gross change in policyholders' surplus [IRIS #7]
- Decrease in surplus (capital and surplus) from any of the prior four years
- Unassigned funds
- Capital Notes and Surplus Notes to surplus
- Change in Capital Notes and Surplus Notes from prior year
- Capital/surplus notes to policyholders' surplus
- Change in capital/surplus notes from prior year

- Review footnote (h) in the Annual Financial Statement, Exhibit of Net Investment Income to Determine whether the insurer reported interest expense on capital or surplus notes during the year.
- Note any stockholder dividend payments or declarations
  - Confirm if required approvals were obtained
- Write-ins for special surplus funds or other than surplus funds to surplus
- Absolute value of current year change to current year surplus for any of the following:
  - Net unrealized capital gains/losses
  - Net unrealized Foreign Exch. capital gains/losses
  - Net deferred taxes
  - Non-admitted assets
  - Provision for reinsurance
  - Surplus notes
  - Change in accounting principle

Procedures/Data – Life/A&H

- Capital and surplus to total admitted assets (excluding separate accounts)
- Net change in capital and surplus [IRIS #1]
- Gross change in capital and surplus [IRIS #2]
- Decrease in capital and surplus from any of the prior four years
- Unassigned funds
- Capital Notes and Surplus Notes to capital and surplus
- Change in Capital Notes and Surplus Notes from prior year
- Review footnote (h) in the Annual Financial Statement, Exhibit of Net Investment Income to Determine whether the insurer reported interest expense on capital or surplus notes during the year.
- Note any stockholder dividend payments or declarations
  - Confirm if required approvals were obtained
- Identify stockholder dividend payments or declarations to determine if any necessary approvals were obtained. Also Identify significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds, as well as other activities during the year related to capital and surplus notes.
- Write-ins for special surplus funds or other than surplus funds to surplus
- Absolute value of current year change to current year surplus for any of the following:
  - Net unrealized capital gains/losses
  - Net unrealized Foreign Exch. capital gains/losses
  - Net deferred taxes
  - Non-admitted assets
  - Liability for unauthorized reinsurance
  - Reserve valuation basis
  - AVR
  - Surplus notes
  - Change in accounting principle

Procedures/Data - Health

- Change in capital and surplus
- Decrease in capital and surplus from any of the prior four years
- Unassigned funds
- Capital Notes and Surplus Notes to capital and surplus
- Change in Capital Notes and Surplus Notes from prior year
- Review footnote (h) in the Annual Financial Statement, Exhibit of Net Investment Income to Determine whether the insurer reported interest expense on capital or surplus notes during the year.

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- Note any stockholder dividend payments or declarations
  - Confirm if required approvals were obtained
- Identify stockholder dividend payments or declarations to determine if any necessary approvals were obtained. Also Identify significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds, as well as other activities during the year related to capital and surplus notes.
- Write-ins for special surplus funds or other than surplus funds to surplus
- Absolute value of current year change to current year surplus for any of the following:
  - Net unrealized capital gains/losses
  - Net unrealized Foreign Exch. capital gains/losses
  - Net deferred taxes
  - Non-admitted assets
  - Liability for unauthorized reinsurance
  - Reserve valuation basis
  - Surplus notes
  - Change in accounting principle

Additional Review Considerations – All Statement Types

- If the insurer or insurance group is subject to ORSA requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk Solvency Assessment (ORSA) of the Handbook. Document any concerns or conclusions regarding the insurer's capital modeling and capital position and their effects on the insurer's ability to establish, implement and oversee an effective business strategy.
- Review the Capital and Surplus section in the Financial Profile Report and/or the Capital and Surplus Analysis (roll forward) in the Annual Financial Statement for unusual fluctuations or trends in the changes in surplus between years. Investigate any significant or unexplained items.
- Compare the surplus (capital and surplus) to assets ratio to the industry average to determine any significant deviation.
- If there has been a change in capital or surplus notes compared to the prior year-end, indicate the current and prior year-end balances and the amount of the change. Also, review any notes issued, principal or interest paid, or any other changes that have been made and whether any necessary approvals were obtained.
- If a significant portion of policyholders' surplus (capital and surplus) is made up of capital/surplus notes, consider performing the following additional procedures (as necessary):
  - Review the Annual Financial Statement, Notes to Financial Statements, Note #13 and Note #11 to identify any unusual terms (e.g., interest rate, date of maturity, assets received, conditions, etc.) and evaluate the impact on the insurer's surplus position.
  - Recalculate important ratios, excluding the amount of surplus notes, to determine the effect of surplus notes on the ratio results.
- Review the write-ins for special surplus and for other than special surplus funds for reasonableness.
- Review the detail of unrealized gains or (losses) in Annual Financial Statement, Exhibit of Capital Gains (Losses) for reasonableness.
- If the insurer declared dividends to stockholders during the year, consider the following procedures:
  - Review Annual Financial Statement, Notes to Financial Statements and Extraordinary Dividend approvals to determine what assets were used to pay dividends:
    - Ascertain whether the amount of the dividend was at a level that required regulatory approval.
    - Determine whether the insurer failed to obtain proper regulatory approvals.
    - If the shareholder dividends paid were at a significant amount that required the liquidation of assets to cash, determine whether there were any liquidity concerns noted.

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  - Review the trend of stockholder dividends along with the results of the Holding Company analysis performed by the lead state. Determine whether the insurer has been relied upon for dividend payments to meet holding company business needs.
- Inquire of the insurer:
  - Information on capital/surplus notes and dividends (if not already received)
  - Information on guarantees and other financial obligations
- Ascertain whether the insurer has historically required capital contributions from its parent to offset operating losses or other decreases in capital and surplus.
- If the insurer is subject to ORSA reporting requirements, review information on the insurer's capital/surplus position in the Lead State's evaluation of the ORSA Summary Report.
- If the insurer issued surplus or capital notes, analysts should consider reviewing the information in the Annual Financial Statement, Notes to Financial Statements #11 and Note #13.
- If either were issued or repaid, or if interest was paid during the year, analysts should consider determining that these transactions were approved by the domiciliary state insurance department.
- iIf surplus notes represent a significant portion of surplus, analysts should consider recalculating important ratios, excluding the surplus notes, to determine their effect on the ratio results. Other steps to consider include the review of the detail of unrealized gains (losses), assessment of any parental guarantees in place and the review of other components of surplus.

Concerns with Parental Guarantees and/or Capital Maintenance Agreements

Procedure #11X assists analysts in aAssessinging current and prospective risk related to existing Parental Guarantees and/or Capital Maintenance agreements.

Parental Guarantees and Capital Maintenance Agreements are commitments aimed at providing assurance that the insurer will be able to meet minimum financial obligations if financial or liquidity issues arise. These documents should be carefully reviewed along with the financial background of the entity required to fund the guarantee or agreement. Analysts may also inquire of the insurer if a contingency plan is in place in the event the parental guarantee or capital maintenance agreement is not honored.

Review and assess any parental guarantees, capital maintenance agreements or other commitments in place and determine if concerns exist regarding financial support or failures to act on these commitments. Analysts should thoroughly review the terms related to the agreement to gain a clear understanding of what is covered in the agreement (e.g., limit on lines of business, commitment to pay policyholder claims, commitment to maintain RBC level, etc.) and the impact to the insurer.

Analysts should also consider the following:
- Expected source and form of liquidity should guarantees be called upon.
- If the parental guarantee or capital maintenance agreement specifically address the concerns identified and provide adequate support to the insurer.
  - If concerns exist, consider requesting additional information, as necessary, to understand the level of commitment.
- Whether the document contains detailed requirements or expectations for capital support.
- The financial stability of the parent holding company to determine if the parent is adequately capitalized to support maintenance of capital in the insurer above certain thresholds.

If a holding company analysis group profile summary (GPS) is available, analysts should review the GPS for insight into the parent company or ultimate controlling person (UCP) and its ability to meet the financial demands of the guarantee currently or prospectively. Review pertinent data on the holding company and its organizational structure as well as the operations and financial condition of the holding company or UCP.

Determine if there are liquidity or other concerns identified within the GPS that warrant additional information from the company.

Procedures

- Review Annual Financial Statement, Notes to Financial Statements, Note #14 to identify any parental/affiliated guarantees, of any form, in place between the company and any member within its holding company system. If guarantees are in place, review and discuss with the company and evaluate the potential effect on the insurer's surplus position.
- Determine whether the insurer has a parental guaranty to maintain capital and surplus at a pre-determined level.

ADDITIONAL PROCEDURES, including prospective risks, are also available if the level of concern warrants further review, as determined by analysts: If the insurer is subject to ORSA reporting requirements, there may be a great deal of information on the insurer's capital/surplus position to be reviewed and evaluated in the ORSA Summary Report, as outlined in procedure #11p. Other possible procedures to perform if concerns are identified are outlined in procedures #11q–#11x. For example, 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, analysts should consider reviewing the information in the Annual Financial Statement, Notes to Financial Statements #11 and Note #13. If either were issued or repaid, or if interest was paid during the year, analysts should consider determining that these transactions were approved by the domiciliary state insurance department. In addition, if surplus notes represent a significant portion of surplus, analysts should consider recalculating important ratios, excluding the surplus notes, to determine their effect on the ratio results. Other steps to consider include the review of the detail of unrealized gains (losses), assessment of any parental guarantees in place and the review of other components of surplus.

Financial Impact of the Federal Affordable Care Act on Capital & Surplus and Risk-Based Capital

Financial Impact of the Federal Affordable Care Act on Capital & Surplus and RBC

PROCEDURE #12 asks analysts to aAssess the impact of the Federal Patient Protection and Affordable Care Act (ACA) assessments, risk-sharing provisions and medical loss ratio (MLR) rebates on the financial solvency of the insurer. This procedure is relevant for reporting entities that wrote accident and health insurance premium that is subject to Section 9010-Health Insurance Providers Fee (Section 9010) of the ACA. If so, the insurer is required to provide information in the Annual Financial Statement, Notes to Financial Statements, Note #22.

Analysts should review the net receivable/payable effect of the Risk Adjustment, Reinsurance and Risk Corridors programs (risk sharing provisions) and determine what the impact they would have on capital and surplus (procedure #12g). Also determine what the impact would be on the company's RBC. In conjunction with the review of strategic risk related to ACA business, consider any related Credit Risk for the collectability of admitted assets related to ACA risk sharing payments, including those receivables from the Federal Government. Also consider any cross-over risk impacting pricing and underwriting assumptions in the Pricing & Underwriting Risk Assessment.

Analysts may also consider performing a comparison of the components of the MLR as reported in the Annual Financial Statement Supplement Health Care Exhibit and the U.S. Department of Health and Human Services MLR Annual Reporting Form to identify any material differences in line items. If, in the analyst's judgment, any material differences require explanation, consider requesting such explanation from the health entity.

The MLR rebates are mandated by the Federal Public Health Service Act to be returned to the policyholders if the ratio of medical losses and various other items paid to the ratio premiums paid (with various adjustments) is below specified thresholds (80% for individuals or small group employers or greater than 85% for large group employers, or a threshold established in state law, and 85% for Medicare plans).

As stated above, analysts should be aware that the preliminary MLR is **not** the MLR to be used for federal rebate calculations and payment purposes. For example, for federal rebate purposes issuers that have blocks of business less than a given size can make a credibility adjustment to their MLR on the Federal MLR Annual Reporting Form. A credibility adjustment refers to the adjustment to account for random statistical fluctuations in claims experience for smaller plans. Blocks of business with less than 1,000 life years are considered non-credible and will not be required to pay rebates in most cases. Blocks of business with greater than 1,000 (but less than 75,000) life years may add a credibility adjustment to the calculated MLR. Blocks of business with greater than 75,000 life years are considered fully credible and cannot use a credibility adjustment. For specific details regarding the credibility adjustment calculation see Issuer Use of Premium Revenue: Reporting and Rebate Requirements, 45 C.F.R. §§ 158.230-158.232 (2016).

If concerns are identified related to ACA assessments, risk sharing provisions or MLR rebates, analysts should perform additional procedures as necessary to evaluate the impact of these concerns on the current and long-term solvency position of the insurer. For example, analysts may request an updated business plan or projections from the insurer in light of concerns in this area.

Procedures/Data

- Determine whether the insurer wrote accident and health insurance premium that is subject to the ACA risk-sharing provision.
- Determine what impact the net receivable/payable effect of the Risk Adjustment, Reinsurance and Risk Corridors (3Rs) programs would have on capital and surplus.
- Ratio of MLR rebate liability to capital and surplus

Additional Review Considerations

- Evaluate the impact of ACA fee assessments, risk sharing mechanisms and MLR rebate liabilities on the insurer's current and long-term solvency position.
- Review the Annual Financial Statement, Notes to Financial Statements, Supplemental Health Care Exhibit Part 1 and the final rebate reporting to the U.S. Department of Health and Human Services (HHS). If the amount of MLR rebate liability reported is material (greater than 5% of capital and surplus), determine whether there are concerns regarding the insurer's liability for rebates.
- If risk sharing provisions have an impact on capital and surplus, determine the impact of the risk-sharing provision on RBC.

~~Additional Analysis and Follow-Up Procedures~~ Additional Procedures Applicable to Strategic Risk

~~***EXAMINATION FINDINGS*** directs analysts to r~~**Examination Findings**

Review the most recent examination report, ~~s~~Summary ~~r~~Review M~~m~~emorandum (SRM) and communication with the examination staff to identify if any strategic risk issues were discovered during the examination.

~~***INQUIRE OF THE INSURER*** directs analysts to consider requesting additional information from the insurer if strategic risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of strategic risk for specific topics where concerns have been identified.~~**Own Risk and Solvency Assessment (ORSA) Summary Report**

~~***OWN RISK AND SOLVENCY ASSESSMENT (ORSA)*** directs analysts to o~~Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing strategic risks faced by the insurer.

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

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

Holding Company Analysis

HOLDING COMPANY ANALYSIS directs analysts to oObtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing risks that could impact the insurer.

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

Example Prospective Risk Considerations

The table provides analysts with example risk components for use in the Risk Assessment and Insurer Profile Summary branded risk analysis section and a general description of the risk component. Note that the risks listed are only examples and do not represent a complete list of all risks available for the strategic risk category.

Discussion of Quarterly Strategic Risk AssessmentProcedures

The Qquarterly Sstrategic Rrisk Repositoryassessment procedures are designed to identify the following:

Impact of News, Press Releases and Industry Reports on Insurer's Strategy

Determine if Cconcerns exist regarding with news, press release or industry reports involving the insurer or insurance group;.

Procedures

- Review any insurance, marketplace or economic industry reports, news releases, press releases and emerging issues to identify if any issues have the potential to negatively impact the insurer's strategy.
  - Examples: NAIC "Insurance Industry Snapshots" and "Insurance Industry Analysis Reports"; NAIC Capital Markets Bureau reports, rating agency reports, insurance news sources, NAIC risk alerts, etc.
- If concerns exist regarding a recent industry report, news release or emerging issue, determine if the news or industry issue has the potential to impact the insurer's strategy, operations or financial solvency.
- Perform additional non-routine procedures where applicable (e.g., survey or questionnaire, stress testing, etc.).

Insufficent Risk Management and Governance Practices

Evaluate the effects of Whether changes in theofficers, directors or organizational chartstructure may have on the potential to affect thestrategic direction of the insurer's strategic risk;.

Procedures/Data

- Determine whether there have been any substantial changes in the organizational chart since the prior quarter end as indicated in General Interrogatories, Part 1, #3.2, of the quarterly financial statement.

Additional Review Considerations

- Review the changes in officers, directors or trustees and any concerns noted during a review of biographical affidavits.

  - Ascertain whether new directors and officers have the required knowledge, experience and training to perform their duties.
  - Determine whether new board of director members are sufficiently independent from management and adequately engaged in performing their duties.
  - Ascertain whether new directors and officers ever been officers, directors, trustees, key employees or controlling stockholders of an insurance company that, while they occupied any such position or served in any such capacity with respect to it (if yes, to any of the following, explain):
    - Been placed in supervision, conservation, rehabilitation or liquidation;
    - Been enjoined from, or ordered to cease and desist from, violating any securities or insurance law or regulation;
    - Suffered the suspension or revocation of its certificate of authority or license to do business in any state.
  - Summarize the insurer's policies and procedures regarding performance of background checks on new management.
- If a significant amount of turnover and/or changes in key positions (i.e., chairman of the board of directors, chief executive office [CEO]) are identified, gain an understanding of and evaluate the impact of such changes on the insurer's strategic direction. Consider requesting updated business plans, holding in-person meetings, conducting conference calls, or taking other steps to understand and address significant changes.
- Determine if there has been any changes in the organization's structure. If so, request the reasons for the changes and the impact on future business plans and strategy.
- Ascertain whether there have been any significant operational or business changes that have resulted in significant changes to staffing levels, consolidations of operations with affiliates, outsourcing of key functions, or placing blocks of business into run-off (closed) blocks.

Lack of Due Diligence in Mergers and Acquisitions / Integration Challenges

~~Whether~~Determine how recent and pending merger and acquisition activity ~~will~~ affects the current and prospective solvency position of the insurer and impacts~~insurer's~~its ability to achieve its business strategy;

Procedures/Data

- Ascertain whether the insurer has been a party to a merger or consolidation as indicated in General Interrogatories, Part 1, #4.1, of the quarterly financial statement.

Additional Review Considerations

- If the insurer has been a party to either a merger or consolidation, note any observations or concerns, ensure Form A or additional filings have been approved, and assess if the insurer is meeting the expectations set forth in the Form A business plan, consider the following additional procedures (as necessary):
  - If regulatory approval of the merger or acquisition was subject to ongoing conditions or restrictions, verify compliance with those requirements.
  - Compare actual results to pre-transaction projections to determine whether results are meeting expectations. If not, gain an understanding of why projections have not been achieved and the company's planned actions to address issues.
  - Request and review information regarding the integration of the new business into the company's processes and systems (systems transition plan), as well as the steps taken to ensure that adequate cybersecurity precautions are taken during the integration process.
  - Gain an understanding of and consider the impact of planned cost-cutting activities, including the nature and magnitude of cuts and their potential impact on risk exposures.

Lack of Strategic Business Planning~~s~~ / Overly Aggressive or Overly Optimistic Business Strategies

Note: *The following does not contemplate repeating analysis of the business plans that may have been performed as part of the annual analysis. However, if timing of the receipt of business plans coincides with quarterly reviews or if business plans contain quarterly financial projections or other mid-year plans, consider including assessment of business plan in the quarterly review.*

Evaluate the effectiveness of the insurer's business/strategic planning process and Wwhether the current updated business plans and projections result in new or emerging strategic risks;

Procedures

- Review previous business plans and financial projections filed with the state insurance department, and determine the following:
    - Have significant changes in business plan or philosophy occurred? If "yes," explain.
    - Assess if initiatives outlined in the business plan have been accomplished.
    - Compare actual with projected financial results to determine whether actual results are consistent with management's expectations.
    - Request an explanation for the variance including an explanation of whether management believes it has achieved its goals for the period and if any noted risks or challenges were not considered in the business plan.
    - Request a revised business plan.
    - Describe any events, transactions, market conditions and/or strategic management decisions that have occurred (or are planned) that may cause a significant positive or negative variance from projections, including new product development or enhancements, changes in sales volume, product mix, or geographical locations.
    - Determine whether there are any internal and/or external prospective risks that have the potential to impact the overall business plan.
- If necessary, request and review an updated strategic business plan, note any areas of concern and if necessary, request additional explanations from the insurer.
    - Determine whether the new business plan reflects significant changes in the strategic goals or philosophies compared to the prior plan. If so, provide an explanation.
    - Describe the insurer's strategic and annual planning process.
    - Describe the board of directors' involvement in developing and implementing the business plan.
    - Assess the insurer's ability to attain the expectations of the business plan and projections. Determine whether the business plan reflects changes that appear unrealistic for the current market environment, financial position of the insurer or other circumstances. If so, provide an explain including the following:
        - Reasonableness of underwriting assumptions
        - Current and anticipated interest rate and economic environment
        - Growth objectives
        - Stability of capital and ability to access additional capital, if needed
        - Quality and sources of earnings (trends and stability)
        - Dividends and dividend payout policy

Adequacy of Reinsurance Strategy

Determine Wwhether any significant changes may have been made into the insurer's reinsurance program or how any significant new reinsurance transactions may affect the insurer's strategic risk;.

Procedures/Data – P/C

- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis
- Gross writings leverage (rolling year)
- Net writings leverage (rolling year)
- Change in leverage ratios from prior year-end

  - Gross writings leverage (rolling year)
  - Net writings leverage (rolling year)
  - Paid reinsurance recoverables to surplus
  - Reserve leverage
  - Change in ceded premiums earned from prior year-to-date
- Change in ceded premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- Change in assumed premiums earned from prior year-to-date
- Change in assumed premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- If the company is a member of a pooling arrangement, determine whether there was any change in agreement or the company's participation as indicated in General Interrogatories, Part 2, #1 of the quarterly financial statement.
- Ascertain whether there were any new reinsurers added since the prior quarter as indicated on Schedule F of their respective quarterly financial statements.
- If so, determine whether any were unauthorized.
- Determine whether there has been a change in provision for reinsurance from prior year-end

Procedures/Data – Life/A&H
- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis
- Change in ceded premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- Change in assumed premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- Ascertain whether there is a balance sheet liability for reinsurance in unauthorized and certified companies.
- Change in balance sheet liability, reinsurance in unauthorized and certified companies
  - From the prior quarter
  - From prior year-end
- Change in capital and surplus account line item relating to the change in liability for reinsurance in unauthorized and certified companies
  - From the prior quarter
  - From the prior year-end
- Ascertain whether there were any new reinsurers added since the prior quarter as indicated on Schedule S of their respective quarterly financial statements.
- If so, determine whether any were unauthorized.

Procedures/Data – Health
- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis
- Ascertain whether there were any new reinsurers added since the prior quarter as indicated on Schedule S of their respective quarterly financial statements.
- If so, determine whether any were unauthorized.

Additional Review Considerations – All Statement Types
- If new reinsurance is reported, obtain a copy of the new reinsurer's A.M. Best Supplemental Ratings Questionnaire, and review the reinsurance section to identify any risks or concerns.

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Concerns with Reinsurance Transactions

Determine Wwhether any unusual reinsurance transactions were completed during the quarter;.

Procedures/Data – P/C
- Ascertain whether there were any agreements to release reinsurers from liability during the quarter as indicated in the General Interrogatories, Part 2, #2 of the quarterly financial statement.] [P/C only]
- Determine whether there were any cancellations of primary reinsurance contracts during the quarter as indicated in the General Interrogatories, Part 2, #3.1 and #3.2 of the quarterly financial statement. [P/C only]
- Determine whether the insurer experienced any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile as required by the Model Act as indicated in the General Interrogatories, Part 1, #1.1 of the quarterly financial statement.
  - If so, determine whether the insurer failed to make the appropriate filing of a Disclosure of Material Transactions with the state of domicile as indicated in the General Interrogatories, Part 1, #1.2 of the quarterly financial statement.
- Determine whether the change in the ceded pure loss ratio from the prior year-end is significantly greater than the change in the gross pure loss ratio. [P/C only]
- Determine whether the change in the assumed pure loss ratio from the prior year-end is significantly greater than the change in the gross pure loss ratio. [P/C only]

Procedures/Data – Life/A&H, Health
- Determine whether the insurer experienced any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile as required by the Model Act as indicated in the General Interrogatories, Part 1, #1.1 of the quarterly financial statement.
  - If so, determine whether the insurer failed to make the appropriate filing of a Disclosure of Material Transactions with the state of domicile as indicated in the General Interrogatories, Part 1, #1.2 of the quarterly financial statement.

Additional Review Considerations – All Statement Types
- If the insurer reported material reinsurance transactions as indicated in General Interrogatory #1.1 of the quarterly financial statement, General Interrogatory #1.1] and if concerns exist relating to significant and/or unusual reinsurance transactions during the quarter, consider the following additional procedures:
  - Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief, or financial reinsurance agreements.
  - Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements.
  - Determine whether transfer of risk criteria have been met.
  - Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly "mirrored."
  - Determine whether proper policyholder consents received before the assumption reinsurance transfer were consummated.
  - Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.

Adequacy of Capital and Surplus

Determine whether ~~C~~concerns exist regarding ~~with~~ the insurer's Risk-Based Capital (RBC) position~~;~~ and the ~~A~~adequacy of the insurer's total capital and surplus position in light of its business/strategic plans and risk exposures.

Procedures/Data – P/C

- Change in surplus from the prior year-end %
- Absolute value of the current year change to capital and surplus for any of the following items:
  - Net unrealized capital gains/losses
  - Net unrealized foreign exchange capital gains/losses
  - Net deferred taxes
  - Non-admitted assets
  - Provision for reinsurance ~~[P/C]~~
  - ~~Liability for unauthorized reinsurance [Life, Health]~~
  - ~~Reserve valuation basis [Life, Health]~~
  - ~~AVR [Life]~~
  - Surplus notes
  - Change in accounting principle
- Surplus to assets ratio
- Ratio of capital and/or surplus notes issued during the quarter to capital and surplus
- Write-ins for special surplus funds or other than surplus funds to capital and surplus
- Stockholder dividends declared during the quarter
- Unassigned funds

Procedures/Data – Life/A&H

- Change in capital and surplus from the prior year-end [Life]
- Change in capital and surplus from the prior year-end [Health]
- Absolute value of the current year change to capital and surplus for any of the following items:
  - Net unrealized capital gains/losses
  - Net unrealized foreign exchange capital gains/losses
  - Net deferred taxes
  - Non-admitted assets
  - Liability for unauthorized reinsurance
  - Reserve valuation basis
  - AVR
  - Surplus notes
  - Change in accounting principle
- Capital and surplus to total admitted assets (excluding separate accounts)
- Ratio of capital and/or surplus notes issued during the quarter to capital and surplus
- Write-ins for special surplus funds or other than surplus funds to capital and surplus
- Stockholder dividends declared during the quarter

Procedures/Data - Health

- Change in capital and surplus from the prior year-end
- Absolute value of the current year change to capital and surplus for any of the following items:
  - Net unrealized capital gains/losses
  - Net unrealized foreign exchange capital gains/losses
  - Net deferred taxes
  - Non-admitted assets
  - Liability for unauthorized reinsurance
  - Reserve valuation basis

- Surplus notes
- Change in accounting principle

- Capital and surplus to total admitted assets (excluding separate accounts)
- Ratio of capital and/or surplus notes issued during the quarter to capital and surplus
- Write-ins for special surplus funds or other than surplus funds to capital and surplus
- Stockholder dividends declared during the quarter

Additional Review Considerations

- Given the current level of RBC and any significant balance sheet or operational changes, consider the impact to RBC. If there are concerns, consider completing and/or requesting an interim RBC projection.
- If the insurer triggered an RBC Action Level event in the prior period and if an RBC plan was filed, review the insurer's RBC plan and monitor the overall progress to-date.
- Review the Capital and Surplus section in the Financial Profile Report and/or the Capital and Surplus Analysis (roll forward) in the Annual Financial Statement for unusual fluctuations or trends in the changes in surplus between years. Investigate any significant or unexplained items.
- If stockholder dividends were declared during the quarter, ascertain whether the amount of stockholder dividends was at a level that required prior regulatory approval?
    - If yes, determine whether the insurer failed to obtain proper prior regulatory approval for stockholder dividends.
- Review the Quarterly Financial Statement, Notes to Financial Statements and Extraordinary Dividend approvals to determine what assets were used to pay dividends. If the shareholder dividends paid were at a significant amount that required the liquidation of assets to cash, determine whether there were any liquidity concerns.
- Determine whether the insurer repaid any principal and/or paid any interest on capital or surplus notes during the quarter.
- For any newly issues capital or surplus note, consider reviewing any notes issued, principal or interest paid, or any other changes made, and whether any necessary approvals were obtained.
- Review the write-ins for special surplus and other than special surplus funds for reasonableness.

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

Draft: 11/6/2024

Financial Examiners Handbook (E) Technical Group
Virtual Meeting
October 31, 2024

The Financial Examiners Handbook (E) Technical Group of the Examination Oversight (E) Task Force met Oct. 31, 2024. The following Technical Group members participated: Eli Snowbarger, Co-Chair (OK); John Litweiler, Co-Chair (WI); Blase Abreo (AL); Laura Clements (CA); William Arfanis (CT); N. Kevin Brown (DC); Cindy Andersen (IL); Grace Kelly (MN); Shannon Schmoeger (MO); Andrea Johnson (NE); Nancy Lee Chice (NJ); Tracy Snow (OH); and Diana Sherman (PA).

1. Adopted its Sept. 23 Minutes

Litweiler stated that the Technical Group met Sept. 23. During this meeting, the Technical Group took the following action: 1) adopted revisions related to affiliated investment management services and agreements; and 2) exposed revisions related to executive compensation and manual adjustments to risk-based capital (RBC) for a 30-day public comment period that ended Oct. 23.

Snow made a motion, seconded by Clements, to adopt the Technical Group's Sept. 23 minutes (Attachment Three-A). The motion passed unanimously.

2. Adopted Handbook Guidance

A. Risk-Focused Surveillance (E) Working Group Referral

Snowbarger introduced revisions to the *Financial Condition Examiners Handbook* (Handbook) regarding the monitoring of run-off insurers. He mentioned that the Risk-Focused Surveillance (E) Working Group finalized revisions after a thorough review process and public comment period. To ensure consistency with the related revisions referred to the Financial Analysis (E) Solvency Tools Working Group, the Risk-Focused Surveillance (E) Working Group recommended that these edits be considered for adoption without an additional exposure period or any significant modification.

B. Executive Compensation

Snowbarger said the second set of revisions to consider for adoption relates to executive compensation practices. He noted that revisions included an example prospective risk within Exhibit V and potential new interview questions in Exhibit Y to help examiners gain insight into the company's executive compensation structure and related risks.

C. Manual Adjustments to RBC

Snowbarger noted the last set of proposed revisions to consider for adoption, which relates to validating the accuracy of manual adjustments to RBC filings by the insurer, including those related to modified coinsurance (modco) reinsurance and separate account assets. Revisions to an existing risk in the capital and surplus repository encourage the examiner to review the manual adjustments made to RBC for modco reinsurance and separate account assets.

Litweiler made a motion, seconded by Sherman, to adopt guidance related to run-off insurer considerations (Attachment Three-B), executive compensation (Attachment Three-C), and manual adjustments to RBC (Attachment Three-D). The motion passed unanimously.

3. Discussed Other Matters

Litweiler reminded the group that the Information Technology (IT) Examination (E) Working Group has been revising the guidance in Exhibit C to further emphasize cybersecurity risks. He noted that these changes will be considered for adoption later today on the group's next call. Having no further business, the Financial Examiners Handbook (E) Technical Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E CMTE/EOTF/FEHTG Minutes 10.31.24 - Final.docx

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Draft: 9/27/24

Financial Examiners Handbook (E) Technical Group
Virtual Meeting
September 23, 2024

The Financial Examiners Handbook (E) Technical Group of the Examination Oversight (E) Task Force met Sept. 23, 2024. The following Technical Group members participated: Eli Snowbarger, Co-Chair (OK); John Litweiler, Co-Chair (WI); Blase Abreo (AL); Laura Clements (CA); William Arfanis (CT); N. Kevin Brown (DC); Cindy Andersen (IL); Andrea Johnson (NE); Colin Wilkins (NH); and Nancy Lee Chice (NJ).

1. Adopted Handbook Guidance

   A. Risk-Focused Surveillance (E) Working Group Referral

Litweiler introduced revisions to the *Financial Condition Examiners Handbook* (Handbook) regarding affiliated investment management services and agreements. He mentioned that the Risk-Focused Surveillance (E) Working Group finalized revisions after a thorough review process with multiple comment periods. To ensure consistency with the related revisions referred to the Financial Analysis (E) Solvency Tools Working Group, the Risk-Focused Surveillance (E) Working Group recommended that these edits be considered for adoption without an additional exposure period or any significant modification.

Clements made a motion, seconded by Andersen, to adopt guidance related to affiliated investment management services and agreements (Attachment Three-A1). The motion passed unanimously.

2. Exposed Handbook Guidance

   A. Executive Compensation

Snowbarger said the first set of revisions to consider for exposure relate to executive compensation practices. This item was added to the Technical Group's project listing as the Handbook has a lighter touch in this area than what is required by other regulatory bodies. He noted that revisions included an example prospective risk within Exhibit V and potential new interview questions in Exhibit Y to help examiners gain insight into the company's executive compensation structure and related risks.

   B. Manual Adjustments to RBC

Snowbarger introduced the last set of proposed revisions to consider for exposure, which relates to validating the accuracy of manual adjustments to risk-based capital (RBC) filings by the insurer, including those related to modified coinsurance (modco) reinsurance and separate account assets. While the RBC instructions allow for manual adjustments to the formula to ensure charges for invested assets are appropriate, these adjustments are not tied to existing annual statement reporting. As such, the adjustments could be inaccurate. Revisions to an existing risk in the capital and surplus repository encourage the examiner to review the manual adjustments made to RBC for modco reinsurance and separate account assets.

As there were no objections, the Technical Group exposed the revisions for a 30-day public comment period ending Oct. 23.

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3. Discussed Other Matters

Litweiler noted that the Information Technology (IT) Examination (E) Working Group is working on revisions to the guidance in Exhibit C for the IT Review to further emphasize cybersecurity risks and align it with the National Institute of Standards and Technology (NIST) Cybersecurity Framework 2.0. He encouraged attendees on the call to follow that group for further information on upcoming guidance updates in this area, as any proposed revisions developed would undergo exposure and adoption at that group without a separate exposure or adoption by the Technical Group.

Having no further business, the Financial Examiners Handbook (E) Technical Group adjourned.

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MEMORANDUM

TO: Eli Snowbarger (OK), Co-Chair, Financial Examiners Handbook (E) Technical Group
John Litweiler (WI), Co-Chair, Financial Examiners Handbook (E) Technical Group

FROM: Amy Malm, Chair, Risk-Focused Surveillance (E) Working Group

DATE: May 30, 2024

RE: Affiliated Services Guidance

In late 2022, the Risk-Focused Surveillance (E) Working Group received a referral from the Macroprudential (E) Working Group recommending updates to NAIC handbooks (Examiners and Financial Analysis) to provide more guidance to regulators on reviewing affiliated investment management services and agreements. The referral was part of a broader initiative to address a list of "Regulatory Considerations Applicable (But Not Exclusive) to Private Equity (PE) Owned Insurers." Because the issue was important for both financial analyst reviews of Form D filings and the subsequent review of affiliated investment services during financial exams, the topic was referred to the Risk-Focused Surveillance (E) Working Group so that guidance could be developed together for both functions.

After a development period that included drafting group work, presentation of the proposed guidance at an in-person meeting, public exposure, and a call to review and finalize an updated draft, the Risk-Focused Surveillance (E) Working Group finalized updated drafts of proposed revisions to the NAIC's *Financial Analysis Handbook* (FAH) and *Financial Condition Examiners Handbook* (FCEH). The proposed edits to the FCEH are provided in **Attachment One** of this memorandum.

As the proposed revisions have been thoroughly reviewed and subject to multiple public comment periods, we recommend they be considered by the Financial Examiners Handbook (E) Technical Group for adoption without additional public exposure or significant modifications, to ensure the guidance remains consistent with the revisions proposed for the FAH.

If there are any questions regarding the proposed recommendations, please contact us or NAIC staff (Bruce Jenson at *bjenson@naic.org*) for clarification. Thank you for your consideration.

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Attachment One

Note: This document includes excerpts from the NAIC's *Financial Condition Examiners Handbook* to which revisions are being proposed to update guidance around the review of affiliated investment management services and agreements. The proposed revisions are shown as tracked changes throughout.

Examination 1 – Section 1-III F. Outsourcing of Critical Functions

III. GENERAL EXAMINATION CONSIDERATIONS

This section covers procedures and considerations that are important when conducting financial condition examinations. The discussion here is divided as follows:

A. General Information Technology Review
B. Materiality
C. Examination Sampling
D. Business Continuity
E. Using the Work of a Specialist
F. Outsourcing of Critical Functions
G. Use of Independent Contractors on Multi-State Examinations
H. Considerations for Insurers in Run-Off
I. Considerations for Potentially Troubled Insurance Companies
J. Comments and Grievance Procedures Regarding Compliance with Examination Standards

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F. Outsourcing of Critical Functions

The examiner is faced with additional challenges when the insurer under examination outsources critical business functions to third parties. It is the responsibility of management to determine whether processes which have been outsourced are being effectively and efficiently performed and controlled. This oversight may be performed through a number of methods, including performing site visits to the third-party or through a review of Statement of Standards for Attestation Engagements (SSAE) 18 work that has been performed. In some cases, performance of site visits may even be mandated by state law. However, regardless of where the business process occurs or who performs it, the examination must conclude whether financial solvency risks to the insurer have been effectively mitigated. Therefore, if the insurer has failed to determine whether a significant outsourced business process is functioning appropriately, the examiner may have to perform testing of the outsourced functions to ensure that all material risks relating to the business process have been appropriately mitigated.

When conducting an examination of insurers that are part of a holding company group, including internationally active insurance groups (IAIGs), the exam team should evaluate whether appropriate due diligence has been performed prior to entering new material outsourcing agreements. The exam team should also take steps to determine the extent to which management at the applicable level (e.g., head of the IAIG, ultimate parent company level, insurance holding company level, legal entity level, etc.) is able to provide ongoing risk assessment and oversight of outsourced functions and any contingency plans for emergencies and service disruptions.

The guidance below provides examiners additional information about the outsourcing of critical functions a typical insurance company may use. The guidance does not create additional requirements for insurers to comply with beyond what is included in state law, but may assist in outlining existing requirements that may be included in state law and should be used by examiners to assess the appropriateness of the company's outsourced functions. Within the guidance, references to relevant NAIC model laws have been included to provide examiners with guidance as to whether compliance in certain areas is required by law. To assist in determining whether an individual state has adopted the provisions contained within the referenced NAIC models, examiners may want to review the state pages provided within the NAIC's *Model Laws, Regulations and Guidelines* publication to understand related legislative or regulatory activity undertaken in their state.

Types of Service Providers

Insurance companies have been known to outsource a wide range of business activities including sales & marketing, underwriting & policy service, premium billing & collections, claims handling, investment management, reinsurance and information technology functions. There are a number of different types of entities that accept outsourced business from insurers including the following:

- Managing General Agent – Person who acts as an agent for such insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent (5%) of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with the following activity related to the business produced adjusts or pays claims in excess of $10,000 per claim or negotiates reinsurance on behalf of the insurer.

- Producer – An insurance broker or brokers or any other person, firm, association or corporation, when, for any compensation, commission or other thing of value, the person, firm, association or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of an insurance contract on behalf of an insured other than the person, firm, association or corporation.

- Controlling Producer – A producer who, directly or indirectly, controls an insurer.

- Custodian – A national bank, state bank, trust company or broker/dealer which participates in a clearing corporation.

- Investment Adviser – A person or firm that, for compensation, is engaged in the act of providing advice, making recommendations, issuing reports or furnishing analyses on securities. In addition to providing investment advice, some investment advisers also manage investment portfolios or segments of portfolios. Other common names for investment advisers include asset managers, investment managers and portfolio managers.

- Affiliated Service Provider – An affiliated person or firm to which the insurer outsources ongoing business services, including cost sharing services and management services.

- Other Third-Party Administrators – Other third-party entities that perform business functions of the insurer.

Additional information on each of the above types of entities has been provided below to assist examiners in reviewing business activities outsourced.

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Investment Advisers

As investments and investment strategies grow in complexity, insurers may consider the use of 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 (SEC) Commission and by the states in which they operate generally based on the size of their business. In certain situations, insurers may use a broker dealer in the capacity of an investment adviser. 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, which provides extensive information about the nature of the organization's operations. To locate these forms, the examiner 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. Locations 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)

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 very valuable to examiners in assessing the suitability of investment advisers providing advisory services to insurers.

Where not prohibited by domiciliary state law and if permitted by the investment adviser agreement, there may be situations in which the investment adviser also acts as a custodian. In these instances, investment advisers are required to obtain an annual examination by an independent public accountant to verify compliance with custodial responsibilities as provided in the federal Investment Advisers Act of 1940 and/or the federal Investment Company Act of 1940. The accountant's report is also available on the Form ADV. It is generally a best practice for the insurer to choose a national bank, state bank, trust company or broker/dealer which participates in a clearing corporation, other than its investment manager/advisor, to hold its assets in custody to promote segregation of duties. See additional discussion under the topic of "Custodian" above for more information.

In performing risk-focused examinations, examiners should identify all advisers utilized by the insurer and take steps to address any significant risks associated with their use. These steps may include determining whether investment advisers are suitable for their role (including registered and in good standing with the SEC and/or state securities regulators), performing procedures to ensure investment advisory agreements contain appropriate provisions, and performing procedures to ensure that the adviser is acting in accordance with the agreement. Additionally, the examiner may consider performing procedures to determine if management/board oversight of the investment adviser is sufficient for the relationships in place.

In evaluating the provisions of the investment advisory/management agreements, examiners should consider whether there are appropriate provisions to adequately address selection of investments, authority

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for transactions, conflicts of interest, calculation of fees, etc. Additional considerations for use in reviewing the investment advisory/management agreements are provided as follows:

a. Selection of Investments

It should be clear from the advisory agreement, how the investment adviser will select investments. This should include specific reference to the insurer's investment strategyand detailed investment guidelines attached as part of the agreement.

b. Authority for Transactions

Advisory agreements should address the level of the authority that will be given to the investment adviser in executing transactions.

c. Conflicts of Interest

To the extent that any conflicts of interest may be known to the insurer, tThe advisory agreement should specifically indicate the manner in which such conflicts of interest will be considered. This is an important protection against an investment adviser's biases as a result of business arrangement (e.g., referral relationships, affiliate product offerings, etc.) that may interfere with the proper execution of the investment strategy. This is an important consideration when the investment adviser has other clients. For example, investment advisers often have affiliates that offer investment options that should be available to the insurer but should not be given preferential treatment if competitor products are determined to be a better fit for the selected investment strategy. The reporting of potential conflicts of interest and how they are addressed should also be included in the insurer's management and controls framework.

d. Fiduciary Responsibility

It is advisable that the investment advisor is registered with the SEC. However, whether or not that is the case, the agreement should acknowledge that the investment advisor is subject to guidance and requirements under the Investment Advisors Act of 1940. Language provided in the investment management agreement should acknowledge the investment adviser's role as a fiduciary in advising the insurer. This is an important legal distinction that may help protect the insurer's interests in the execution of the company's investment strategy. The fiduciary standard is generally implied when an asset manager is registered as an investment advisor, which may be required at the federal (SEC) or state level (state securities regulator) depending on the nature and extent of services provided. If not already performed by the financial analyst, the exam team should consider confirming whether the advisor is formally registered in accordance with existing legal requirements and in good standing with its securities regulators. If the advisor asserts that it is exempt from registration requirements, the exam team should consider verifying that the advisor continues to meet the exemption criteria.

e. Calculation of Fees

Management fees should reflect the current market conditions and should reflect the kind of assets and type of asset management performed. It is important that the manner in which fees are calculated is well defined in the management agreement and that the structure of the fee is considered as management assesses the adviser's performance. For example, if the advisory fee is computed based on volume of transactions, it would be important for management to closely review the frequency of trades to help avoid excessive charges Special attention should be paid if there are any performance or incentive fees over and above a base management fee. In the case of affiliated asset managers, special attention should be paid to the total amounts paid by the insurer to guard against such fees becoming a way around dividend restrictions.

f. Sub-advisors

Can the investment advisor engage sub-advisors? Is consent of the insurer required, or can the insurer revoke the engagement? Who is responsible for the fees of the sub-advisor and are they included in the overall fee structure (i.e., not overlapping)?

g. Reporting

Are there adequate provisions for reporting to the insurer on regular basis. There should be provision for any regulatory needs and any other needs of the insurer that are within reason.

h. Termination

Are there appropriate termination provisions, both with and without cause? Is there language providing for the transition to another investment adviser.

~~f.~~i. Review of Performance and Compliance

Agreements should include consideration of information that will be provided to the company to permit the company to perform adequate review of the adviser's performance and execution of the investment strategy, including compliance with adopted investment guidelines.

There may be other terms that examiners consider to be significant and can therefore tailor their review based on judgment and the specifics of the insurer under exam. For related guidance regarding affiliated investment manager agreements, please see Section V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures of the NAIC's *Financial Analysis Handbook*.

Examiners may consider leveraging risk, control and test procedure language provided in the Investment repository when determining an appropriate examination response. The examiner may also consider concepts discussed in the "Other Third-party Administrators (TPAs)" and "Custodial or Safekeeping Agreements" to ensure that risks are adequately addressed as part of examination fieldwork.

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Examination 2 – Investments Repository Excerpts

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
Other Than Financial Reporting Risks						
The board of directors (or committee thereof) and management do not effectively monitor or supervise contracted third parties (including affiliates) in the implementation of the investment policy/strategy. *See Section 1 Part III of the Handbook for additional guidance relevant to reviewing third-party investment advisers and associated contractual arrangements.	CR MK	Other	AIPS	Prior to entering into a contract with a third party, management reviews the third party's credentials to ensure that they are qualified to perform the service and verifies that no conflict of interest exists. Management ensures that third-party contracts include appropriate provisions and recognize fiduciary responsibility to the insurer. Contracts are reviewed for appropriate provisions related to: • Investment guidelines/selection. • Authority for transactions. • Reporting of transactions in sufficient detail and frequency. • Conflicts of interest. • Appropriateness of fees.	Review procedures that ensure management reviews the credentials, including confirming registration as investment advisor/manager, of the third party and that no conflict of interest exists. Verify the insurer control to ensure appropriate contract provisions. Specifically consider any situations and transactions where the potential of conflict of interest exists. This includes transactions with other accounts managed by the third-party manager, through brokers affiliated with the third-party manager and investments in funds managed separately by the third-party manager.	Assess the suitability of investment advisers through a review of information provided to the U.S. Securities and Exchange Commission (SEC) in Form ADV (if available) or other available information. Determine if there are any disciplinary actions or background information that might call into question the advisers' suitability for providing services rendered. Review significant investment advisory/management agreements for appropriate provisions. Review recent performance and benchmark reports in comparison with the company's plan. Test the insurer's investments for compliance

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Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
				• Review of performance. • Termination. The insurer monitors investments purchased, those sold, the performance of the investment portfolio against prior year or budgeted results, and what the insurer holds. It also monitors compliance with the investment strategy that has been established by the board of directors (or committee thereof). This monitoring can be performed by senior management, an investment advisory board or internal auditors and is reported to the board of directors (or committee thereof). Processes are in place to ensure proper disclosure, regulatory approval (if applicable) and reporting of all authorized investment advisors and sub-advisors.	Obtain a copy of the report that is used by the insurer to report investment policy compliance to the board of directors (or committee thereof), and verify the board's review of the investment activity. Verify that a discussion of investments took place at the board of directors (or committee thereof) meeting by reviewing a sample of meeting minutes. Review and test company processes in place (including supervisory review) to ensure proper disclosure, reporting, and regulatory approval (if applicable) of all authorized investment advisors and sub-advisors	with its investment policy guidelines. Assess significant changes in portfolio profile year over year and over the course of recent years to determine suitability of changes for the company. Verify that all investment management agreements with affiliated entities have been filed with the department for approval. Verify that information related to investment advisors is properly disclosed in the general interrogatories.

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Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
						Verify that information on investments is properly reported as to the affiliated/related-party status in the annual statement investment schedules.
Structured security or other complex investments originated and managed by an affiliate or related party may present an increased exposure to solvency risks.	CR ST MK	Other	AIPS VIIA	The insurer verifies that its affiliate/related party asset manager has adequate experience and knowledge in originating and managing the types of investments held by the insurer. The insurer verifies that its affiliate/related party asset manager follows appropriate underwriting practices in originating investments. The insurer has established guidelines for investments originated and managed by affiliates/related parties to ensure that: • The fee structure is transparent, ~~and~~ equitable, and	Review documentation demonstrating that management reviews the credentials of the affiliate/related party, including confirming registration as investment advisor/manager and that no conflict of interest exists. Review internal audit (IA) work, board minutes, and/or other documentation demonstrating effective oversight of the affiliated asset origination process. Review documentation demonstrating that the insurer has reviewed the investments originated and managed by an affiliate or related party for compliance with regulatory investment limitations and reporting requirements.	Review significant investment advisory/management agreements for appropriate provisions. Test the insurer's investments for compliance with its investment policy guidelines and regulatory requirements. If necessary, use an investment specialist to analyze the insurer's structured securities portfolio. Review Jumpstart reports to identify potential designation exceptions for structured securities and address exceptions, as appropriate. If deemed necessary, review individual securities for

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Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
				avoids overlapping and excessive fees. • Concentration of such investments is in accordance with affiliated investment limitations. • Investments offered to the public are in compliance with applicable requirements.		compliance with NAIC designation reporting requirements. If deemed appropriate, select a sample of material investments and review the underlying details to determine if the investments are properly classified in the respective investment schedules in the annual statement.
				The insurer has a process in place to have its structured securities effectively rated by a qualified third party and assesses the appropriateness of ratings and designations.	Obtain documentation demonstrating management's review and approval of third-party ratings for structured securities.	
				The insurer has a process in place to ensure that investments managed and originated by affiliates/related parties are properly identified and reported in accordance with statutory accounting guidelines. • This includes proper classification of	Review the insurer's process for identifying reporting investments managed and originated by affiliates/related parties, and determine whether it is operating effectively. Obtain documentation demonstrating how management determines the	

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Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
				holdings reported in the "Investments Involving Related Parties" column of each investment schedule in the annual statement.	classification of investments in the annual statement.	

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NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: Eli Snowbarger (OK), Co-Chair, Financial Examiners Handbook (E) Technical Group
John Litweiler (WI), Co-Chair, Financial Examiners Handbook (E) Technical Group

FROM: Amy Malm, Chair, Risk-Focused Surveillance (E) Working Group

DATE: October 10, 2024

RE: Runoff Insurer Guidance

In spring of 2024, the Risk-Focused Surveillance (E) Working Group received a referral from the Financial Analysis (E) Working Group (FAWG) recommending additional best practices in the oversight of solvent runoff insurers. Because the recommendations were relevant to both financial analysis and financial exams, the topic was referred to the Risk-Focused Surveillance (E) Working Group so that guidance could be developed together for both functions.

During its July 17 virtual meeting, the Working Group discussed proposed additions to NAIC handbooks to incorporate the best practices recommended by FAWG. The proposed revisions were then exposed for a 45-day public comment period, with comments received from various interested parties as a result of the exposure. During its Oct. 10 virtual meeting, the Working Group discussed the comments received, as well as an updated draft of the proposed guidance that was modified to address the comments received. During that meeting, the Working Group agreed to finalize the proposed examination guidance and refer it to the Financial Examiners Handbook (E) Technical Group for consideration of adoption. The proposed edits to the NAIC's *Financial Condition Examiners Handbook* are provided in **Attachment One** of this memorandum.

As the proposed revisions have been thoroughly reviewed and subject a public comment period, we recommend they be considered for adoption without additional public exposure or significant modifications, to ensure the guidance remains consistent with guidance proposed for the NAIC's *Financial Analysis Handbook*.

If there are any questions regarding the proposed recommendations, please contact us or NAIC staff (Bruce Jenson at *bjenson@naic.org*) for clarification. Thank you for your consideration.

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III. GENERAL EXAMINATION CONSIDERATIONS

This section covers procedures and considerations that are important when conducting financial condition examinations. The discussion here is divided as follows:

A. General Information Technology Review
B. Materiality
C. Examination Sampling
D. Business Continuity
E. Using the Work of a Specialist
F. Outsourcing of Critical Functions
G. Use of Independent Contractors on Multi-State Examinations
H. Considerations for Insurers in Run-Off
I. Considerations for Potentially Troubled Insurance Companies
J. Comments and Grievance Procedures Regarding Compliance with Examination Standards

H. Considerations for Insurers in Run-Off

Run-off may be either a voluntary or state mandated course of action where the insurer ceases writing new policies on a portion of business or all business written. During run-off, the insurer typically continues collecting premiums on mandatory policies for a statutorily mandated period and to policy expiration dates. The degree and timing of the reduction in premiums should be closely monitored through projections, which are often provided within a run-off plan. The run off of claims becomes the focus of attention until the last dollar of exposure is paid. The risk exposures for insurers in run-off are likely to be different than that of an insurer writing new business; therefore it may be necessary for an examiner to narrow the focus of the financial condition examination and ongoing solvency oversight of the insurer. For example, when examining a company in run-off, the examiner may be able to reduce testing performed in traditional areas, such as underwriting. The focus of the examination of a run-off insurer may include, but not be limited to, the following:

Run-off Plan

Please note that the following guidance pertains to solvent run-off insurers, as the Handbook guidance is not applicable to those companies in receivership[1]. In particular, the below guidance most directly applies to insurers whose entire company is in run-off. Some elements of the guidance may be applicable in other run-off situations (e.g., one block of business is in run-off), and the examiner should use judgment in determining which elements may be relevant and in applying them to the risk-focused process.

A company in run-off should ~~will typically~~ prepare a run-off plan outlining how it will manage its resources in this stage of its operations. The specific content of the run-off plan may vary depending upon the line and nature of business in run-off and the financial condition of the insurer; however, at minimum, the plan should include the size of the operations during run-

[1] For further guidance on run-off of insurers deemed to be financially troubled, refer to the NAIC *Troubled Insurance Company Handbook* (regulator only publication). For further guidance on insurers in receivership, refer to the NAIC *Receiver's Handbook for Insurance Company Insolvencies*.

off, employee retention plans, and key performance indicators and metrics for the run-off (e.g., cashflow projections and ALM plans). If the company has prepared a run-off plan, the examiner should obtain, from the analyst, the plan that was received at the beginning of the run-off process (and any adjustments between its receipt and the beginning of the examination) ~~and~~ to gain an understanding of the process the company has chosen for winding down its business and the primary risks that remain. In addition, the examiner should track the company's progress against its plan to assist in evaluating the effectiveness of the run-off. If the company has entered into run-off since the prior exam, the department analyst may have already obtained the run-off plan. Therefore, the examiner should consult with the analyst prior to requesting the run-off plan from the company.

Corporate Governance

Insurers in run-off are faced with unique challenges in maintaining effective oversight and staffing in circumstances of decreasing resources. Some areas of corporate governance that may be more critical for an insurer in run-off include employee compensation and retention, succession planning, and adequate oversight of critical functions by the Board of Directors and senior management. Evaluating the suitability of key management becomes of increased importance in an environment of high turnover and changing responsibilities. As such, it may be appropriate to closely monitor employee turnover and request additional reporting on any changes in senior officers throughout the run-off period. The examiner may also consider the need for an insurer in run-off to retain essential IT staff, and whether the company's decreasing resources create segregation of duties issues that limit the effectiveness of the company's internal control structure. ~~.~~

Capital and Liquidity Management

An objective of an insurer in run-off is to manage its assets and liabilities and maintain sufficient cash flow to ensure claim payments are met. Ideally, the insurer will reduce liabilities over time while ensuring its balance sheet maintains liquid assets to pay claims. When assessing liquidity and surplus adequacy, the examiner should evaluate the appropriateness of the insurer's investment portfolio, including proper asset/liability matching. An insurer in run-off would generally be expected to maintain a conservative strategy in order to preserve the ability of invested assets to meet run-off obligations. An aggressive strategy may warrant additional scrutiny by the examiner. The examiner may also evaluate whether the insurer has performed analyses to determine further cash flow needs and stress testing to assess its capital needs. One metric to be considered in evaluating both liquidity and capital adequacy would be to monitor investment income in relation to operating expenses, using pro forma projections and reconciling differences. If operating expenses exceed investment income, the resulting losses could quickly erode policyholder surplus and create liquidity issues. In some circumstances, the examiner may consider involving an actuarial specialist to assist in evaluating the adequacy of the insurer's capital.

Loss and Loss Adjustment Expense (LAE) Reserves

Loss reserves are the largest liability reported by an insurer and one of the most critical pieces of data in assessing an insurer that has entered run-off. Many run-off insurers are thinly capitalized. Given the materiality of this liability, a slight variance in reserves can have a significant impact on the insurer's ability to continue as a going concern. As a result, there is increased importance placed on highly accurate reserve estimations as well as close

monitoring of loss reserves. Therefore, the exam team may consider suggesting, through the SRM, the analyst consider performing more frequent independent reserve estimations or calling a targeted exam before the next scheduled full scope exam. When examining an insurer in run-off, the examiner should consider focusing procedures on the company's processes for determining loss reserves, reviewing loss reserve development trends, and involving an actuarial specialist in evaluating the overall adequacy of the reserves held.

Loss reserves of run-off insurers can be significantly impacted by litigation activity, or changes in legislation or case law that impact claims liabilities. Therefore, it may be appropriate to require the insurer to provide regular legal risk update reports, involve those with legal knowledge and expertise in monitoring the company, or take other actions to monitor the legal and regulatory risks more closely on run-off companies.

Other Considerations

Given the nature of run-off insurers, there are a number of other considerations to take into account during an examination. In addition to the above areas, the exam of a run-off insurer may have greater focus on the following:

- Gaining an understanding of a run-off insurer's record keeping process, particularly in regard to claims records and data sources, including the ability to transfer claims data as needed in a timely manner. For property and casualty companies, examiners should review data sources to ensure that they are in either UDS format or in a form that can easily be transformed into UDS format (i.e. CSV file that retains all the required elements). The data should be made available for transfer timely and in a usable manner (the UDS format). For more information on UDS, please see the NAIC Uniform Data Standard Operations Manual.
- Developing an understanding of the insurer's use of service providers and/or third-party administrators and continuity of service plans as the company operations shrink over time. If service providers or third-party administrators are utilized for claims records and data sources, consider reviewing the ability to transfer usable claims data in a consistent and timely manner in the event of an insolvency.
- Developing a plan to communicate necessary information to other key stakeholders (e.g., other state regulators and/or receivership/guaranty fund contacts, if applicable—see "Pre-Receivership Considerations" below) in a timely and effective manner throughout the course of the run-off. Ensure appropriate confidentiality measures are in place to protect these communications, such as the memorandum of understanding highlighted in the guidance below.
- Reviewing the run-off insurer's IT systems to ensure that they are kept up to date and secure, while also ensuring cost effectiveness. While the IT systems are reviewed during full-scope examinations, it may be pertinent to consider targeted exams in between full-scope exams to assess the IT systems more frequently.
- Closely monitoring the company's reinsurance operations, as reinsurance recoverable amounts and the associated credit risk can be material to a run-off insurer's solvency.

Insurance Business Transfers (IBT's) and Corporate Divisions (CD's)

Over the past few years, states have begun enacting statutes which provide opportunities for solvent insurers considering run-off of certain lines or their entire book of business to

restructure their run-off with finality. These processes can be broken down into two categories generally referred to as insurance business transfer ("IBT") and corporate division ("CD").

An insurance business transfer (IBT) represents a transaction designed to transfer existing insurance obligations of one insurer (transferring insurer) to a second insurer (assuming insurer) without policyholder consent, subject to approval regulatory approval and court approval. While policyholder consent is not required, notice to policyholders, key stakeholders and the general public is required, and concerns regarding the transaction will be considered in the regulatory and/or court approval process. Following an IBT, the assuming insurer becomes directly liable to policyholders and the transferring insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the transferring insurer.

A corporate division (CD) is a division of one dividing insurer into two or more resulting insurers. The dividing insurer's assets and liabilities are allocated between or among the resulting insurers without requiring affirmative policyholder consent. Following a CD, the resulting insurer(s) becomes directly liable to policyholders and the dividing insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the dividing insurer.

Refer to the work of the Restructuring Mechanisms (E) Working Group, including the draft "Restructuring Mechanisms White Paper" and the draft regulatory "Best Practices Procedures for IBT/Corporate Divisions" currently proposed, for additional information specific to IBTs and CDs that may warrant consideration in the examination and solvency oversight of these entities.

I. Considerations for Potentially Troubled Insurance Companies

A troubled insurance company is broadly defined as an insurance company that is either in or is moving towards a financial position that subjects its policyholders, claimants and other creditors to greater-than-normal financial risk, including the possibility that the company may not maintain compliance with the applicable statutory capital and/or surplus requirements (*Troubled Insurance Company Handbook*). The "Prioritization Framework" as discussed in the NAIC's *Financial Analysis Handbook* identifies troubled companies as Priority 1.

In situations in which an examination is being planned for a troubled insurance company (i.e., Priority 1 company), the NAIC's *Accreditation Program Manual* (Part B3: Department Procedures and Oversight) indicates that "the department should generally follow and observe procedures set forth in the NAIC *Troubled Insurance Company Handbook*." However, regulators may also consider leveraging the insights in the Troubled Insurance Company Handbook for Priority 2 companies, which are defined in the *Financial Analysis Handbook* as "high-priority insurers that are not yet considered troubled but may become so if recent trends or unfavorable metrics are not addressed."

The following guidance provides an overview of key elements to consider during an examination. Additional insights to assist in enhancing a state's monitoring and surveillance of troubled insurance companies, including regulatory actions available to Departments of Insurance (DOIs), can be found in the *Troubled Insurance Company Handbook*.

Communication Expectations

If an examination is planned or ongoing for a troubled or potentially troubled company, or through the course of the examination that the domestic regulator elevates the priority level of the company to troubled or potentially troubled, it is critical that the domestic regulator communicates proactively and timely with other impacted state insurance regulators. It is also important that the non-domiciliary state communicates with the domestic regulator prior to taking any action against the insurer. This can be particularly important if the corrective action plan implemented by the domestic regulator depends on continued operations of the insurer in other states. Depending on the circumstances, it may also be appropriate to communicate certain information with other parties, such as other regulatory bodies, company management, and state guaranty funds. Establishing a coordinated communication system among the relevant parties will help facilitate the domestic regulator's surveillance of the troubled company.

The timeliness of communication with other regulators should be commensurate with the severity of the event, and it should include information about the troubled company's situation and the proposed corrective action. It may also include a request for other jurisdictions to assist in the implementation of the plan. When determining which states to notify, the department may consider those in which the company: 1) has a significant amount of written, assumed or ceded insurance business; 2) has significant market share; 3) is licensed; 4) has affiliates; 5) utilizes fronting entities; 6) has pooled companies; and 7) is seeking to write business or obtain a license. If it is reasonably anticipated that corrective plans will not prevent a finding of insolvency or insolvency is reasonably possible, advance communication to the guaranty funds is critically necessary for a successful transition to liquidation. If the guaranty funds are notified in a timely manner, they may be able to provide additional guidance and assistance in preparing the company for liquidation. The memorandum of understanding, which is maintained on the Receivership and Insolvency (E) Task Force web page, is an optional tool available to state insurance regulators that can help facilitate this communication and information sharing, as well as transitional planning and preparation.

Pre-Receivership Considerations

Depending on the circumstances of the troubled company's situation, the department may determine that the appropriate course of action is to place the company in receivership. There are several steps that the department can take to ensure a smooth transition to receivership, should that be necessary. Having a thorough understanding of the company's rights and ownership of its assets, as well as its liabilities and obligations can help the department manage the possible transactions that could occur if the company is placed in receivership. It may also help the regulator understand if inappropriate transactions occur in anticipation of receivership, such as preferential payments to related entities and payment of management bonuses or expense reimbursements. As part of the corrective plan, the department may consider requesting the implementation of controls surrounding the troubled company's operations. For instance, it may be necessary for management to establish controls around acceptance of new business or new commitments by the company, as well as recordkeeping requirements if the insurer is involved with reinsurance.

If an examination is planned or ongoing for a troubled or potentially troubled company, the examination should increase its review of risks and controls surrounding financial reporting processes in the areas discussed above. For example, the exam may have a greater focus on the following areas:

- Gaining an understanding of the location (i.e., bank accounts, deposits, custodial accounts, letters of credit, etc.) and ownership (i.e., funds held with reinsurers, intermediaries, MGAs/TPAs, etc.) of company assets.
- Gaining an understanding of possible encumbrances on company assets that may be triggered if the financial position of the company continues to deteriorate.
- Gaining an understanding of the provisions within various agreements that the company has entered into (i.e., reinsurance agreements, agreements with service providers, investment advisors, etc.) that could be impacted by being placed into receivership.
- Reviewing transactions involving the movement of company assets.
- Identifying primary responsibility for obligations and liabilities, such as tax payments, pension plan contributions, pledges of assets, etc.
- Additional testing to ensure the completeness of policy and claims data.

If receivership or liquidation is triggered, and assets are transferred to the receiver or guaranty fund to settle obligations, it is important that the company's data be maintained in such a format to ensure that policies can continue to be maintained and claims can continue to be paid. For example, the company should have the ability to export its claims data through a defined format, either in (Uniform Data Standards [UDS]) format or in a form that easily can be transformed into UDS format (i.e. CSV file that retains all required elements) that would allow the data to be received and utilized by a third-party guaranty fund. It is imperative that the data be able to be transferred in a consistent, timely, and usable manner on the date that the Order of Liquidation is signed. Therefore, the examination may include additional procedures as part of the IT review to identify and locate data storage and processes, understand the format of the data, and ensure that proper functionality exists for timely and efficient export of policy and claims data in the event of a receivership.

EXHIBIT V – OVERARCHING PROSPECTIVE RISK ASSESSMENT

Background

The concept of risk on a risk-focused examination encompasses not only risks as of the examination date, but also risks that extend or commence during the time in which the examination was conducted, as well as risks that are anticipated to arise or extend past the point of examination completion. As such, consideration of prospective risks (including moderate or high residual risks existing at the balance sheet date that will impact future operations, risks anticipated to arise due to assessments of company management and/or operations, or risks associated with future business plans of the company) is an intrinsic element of a risk-focused examination and should occur throughout all phases of the examination process.

Use of this Exhibit

In completing this exhibit and documenting the examiner's consideration of prospective risks throughout the examination process, the examiner should conduct an evaluation and, if possible, conduct examination procedures on the noted prospective insolvency risks to assess the degree of risk present and recommend future monitoring. Throughout the examination process and at the conclusion of the exam, the examiner should communicate with the department's financial analysts to keep them informed of the identified prospective risks and examiner assessments. The branded risk classifications, risk assessment level and trend and associated rationale should be used to summarize prospective risks identified for communication to the analyst via Exhibit AA—Summary Review Memorandum. This communication should include relevant details obtained during the examination that will enhance the ongoing monitoring of the company.

In conducting examinations of insurers that are part of a holding company group, it is important to note that many prospective risks may occur at the holding company level. The exam team should seek to coordinate the identification and assessment of prospective risk in accordance with the exam coordination framework and lead state approach outlined in Section 1 of this Handbook. Where possible, in a coordinated examination, the lead state's work on prospective risk should be utilized to prevent duplication of effort and to leverage examination efficiencies.

The consideration of prospective risks should occur throughout each phase of the examination process. If the examiner identifies a prospective risk that relates to one specific key activity of the company, this prospective risk should be documented in the corresponding risk matrix for that key activity and treated similarly to other identified risks. However, if the examiner identifies an overarching prospective risk (a prospective risk that does not relate to a specific key activity, or relates to more than one key activity), the examiner should utilize this exhibit to document the investigation of the overarching prospective risks. Individual risks should either be addressed on Exhibit V or a key activity matrix, but not both.

By the end of Phase 1, the examiner should have a preliminary listing of overarching prospective risks included on Exhibit V – Overarching Prospective Risk Assessment. By the end of Phase 2, the list of risks on Exhibit V should be updated to include all significant overarching prospective risks identified on Exhibit CC – Issue/Risk Tracking Template.

Prospective risks may continue to be identified beyond Phase 1 and Phase 2, but all significant overarching prospective risks identified during later phases of the exam should continue to be documented and investigated on Exhibit V, regardless of the phase in which the risk was identified.

The investigation of prospective risks on Exhibit V should be completed by the end of Phase 5. It is not required that the various steps to investigate prospective risks on Exhibit V directly coincide with the seven-

phase exam approach, but it is recommended that examiners complete each step of Exhibit V as early in the exam as practical to ensure each risk identified is sufficiently tested and reviewed.

Exhibit V, Part One – Overarching Prospective Risk Testing Template

Examiners should use this worksheet to document a review and investigation of overarching prospective risks throughout the examination. Examiners may also use the examples provided on the template as a guide to assist in determining the nature and extent of the prospective risk review to be performed. **Please Note:** The risk mitigation strategies identified in the template are only examples, and the examiner should be aware that the insurer might use other strategies to mitigate the identified risk. Instructions for completing and documenting a review of prospective risk within the template are as follows:

Template Column	Instructions for Completing
Overarching Prospective Risk Identified	Based on the knowledge and understanding of the company obtained during the planning stages of the exam, document any overarching prospective risks identified.
Branded Risk Classification	For each identified risk, document the associated branded risk classification(s) from the following list: Credit (CR), Legal (LG), Liquidity (LQ), Market (MK), Operational (OP), Pricing/Underwriting (PR/UW), Reputation (RP), Reserving (RV), and Strategic (ST).
Risk Mitigation Strategies	Identify risk mitigation strategies in place at the insurer (if any) to address the prospective risk.
Investigate Risk Exposure	Test the mitigation strategies identified by management. Consider both the design and operating effectiveness of the mitigation strategies as part of the procedures performed. Provide corroborating evidence and documentation to support the procedures performed. Perform additional independent testing, if necessary, to further understand or address the risk. Testing may include evaluation of the company's historical trends, stress testing of company exposures, or other additional procedures specifically tailored by the examiner based on the company's risk. Attach and reference supporting workpapers.
Risk Assessment Level	Document the risk assessment level of the identified risk considering the test procedures performed; (i.e., Significant, Moderate, or Minimal). Refer to Exhibit AA—Summary Review Memorandum for guidance on determining an appropriate risk assessment level.
Trend	Document the trend level of the identified risk considering the test procedures performed to indicate the direction the risk is moving; (i.e., Increasing, Static, or Decreasing). Refer to Exhibit AA—Summary Review Memorandum for guidance on determining an appropriate trend level.
Rationale	Document the rationale for the trend and level of concern.
Communicate Findings to Financial Analysis	Document specific information to be communicated to the department analyst. Information should include specific procedures for continual monitoring, specific documents to obtain from the company, expected timelines for follow-up, and contact information.

Exhibit V, Part Two – Common Areas of Concern

Exhibit V, Part Two may be used as a reference guide to assist in identifying categories of prospective risk that may be relevant for review and inclusion on the Exhibit V, Part One. Note: examiners are not required to identify a risk from each category listed or provide a rationale for not identifying risks from the common areas of concern.

PART ONE – OVERARCHING PROSPECTIVE RISK TESTING TEMPLATE

Overarching Prospective Risk Identified	Branded Risk	Risk Mitigation Strategies	Investigate Risk Exposure	Risk Assessment Level	Trend	Rationale	Communicate Findings to Financial Analysis
Example Prospective Risk 1: *The company may experience rating agency downgrades, causing the company to be unable to sell its products.*	*ST* *RP*	*The company has processes in place to monitor and manage its financial performance in accordance with metrics considered significant by rating agencies.* *The company utilizes modeling to determine its economic and rating agency capital needs.*	*Reviewed financial reports for evidence of monitoring of rating agency performance measures and management review, noting that the company appears to be meeting its benchmarks (See wp A.1.4).* *Obtained and reviewed the economic capital calculation at 12/31/XX, noting that rating agency considerations are included in the process and that the company appears to hold capital in excess of the calculated amount. See*	*Moderate*	*Static*	*The company has product lines sensitive to a ratings decrease; however, it appears the company has appropriate controls and strategies in place to maintain strong ratings.*	*If a future rating downgrade occurs the DOI should meet to determine an appropriate course of action (e.g., limited scope exam).*

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Overarching Prospective Risk Identified	Branded Risk	Risk Mitigation Strategies	Investigate Risk Exposure	Risk Assessment Level	Trend	Rationale	Communicate Findings to Financial Analysis
Note: Only P/C insurers.		*of directors at the next annual meeting.*					*of directors on the impact of climate scenarios on the company's long-term business strategy. In addition, the analyst should request updated medium-term climate scenario results from the company annually to track changes in estimated future exposures.*
Example Prospective Risk #5: *The company's executive compensation plans include incentives based on financial metrics which may*	*OP*	*The Board of Directors reviews and approves executive compensation plans, including any incentive plans. Incentive plans and variable compensation practices are intended to emphasize long-term financial goals and avoid excessive focus on short-term growth and performance.*	*Obtained the board minutes to ensure board review and approval of the executive compensation plan structure, which does incorporate some long-term goals. However, much of the incentive compensation*	*Moderate*	*Increasing*	*The Company's executive compensation plan has been reviewed and approved by the Board; however, the incentives are largely dependent upon some*	*The analyst should continue to monitor fluctuations in the company's general expenses, as well as the overall expense ratio and profitability to identify potential issues regarding the executive*

Overarching Prospective Risk Identified	Branded Risk	Risk Mitigation Strategies	Investigate Risk Exposure	Risk Assessment Level	Trend	Rationale	Communicate Findings to Financial Analysis
encourage riskier decision making.		The Company pays out incentive compensation based on achievement of performance goals and maintains a claw back policy that allows the Company to recover incentive compensation in the event that financial statements must be restated.	continues to be based on short-term growth and performance goals (Refer to A.4.2). Obtained and reviewed detailed support for incentive payment calculations, verifying the accuracy of calculations in accordance with the written plan. Also reviewed and verified the Company's claw back policy. (Refer to A.4.5).			metrics (i.e., annual premium growth) that have the potential to encourage excessive risk taking by executives.	compensation structure. Review the Corporate Governance Annual Disclosure (CGAD) for information referring to the executive compensation practices and follow-up on any changes identified.

PART TWO – COMMON AREAS OF CONCERN

The prospective risk categories provided within this exhibit are not designed to be an all-inclusive list and might not apply to all insurance companies under examination. The examiner's understanding of the company obtained in Phase 1, including a review of the company's Enterprise Risk Report (Form F) and/or Own Risk and Solvency Assessment (ORSA) Filing, should be utilized to determine whether risks in these categories might be applicable to the company. The company will likely face additional prospective risks that do not fit within the categories in this exhibit.

Prospective Risk Category	**Comments**
Merger and Acquisition Activity	If applicable, review the company's process to identify and perform due diligence on potential acquisitions. In addition, consider reviewing the company's process to integrate acquired entities and business into its systems.
Product Development	If applicable, review and assess the company's process to identify, develop, price and market new products in accordance with the company's strategy and business needs.
Legal and Regulatory Changes	If applicable, review how the company identifies, monitors and addresses changes to the legal and regulatory environment it operates within. For example, review the company's processes in place to analyze the impact that health care reform could have on the company, including support for company projections and strategies for appropriateness.
HR/Personnel Risks	If applicable, review and assess the company's HR processes to identify, mitigate and monitor risks related personnel management (including succession planning for critical positions) as well as hiring, managing, retaining and terminating personnel in accordance with company needs.
Strategic Planning	If applicable, review and assess the company's processes for strategic planning to determine whether the company regularly analyzes its strengths and weaknesses, as well as opportunities and threats, on an ongoing basis. In addition, it might be appropriate to review the company's process to update its overall business plan on a regular basis.
Compensation Structure	If applicable, review the company's process for developing, ~~monitoring~~monitoring, and adjusting its compensation structure to ensure that employees are appropriately compensated without creating an incentive to misrepresent financial results or take excessive risks.
Rating Agency Downgrade	If applicable, review the company's process to monitor and prepare for potential adverse changes in its credit ratings. If a future rating agency downgrade is deemed likely, consider whether the company is adequately prepared to handle the results of such a downgrade.
Costs of Capital	If applicable, review the company's access and ability to obtain capital, reinsurance and letters of credit, if necessary, to meet funding and risk diversification needs.
Business Continuity	If applicable, review the company's business continuity plan. Follow the steps outlined in Section 1, Part III.
Climate Change	If applicable, review the company's process for identifying and monitoring risks resulting directly or indirectly from the impact of climate change risk. The insurer may assess energy transition and asset devaluation risk on its investment portfolio, or physical risk due to climate change with scenario analysis or modeling. If material, the company should evaluate the impact of climate risk on its longer-term business strategy and inform its board of directors regarding the results of transitional and physical risk stress scenarios and modeling.
Provider Contracting (Health)	If applicable, review the company's process for negotiating contracts with key providers and ensuring an adequate and competitive provider network.

EXHIBIT Y

EXAMINATION INTERVIEWS

Overview

Interviews are a useful examination tool to gather information about key activities, risks and risk mitigation strategies. Employees can also provide information on fraudulent activity within the company. It is critical for the examination team to understand and leverage the company's risk management program; i.e., how the company identifies, controls, monitors, evaluates and responds to its risks. The discipline and structure of risk management programs vary dramatically from company to company. Interviews should be performed in the early stages of the examination so that regulators can adjust their procedures accordingly. An examiner can perform alternate, additional or fewer detail and control tests as a result of interviews with the company.

Interviews should be conducted with key members within management of the company, as well as members of the board of directors, audit committee, internal/external auditors and any other employees deemed necessary. These interviews can be used at the beginning of the examination or at any time during the examination, as necessary. In order to conduct a productive interview, the examiner should have a basic understanding of the company prior to commencing the interview process. When possible, the examiner should meet with the department analyst prior to scheduling interviews with company personnel to assist in gaining this basic understanding. Examiners should continue to tailor each interview as information is learned about the company throughout the planning process.

Examiners should consider the size and complexity of the organization in determining which individuals to interview. The interview process is a key step in the "top–down" approach, beginning with senior management and then drilling down through the various levels of management to obtain a thorough understanding of the organization to assist in scoping the examination. In order to select the individuals to interview, the examiners should obtain an organizational chart from the company and compile a list of potential interviewees. Interviews of board members and senior company management should be conducted by examiners who possess the appropriate background and training. The examiner should also carefully consider the order of interviews, as information gleaned from certain "C"-level individuals can inform subsequent interviews. For example, the Chief Risk Officer (CRO) is uniquely positioned to have an awareness of the various risks facing the company from multiple perspectives. The information obtained through an interview with the CRO can help the examiner have a greater understanding of the key risk areas of the company, which can then be used to further customize subsequent interviews, as well as determine which additional members of management should be interviewed. This may be particularly important if the company under examination is part of a larger coordinated holding company group exam as the CRO at the enterprise level reviews and establishes risks for the holding company as a whole. Questions asked of management of each regulated entity in the holding company group, such as those for climate-related risks, may be more appropriately directed to the CRO. While it can be challenging to coordinate the interview schedule with company personnel at this level, examiners are encouraged to attempt interviewing the CRO as early in the interview process as possible.

If the company under examination belongs to a holding company group that has been identified as an internationally active insurance group (IAIG), as defined in the *Insurance Holding Company System Regulatory Act* (#440), the group-wide supervisor should consider conducting additional interviews at the head of the IAIG, including key members of management and the board of directors. Such interviews would assist the group-wide supervisor in determining the consistency of governance practices across the IAIG, as well as whether the group's risk management framework encompasses the head of the IAIG and legal entities within the IAIG.

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Sample Interview Questions for Board or Committee Members

Experience and Background

- How has your professional experience and background prepared you to serve on the board of directors for this company?

Duties and Responsibilities

- How often does the board/committee meet? Why is that sufficient?
- Briefly describe your duties and responsibilities, including what types of company information you monitor on a continuous basis.
- How does management establish objectives and how does the board of directors monitor achievement of those objectives?
- What role does the board of directors play in determining executive compensation?

  The following questions may be appropriate for a member of the compensation committee for further details surrounding the company's executive compensation structure:

  - Describe how incentive programs are structured. What metrics are used? What percentage of the incentives are short-term vs long-term?
  - How does the board ensure that the compensation policy is in line with stakeholder interests?
  - How does the board ensure that the compensation policy does not incentivize excessive risk taking?
  - How often are compensation and incentive plans evaluated for any adjustments or updates?
- What areas are discussed and what type of decisions are made by the board/committee?
  - How does the board ensure that sufficient information is received to make informed decisions on behalf of the company?
- Does the board/committee review related-party transactions?
- What role does the board/committee play in overseeing the actuarial function as well as associated internal controls?
- Do you have a board member or committee that is responsible for monitoring the financial risks (short-term and long-term) associated with climate change?
  - How often and at what level of detail does the board discuss these risks?

Reporting Structure

- Describe the reporting structure of the company, including who reports to the board/committee.
- Describe the interaction the board of directors has with the internal/external auditors, shareholders and senior management.

Ethics

- Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain the commitment to ethics by the board/committee and explain how the board/committee conveys that commitment to employees.
  - How does the board obtain an understanding of the "tone" throughout the organization?
- How does the company compare to others, in terms of its position on ethics?
- Do you have any knowledge or suspicion of fraud within the company?

Risk Areas

- How does the board identify and monitor key risks faced by the company?
  - What are the key risks the board has identified?

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EXAMINATION REPOSITORY – CAPITAL AND SURPLUS

Own Risk and Solvency Assessment (ORSA)

During the review of the ORSA filing (if applicable), the examiner may identify risks and controls that are relevant to be considered when creating the Capital and Surplus Key Activity Matrix. Additionally, examiners may perform test procedures related to the information contained within the ORSA filing that provides evidence regarding the sufficiency of an insurer's capital and surplus. Examiners are encouraged to leverage the information contained within the ORSA, and associated test procedures, when populating the Key Activity Matrix.

Annual Statement Blank Line Items

Listed below are the corresponding Annual Statement line items that are related to the identified risks contained in this exam repository:

Capital Notes and Interest Thereon
Aggregate Write-ins for Special Surplus Funds
Common Capital Stock
Preferred Capital Stock
Aggregate Write-ins for Other than Special Surplus Funds
Surplus Notes
Gross Paid-in and Contributed Surplus
Unassigned Funds (Surplus)
Treasury Stock

Relevant Statements of Statutory Accounting Principles (SSAPs)

All of the relevant SSAPs related to other liabilities and surplus, regardless of whether or not the corresponding risks are included within this exam repository, are listed below:

No. 41 Surplus Notes
No. 72 Surplus and Quasi-reorganizations

† Risks identified with this symbol may warrant additional procedures or consideration at the head of the internationally active insurance group (IAIG) or level at which the group manages its aggregated risks. Where IAIGs have a decentralized business model, at least in regard to certain operations and management of related risks, examiners should consider evaluating those risks at the subgroup or legal entity level. Refer to Section 1, Part I for additional guidance for examinations of IAIGs.

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Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
and future business operations.				Underlying assets to be considered may include: • Deferred tax assets • Significant receivables • Goodwill • Investment in subsidiary • Encumbered assets • Defined benefit pension asset The insurer maintains documentation regarding permitted practices that could impact the quality of available capital and reviews all associated calculations to ensure compliance.	Obtain documentation of the insurer's review of its compliance with permitted practices.	consideration of the liquidity of the assets under review. Review the make-up of the insurer's capital and assess how the categories (e.g., common stock, preferred stock, surplus notes, paid-in-capital, etc.) support the ongoing and future business operations. Review the insurer's calculations to ensure they comply with the permitted practices granted by the domiciliary insurance commissioner. Review the effects of the permitted practice on RBC calculations, including subsequent examination adjustments.
The insurer is not accurately calculating, reporting and monitoring RBC, including any manual adjustments to RBC charges (i.e., Modco Reinsurance, Separate Accounts, etc.).	OP	CM	CMT	RBC calculations are performed in accordance with instructions and subject to supervisory review. The company has a process to ensure that RBC reports and supporting data are filed with the NAIC in a timely and complete manner.	Test controls relating to the insurer's supervisory review process for RBC. Review the NAIC RBC crosscheck letter from the insurer or the NAIC, if applicable, and response letter from the insurer to determine the	Obtain and review the insurer's supporting workpapers to test whether material values in the RBC report were properly classified, valued and included (e.g., catastrophe risk exposure data, C-3 Phase II, Modco reinsurance adjustments, separate account assets)

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
					completeness and accuracy of the insurer's RBC report. Contact the NAIC quality assurance department if such correspondence is unavailable.	in accordance with SSAP guidance and RBC instructions. Compare the data provided in the RBC filing against other filings and information available to the department for consistency. (This procedure may only be necessary for values not obtained directly from the annual financial statement and not subject to the NAIC RBC crosscheck procedures.)
				The company reconciles data filed in support of the RBC calculation (including any manual adjustments) back to system data and/or source documentation.	Test the insurer's reconciliation of supporting data back to the system and/or source documentation.	Determine the impact of examination changes on the RBC calculation.
				The company utilizes the same modeling approach, assumptions and data to determine significant components of its RBC charge (e.g., catastrophe risk exposure, C-3 Phase II) as it uses for its own internal risk management and regulatory accounting/reserving purposes.	Test the operating effectiveness of company controls to verify that modeling approaches, assumptions and data used to determine significant components of RBC charges are reconciled/agreed to those used in internal risk management and accounting/reserving processes.	Compare the modeling approaches, assumptions and data filed in support of RBC calculations with those used by the company for internal risk management and regulatory accounting/reserving purposes (including interrogatories, actuarial filings, AS exhibits, etc.). Investigate any significant variances or inconsistencies for appropriateness.

Draft: 11/1/24

Information Technology (IT) Examination (E) Working Group
Virtual Meeting
October 31, 2024

The Information Technology (IT) Examination (E) Working Group of the Examination Oversight (E) Task Force met Oct. 31, 2024. The following Working Group members participated: Ber Vang, Chair (CA); Shane Mead, Vice Chair (KS); Blase Abreo (AL); Mel Anderson (AR); Michael Shanahan (CT); Ginny Godek (IL); Dmitriy Valekha (MD); Kim Dobbs and Cynthia Amann (MO); Colton Schulz (ND); Andrea Johnson (NE); Eileen Fox (NY); Metty Nyangoro (OH); and Eli Snowbarger (OK).

1. Adopted its Oct. 10 Minutes

The Working Group met Oct. 10. During this meeting, the Working Group took the following action: 1) discussed current and plans for updating IT review guidance based on a Cybersecurity (H) Working Group referral; and 2) exposed revisions to Exhibit C, Part 2 for a 14-day public comment period ending Oct. 24.

Schulz made a motion, seconded by Amann, to adopt the Working Group's Oct. 10 minutes (Attachment Four-A). The motion passed unanimously.

2. Adopted Revisions to Exhibit C, Part 2

Topher Hughes (NAIC) stated that Missouri and Kansas submitted comments during the exposure period, recommending multiple edits throughout Exhibit C, Part 2 that were deemed non-substantive and, therefore, incorporated into the draft included in the meeting materials.

Hughes stated that the Working Group also received a comment letter from the National Association of Mutual Insurance Companies (NAMIC) (Attachment Four-B) during the exposure period. In its letter, NAMIC provided comments on the proposed revisions to APO 10, APO 12, and APO 14 within Exhibit C, Part 2. Hughes noted that NAMIC's suggested edits to APO 10 were also considered non-substantive and similarly incorporated into the draft included in the meeting materials.

For APO 12, Colleen Scheele (NAMIC) said that the proposed language "information sharing forums" was otherwise undefined and vague regarding how often a company should assess these risks.

Bruce Jenson (NAIC) stated that the phrase "information sharing forums" was specifically used to address a perceived gap from the National Institute of Standards and Technology (NIST) Cybersecurity Framework (CSF) 2.0. After discussion, Scheele asked if the Working Group would accept changing the language to "periodically assessing" to better indicate the expectation of the frequency of checking. Vang stated that this sounded like a fair revision.

For APO 14, Scheele stated that data practices are a very important piece of the risk management puzzle, but NAMIC believes the draft may be better served by focusing on material financial risks to solvency, such as in the *Insurance Data Security Model Law* (#668). Scheele stated that the Working Group should wait for other NAIC groups charged with overseeing and monitoring data privacy and cybersecurity issues to reach a consensus on data governance and hygiene to avoid potential conflicts.

Dobbs stated that data security is not a new concept for IT security and that IT examiners already ask questions of insurance companies concerning data security when appropriate. Dobbs also stated that many small- and medium-sized insurers have gone out of business following a data breach, an example of why data security is a solvency concern. Amann added that the Cybersecurity (H) Working Group issued the referral because it believes it is important to provide insurance-specific guidance sooner rather than later. Amann stated other regulatory bodies already have similar guidance available and emphasized the importance of moving forward with this guidance as the insurance industry is seeing the consequences of data breaches and bad cyber hygiene practices. As the work of the Privacy Protections (H) Working Group is likely to continue for several more years, the Working Group should not wait to issue guidance in this area.

Schulz said that groups like the Privacy Protections (H) Working Group would likely develop more prescriptive guidance that would then be applied to insurers at the state level, whereas Exhibit C would be customized to the size and needs of the individual company by IT examiners.

Schulz made a motion, seconded by Dobbs, to adopt the proposed edits to Exhibit C, Part 2, including the modification to the language in APO 12 (Attachment Four-C). The motion passed unanimously.

Having no further business, the IT Examination (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E CMTE/EOTF/ITEWG Minutes 10-31-24

Draft: 10/11/24

Information Technology (IT) Examination (E) Working Group
Virtual Meeting
October 10, 2024

The Information Technology (IT) Examination (E) Working Group of the Examination Oversight (E) Task Force met Oct. 10, 2024. The following Working Group members participated: Ber Vang, Chair (CA); Shane Mead, Vice Chair (KS); Blase Abreo (AL); Mel Anderson (AR); Michael Shanahan (CT); Ginny Godek (IL); Jerry Ehlers (IN); Dmitriy Valekha (MD); Kim Dobbs and Cynthia Amann (MO); Colton Schulz (ND); Andrea Johnson (NE); Eileen Fox (NY); Metty Nyangoro (OH); and Eli Snowbarger (OK).

1. Discuss Current and Future Plans for Updating IT Review Guidance Based on Cybersecurity (H) Working Group Referral

Vang stated that the drafting group activities since the last meeting address the referral from the Cybersecurity (H) Working Group. The referral requested that the IT Examination (E) Working Group review the IT exam process and evaluate if there would be a benefit to making the process more cybersecurity-focused. The referral suggested several frameworks and documents that could be useful in addressing the request, including the cybersecurity performance goals (CPGs) of the Cybersecurity and Infrastructure Security Agency (CISA), the Cybersecurity Framework (CSF) 2.0 of the National Institute of Standards and Technology (NIST), or the benchmarks of the Center for Internet Security (CIS).

The drafting group determined that there could be a benefit to enhancing the cybersecurity procedures in Exhibit C. After evaluating several sources of guidance, the drafting group decided to incorporate updates based on the NIST CSF 2.0. The drafting group selected the NIST CSF 2.0 because NIST was introducing concepts not currently in the IT exam process while also being in a format similar to the current Exhibit C.

Vang explained that due to time constraints for incorporating changes into the *Financial Condition Examiners Handbook* before the end of this year, the drafting group chose to take a two-step approach to these changes. In the first step, the drafting group performed a gap analysis, and Exhibit C procedures have been modified to address critical gaps between the current Exhibit C and the NIST CSF 2.0.

In the next step, which is anticipated to extend well into 2025, the drafting group will separate procedures needed to establish the reliability of IT general controls from those needed to examine cybersecurity. Care will be taken to ensure findings concerning IT general controls can be made before the end of phase 2, while it is possible that a finding on cybersecurity matters may take place later in the exam process. It is foreseen that some current procedures from Exhibit C will also be eliminated during this process, as they will be found redundant or otherwise no longer needed. It is important that the resulting IT general controls and cybersecurity reviews remain right-sized for examination purposes.

2. Exposed Revisions to Exhibit C, Part 2

Vang explained that the drafting group had divided into two subgroups. Subgroup 1 addressed the Govern and Protect functions of CSF 2.0 while Subgroup 2 addressed Identify, Detect, Respond, and Recover.

Mead provided examples of proposed changes made by Subgroup 1 to address the Govern and Protect functions of CSF 2.0. There were numerous small edits made to add emphasis to cybersecurity. One example is in APO 01.01-

01.02, where the phrase “including cybersecurity” was added to the common control, and a new possible test procedure was added to review and assess the adequacy of cybersecurity staffing and/or resources. Additionally, Mead highlighted larger changes made to APO 10, BAI 03.07-03.08, BAI 10.01-10.05, and DSS 05.06. Mead also noted that Subgroup 1 proposed adding part of APO 14, based on APO 14.01 and APO 14.08-14.09, to better address data protection and retention.

Vang then addressed the changes proposed by Subgroup 2. Vang highlighted larger proposed edits to DSS 02.01, DSS 05.07, and MEA 02.01, while noting that Subgroup 2 proposed adding controls based on DSS 02.05 to better address the recovery process following an incident.

Colleen Scheele (NAMIC) asked about the addition of APO 14, concerning the data life cycle. Mead stated that the NIST CSF 2.0 had controls in it that dealt with items not previously in Exhibit C and that the Subgroup considered trying to fit the control into DSS 05.06 but believed that APO 14 better addressed the issue, as it already dealt with the data life cycle and was the more logical solution.

There were no objections to exposing the revisions for a 14-day public comment period ending Oct. 24. Vang stated that the shortened exposure period was so that revisions could be adopted before the next NAIC national meeting and included in this year’s revisions to the *Financial Condition Examiners Handbook*.

Having no further business, the IT Examination (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E CMTE/EOTF/ITEWG Minutes 10-10-24

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Deputy Commissioner Ber Vang

Information Technology (IT) Examination (E) Working Group

National Association of Insurance Commissioners

Via Email: Topher Hughes, chughes@naic,org, and Bruce Jenson, bjenson@naic.org

RE: Request for Comments on Exhibit C- Part 2

Dear Deputy Commissioner Vang,

Thank you for the opportunity to comment on the exposed revisions to Exhibit C- Part 2 of the Information Technology piece of the Financial Condition Examiner's handbook (Exposure). The National Association of Mutual Insurance Companies (NAMIC) membership reflects many of the country's largest national insurers as well as regional and local mutual insurance companies on main streets across America. NAMIC members write $391 billion in annual premiums and account for 68 percent of homeowners, 56 percent of the automobile, and 31 percent of the business insurance markets. NAMIC offers the following comments on this Exposure, organized by topics of third-party vendors and data practices.

Third-Party Vendors

The Exposure makes several changes to how insurers will be expected to interact with and monitor their third-party vendors.

In APO 10, a control was added that states:

> The company has a formal process in place whereby;
>
> 1. *An inventory is completed and maintained of the company's vendors and service providers, including information concerning their risk and their supply chain criticality.*
> 2. Risk is assessed based on the company's understanding of the third-party service providers information security program as well as by the company's ability to verify elements of the third-party service provider's security program and the data exposed to the third party, such as PII; Supply chain criticality is assessed on mission function, and availability of alternatives.

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Subsequentially, a preliminary information request was added that asks insurers to "*verify an inventory of service providers is created, maintained, and includes sufficient information to rank providers based on both risk and supply chain criticality*." Possible test procedures have been edited to include:

Review the company's third-party *vendor and* service provider management process including consideration of:

1. Whether the listing of third-party service providers is comprehensive and complete;
2. *Whether the listing considers both risk and supply chain criticality in ranking;*
3. Whether the company*, service, or program* has appropriately determined access rights based on its risk assessment *and supply chain criticality*; and
4. Whether the company has designed appropriate controls that are consistent with the company's ~~risk assessment~~ *ranking*.

Such an above referenced inventory would be enormous and quite labor-intensive to maintain and continuously update rankings. There is a concern about adding *supply chain* to the evaluation factors for third party vendors. It is very difficult, particularly for vendor owners spread across the business, to accurately assess supply chain risk or even to understand how supply chain risk is being interpreted or defined. While we do not support introducing substantive concepts via a handbook (rather than in a legal/regulatory forum with administrative procedure and transparency of expected compliance requirements) if regulators are going to proceed with introducing such a concept perhaps consider the phrasing of a "*material adverse impact to the business, operations or security*", which is used in the NYDFS Cybersecurity Regulation.[1] It's almost impossible for anyone to accurately assess supply chain risk unless they have an investor-level understanding of each company and product. As examples, recently both Crowdstrike and SolarWinds had massive supply chain/process failures that caused huge damages to their customers. Both companies were thought to be exemplars of controls and quality prior to those catastrophic supply chain failures.

As previously written, APO 10 and Insurance Data Security Model Law 668 (Model 668) are generally aligned in the scope of their oversight except where APO 10 requires the entity to maintain an inventory and scoring system based on risk and supply chain criticality. It is important to note that here, compliance with Model 668 would not result in meeting the standard set forth in APO 10. Without going through the sanctioned process of amending Model 668, APO 10 replaces that model's *'appropriate measures'* with the inventory and risk/supply chain criticality ranking and is imposing completely new requirements on insurers via a handbook. In practice, 'appropriate measures' may be sufficient to cover what the Exposure is intending. NAMIC does not believe that any edits to this APO are necessary.

[1] 23 NYCRR 500.

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Regardless of our concerns, NAMIC offers alternative edits below to the exposed language the preliminary information request and the possible test procedures that would alleviate some of the anxieties surrounding creating a ranked list of third-party vendors.

Preliminary Information Request Edits:

Verify an inventory of service providers is created, maintained, and includes sufficient information to ~~rank~~ *group or classify* providers based on risk and *material adverse impact to the business, operations or security* ~~and supply chain criticality~~.

Possible Test Procedures Edits:

Review the company's third-party vendor and service provider management process including consideration of:

1. Whether the listing of third-party service providers is comprehensive and complete;
2. Whether the listing considers both risk *and material adverse impact* ~~and supply chain criticality~~ in ~~ranking~~ *classifying or grouping;*
3. Whether the company, service, or program has appropriately determined access rights based on its risk assessment *and material adverse impact* ~~and supply chain criticality~~; and
4. Whether the company has designed appropriate controls that are consistent with the company's ~~ranking~~ *classifying or grouping*.

In APO 12, the Exposure adds language into possible test procedure:

Review risk profile and assessments for timely and relevant information on the organization's most significant IT risks, *including cybersecurity and third-party risk*, and subsequent mitigating controls. *Determine whether threats and vulnerabilities identified through information sharing forums are incorporated into the risk profiles*.

As written, it implies ongoing perpetual review of third-party vendors in an incredibly vendor heavy world. This seems like an attempt to make sure that the cybersecurity personnel are involved in the broader security discussion and paying attention to various "sharing forums." While all insurers do pay attention to several industry forums, it may not be best practice, attribute specific changes to our risk assessments back to the source(s) that brought them to our attention. It is appropriate to ask about cybersecurity continuing education and broader industry awareness, but this test does not get to the point of third-party vendors' risk to ERM as finely as it could.

NAMIC suggests the below edits to APO 12's edited possible test procedure:

Review risk profile and assessments for timely and relevant information on the organization's most significant IT risks, including cybersecurity and third-party risk, and subsequent mitigating controls. *This includes periodically assessing*

> *third party vendors which would incorporate threats or vulnerabilities into risk profiles.* ~~Determine whether threats and vulnerabilities identified through information sharing forums are incorporated into the risk profiles.~~

This approach in this suggested wording is also more consistent with the language contained in Section 4 of Model 668.

Data Practices

The Exposure adds a new section, APO 14, which concerns the risk that the company does not effectively manage their data across the data life-cycle. This is not a new concern for regulators and insurers, but the way in which this Exposure frames it is different than existing guidance. The SEC looks at cybersecurity events as a potential reporting requirement in the context of *"materiality,"* which is defined as the consequence the event would have on the financial condition of the entity, specifically with concern as to whether the consequence of the event would affect the decision-making process of an investor or potential investor.[2] If the financial examiner were to focus on cybersecurity risk as a protection of financial viability, it may make sense, but that risk assessment should be focused on material financial consequence, analogous to the SEC requirement being focused on its interest in protecting innocent investors.

The current NAIC guidance on this topic exists in Model 668, Section 4, Information Security Program (Section 4). Section 4 (B) states that a licensee's information security program shall be designed to:

1. Protect the security and confidentiality of Nonpublic Information and the security of the Information System;
2. Protect against any threats or hazards to the security or integrity of Nonpublic Information and the Information System;
3. Protect against unauthorized access to or use of Nonpublic Information, and minimize the likelihood of harm to any Consumer; and
4. Define and periodically reevaluate a schedule for retention of Nonpublic Information and a mechanism for its destruction when no longer needed.

Section 4 (D) provides guidance on risk management and how the information security program should mitigate identified risk, commensurate with the size and complexity of the insurer's activities, including its use of third-party service providers. The financial exam already incorporates some of these ideas into its scope and test controls.

Another concern is the subject matter of this APO. APO 14 is connected to solvency but truly gets to the heart of privacy and security issues, which are not traditional solvency topics. To effectively manage this new topic, examiners must have sufficient knowledge about controls and technology to understand best practices as well as what insurer responses mean. The financial exam is a flexible exam, meant to meet companies where they are in both size, scope, and complexity of business practices.

[2] Security and Exchange Commission, 17 CFR Parts 229, 232, 239, 240 and 249 (2023- 16194).

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Data retention may not be the largest threat to solvency in the IT space. *NAMIC suggests the Working Group not move forward with APO 14 at this time, holding back this piece of Exposure and investigating areas such as ransomware protections and practices.*

NAMIC is appreciative of the extensive work done the Working Group as it relates to insurer practices related to third party vendors. We welcome the opportunity to work with regulators and NAIC staff on the inclusion of these risks into the financial exam.

PART TWO – EVALUATION OF CONTROLS IN INFORMATION TECHNOLOGY (IT) WORK PROGRAM – ALIGN, PLAN AND ORGANIZE (APO)

Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
APO 01	IT organizational structure is inadequate to support business objectives.	APO 01.01 – APO 01.02	The company's IT management organizational structure, with clearly defined roles and responsibilities, supports business objectives and IT priorities (including cybersecurity) and enables efficient decision-making.	Provide the IT organization chart showing job title and names of IT executives and managers and reporting lines to CEO and the BOD. Provide job descriptions for key IT positions, including cybersecurity, plus resumes or biographical information for incumbents of those positions. Provide a list of IT governance committees (e.g., IT strategy, steering committees, etc.)	Review and assess adequacy of IT governance model. Review and assess adequacy of cybersecurity staffing and/or resources. Consider segregation of duties and clearly defined roles and responsibilities. Review IT governance committees to determine whether business is adequately represented to facilitate IT priorities in supporting business objectives.
		APO 01.03- APO 01.04	The company has established and communicated IT standards to ensure consistency and to drive compliance across the organization.	Provide IT policies and procedures, including security, HR policies and IT training program documentation, including for specialized roles such as cybersecurity professionals.	Assess policies and procedures to ensure currency and completeness. Determine whether IT security is embedded in HR policies for all employees. Review training programs and schedules to confirm that management and employees, as

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
					well as those in specialized roles, are provided with sufficient training to understand the importance of compliance with IT and cybersecurity policies, including awareness of concepts of phishing, malware, and data loss prevention, as appropriate. Assess the level of security awareness throughout the organization, including the awareness of the board of directors and senior management, as appropriate to their distinct roles.
APO 02	Enterprise business objectives cannot be attained due to the development of an IT strategy that is inadequate, ineffective and not in alignment with business objectives, including inadequate management oversight over the achievement of the IT strategy.	APO 02.01-APO 02.05	The IT strategic planning processes considers the current enterprise environment and business processes, as well as the enterprise strategy and future objectives. Additionally, consideration is given to the external environment of the enterprise (e.g., industry drivers, relevant regulations, basis for competition).	Provide copies of IT strategic plans and evidence of strategic planning meetings, including membership, attendance, agendas and minutes.	Verify that strategic plans are developed by an IT steering committee (or its equivalent) with adequate input and involvement of IT management and key executive personnel from all significant business units. Interview senior IT personnel and review the IT strategic plan development process to understand how the IT strategic plan is developed and updated in alignment with the business. Interview IT steering committee members to verify the following: 1) The strategic IT plan is consistent with business objectives. 2) Contributing committee members are aware of corporate short-term and long-term goals. 3) The IT strategic plan is based on a current understanding of systems, including input from stakeholders. 4) Risk and cost/resource implications of the

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
					required IT capabilities were considered.
APO 03	Enterprise goals may not be met because the data and systems architecture is poorly defined and/or fragmented.	APO 03.01 – APO 03.03, APO 03.05	The company has an information architecture model that addresses the creation, use and sharing of data between applications that maintain data integrity, flexibility, functionality, cost-effectiveness, timeliness, security and availability.	Provide documentation to support the company's information architecture model and the associated standards.	Review the information architecture model and verify that the model considers all significant business processes, including user-developed applications such as spreadsheets and Access databases. Compare the information architecture model to the system summary grid to verify that all significant areas are addressed. Review the information architecture model to verify that the company has created standards that address data integrity, flexibility, functionality, timeliness, cost-effectiveness, availability, and security between applications.
				Provide a copy of the membership, agendas, and minutes of the meetings of the information architecture board.	Review membership, agendas and minutes of the Information Architecture Board to verify that they are involved in the oversight of technology.
APO 04	Company operations may lack efficiency and competitive advantage because system technology is obsolete and poorly aligned with business objectives.	APO 04.02	The company has an IT steering committee (or equivalent) that provides direction and input to IT for system and application solutions.	Provide a copy of the membership, agendas, and minutes of the meetings of the IT steering committee.	Review membership, agendas and minutes of the IT steering committee to verify that they are exercising the appropriate oversight of IT, including prioritization of IT investments and consideration of innovation.
		APO 04.04 – APO 04.05	The company has a technology advisory board (or equivalent) that identifies emerging technologies and/or	Provide a copy of the membership, agendas and minutes of the meetings of the technology advisory board.	Review membership, agendas and minutes of the technology advisory board to verify that they are providing information on emerging technologies and other IT innovations, as well as evaluating and monitoring the results of

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
			other IT innovations.		proof of concept initiatives.
APO 06	The IT budget is not representative of the organization's goals and business needs, and IT expenses are not properly allocated.	APO 06.01 - APO 06.05	The IT budget is developed based on strategic plan initiatives.	Provide evidence that the IT budget is based on supporting the strategic plan.	Review budget documentation to verify consistency with the IT strategic plan. Interview senior IT management to verify that the IT budget is created based on the IT strategic plan. Determine if a chargeback system exists and verify that the IT costs appropriately transfer to business units for IT services rendered.
			The company has a formal budget monitoring process to identify and address budget variations.	Provide evidence of the budget monitoring process.	Review company documentation to verify that the company is adequately monitoring IT costs, service levels, and service improvements.
				Provide a copy of the budget variance report, or similar document.	Review the company's budget and variance explanations for reasonableness. Identify whether the variances were the result of control deficiencies that need to be addressed.
APO 09	IT-enabled services and internal service levels are not managed to ensure that IT services align with enterprise needs and expectations.	APO 09.01- APO 09.05	The company has a defined framework that provides a formalized service level management process between the customer and service provider. The framework should: 1) Provide for the creation internal service level agreements (SLAs) that formalize IT services provided, including performance	Provide a copy of policies and procedures relating to support provided for IT services.	Verify that the performance standards are being achieved. For performance standards that are not met, ensure that there is a proper resolution process.
				Provide a listing of internal SLAs, supporting IT services provided to business customers.	Select a sample of SLAs from the listing obtained. Inspect and verify SLA policies and procedures to ensure that agreements: 1) Are approved by responsible company personnel. 2) Contain measurable performance standards. 3) Align SLA objectives and performance measures within business objectives and IT strategy.

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
			measures. 2) Provide for continuous alignment with business requirements. 3) Include processes and procedures such as monitoring of availability, reliability, performance, capacity for growth, levels of support, continuity planning, security and demand restraints. 4) Ensure that regular reviews of SLAs and supporting contracts are performed to ensure that formalized IT services are being provided.		Ensure that SLAs are reviewed and revised when needed.
APO 10	Third-party service provider risks are not properly assessed, addressed, and mitigated.	APO 10.01 - APO 10.05	The company has a formal process in place to manage service providers. The company creates formal agreements with the service provider to identify roles and responsibilities, expected deliverables, performance standards and credentials.	Provide a copy of the company's vendor-management policies and/or procedures. Provide a list of third-party service providers (suppliers), including the type of services provided, their significance and criticality.	Inspect a sample of third-party provider contracts (agreements), including those who are considered significant to the company, SLAs and other documentation to ensure that the contracts: 1) are current; 2) have been properly approved and correspond with the company's policies and procedures; and 3) conform to business, legal and regulatory requirements. Through review of company policies and procedures, along with interviews of staff, verify that the company adequately addresses ownership or relationship management responsibilities for ensuring that the outside

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
			Contracts conform to business standards in accordance with legal, regulatory and/or statutory requirements. Nondisclosure agreements, escrow accounts and conformance with security requirements are included as considered necessary.		service provider continues to be viable, and that contracts are maintained, monitored and renegotiated as required to continuously meet business requirements.
			Reviews are performed on outside service providers during the contracting process to evaluate the appropriateness and effectiveness of their control environment (including cybersecurity).	Provide details of vendor risk reviews performed during the vendor selection or contracting process.	Review available reports to help verify that the company reviews the effectiveness of service provider controls. Consider the impact of any exceptions identified.
			The company has a formal process in place whereby: 1) An inventory of the company's vendors and service providers is completed and maintained and includes information concerning their risk and their ~~supply~~	Verify an inventory of vendors and service providers is created and maintained, and includes sufficient information to ~~rank~~ group and classify providers based on both risk and ~~supply chain criticality~~ material adverse impact to the business, operations, or security.	Review the company's third-party vendor and service provider management process including consideration of: 1) Whether the listing of third-party service providers is comprehensive and complete; 2) Whether the listing considers both risk and ~~supply chain criticality~~ material adverse impact in ~~ranking~~ classifying or grouping; 3) Whether the company, service, or program has appropriately determined access rights based on its risk assessment and supply chain criticality; and

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
			~~chain criticality~~ material adverse impact to the business, operations, or security. 2) Risk is assessed based on the company's understanding of the third-party service providers information security program as well as by the company's ability to verify elements of the third-party service provider's security program and the data exposed to the third party, such as PFI, PHI, and PII; 3) ~~Supply chain criticality~~ Material adverse impact to the business, operations, or security is assessed based on mission function, and availability of alternatives. 4) Based on the company's risk ~~and supply chain~~	Provide a summary of the company's third-party service provider management process.	4) Whether the company has designed appropriate controls that are consistent with the company's ~~ranking~~ classifying or grouping.

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
			~~criticality~~ and material adverse impact to the business, operations, or security, the company groups and classifies vendors and uses a vendor's ranking to determine depth and frequency of review procedures performed related to ongoing vendor relationships; 5) The company determines appropriate access rights, based on the risk assessment and company needs; 6) The company designs specific mitigation strategies ,including network monitoring specific to third-party service providers and access controls, where appropriate.		
APO 12	IT-related enterprise risks have not been integrated into the overall enterprise	APO 12.02 – APO 12.05	The company maintains a documented and functioning ERM program that identifies IT-related enterprise	Obtain copies of the ERM program.	Review the ERM program to determine IT integration. Interview IT senior management to verify that an IT risk and control framework has been

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
	risk management (ERM) program.		risks.		adopted throughout the organization and to verify that appropriate reports relating to adoption of the framework have been provided to the board of directors or a committee of the board, as appropriate.
			An IT risk profile is actively maintained describing known risks and risk attributes and of related resources, capabilities and current control activites.	Provide the company's IT risk profiles. Obtain a copy of the most recent risk assessment.	Review risk profile and assessments for timely and relevant information on the organization's most significant IT risks, including cybersecurity and third party risk, and subsequent mitigating controls. Determine whether threats and vulnerabilities identified through information sharing forums are periodically assessed and incorporated into the risk profile.
			Continual communication on current state of IT-related exposures and opportunities.	Obtain risk analysis and risk profile reports provided to all stakeholders.	Review evidence that the company is providing risk analysis information to stakeholders to communicate the current state of significant IT risks and the adequacy of risk response. Assess management awareness of risk analysis and risk profile reports and, if applicable, review and/or verify initiatives as a result of IT-related exposures and opportunities.
APO 14	The company does not effectively manage its data across the data life-cycle.	APO 14.01	The company defines and communicates its data management strategy, and roles and responsibilities.	Provide a copy of the data management strategy, policy, and procedures. Identify personnel filling identified roles and responsibilities.	Review the policies and procedures for completeness. Obtain organizational charts and job descriptions for personnel with responsibilities for data management.
		APO 14.08 – 14.09	The company has established data	Provide a copy of the company's policies or	Review the procedures for production data encryption, access controls, or data masking

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
			protection policies and procedures in place to support data confidentiality, integrity, and availability.	procedures to protect data in use from unauthorized access, modification, or denial of availability.	techniques in use.
			The company has established and adheres to data archival and retention policies and procedures.	Provide a copy of the company's data archival and retention policies and procedures.	Review company documentation to verify that there are data archival and retention policies in place. Review company documentation to verify that the company follows its data archival and retention policies.

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PART TWO – EVALUATION OF CONTROLS IN INFORMATION TECHNOLOGY (IT) WORK PROGRAM – BUILD, ACQUIRE AND IMPLEMENT (BAI)

Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
BAI 01	IT projects may fail to meet business objectives/ERM goals or run over budget in the absence of an effective program and project-management methodology.	BAI 01.01–BAI 01.05, BAI 01.07–BAI 01.10, BAI 01.12, BAI 01.14	A methodology exists to maintain the portfolio of projects that includes identifying, defining, evaluating, prioritizing, selecting, initiating, managing and controlling projects.	Provide a copy of the existing IT project-management and System Development Life Cycle (SDLC) methodologies.	Review the project life cycle and SDLC methodologies and verify that it addresses the key aspects of projects, including responsibilities, project plans, project resources, timeliness, deliverables, approval requirements, benchmarking based on key indicators (including risk management and project quality plans) and post-implementation reviews. Review a sample existing project to verify adherence to the project-management standards and methodology.
BAI 02	Projects are initiated without proper authorization and/or analysis.	BAI 02.01–BAI 02.03	The company has a defined process to identify and approve automated solutions, which include business functional and technical requirements, risk analysis reports and feasibility studies.	Provide evidence that business functional and technical requirements, risk analysis reports and feasibility studies are appropriately considered in the project approval process.	Evaluate the documentation received from the company for existence, approval, timeliness and appropriateness.
				Provide evidence of IT procurement policies and procedures.	Review the company's IT procurement policies and procedures to verify that management approval, cost justification, business suitability needs, legal review of contractual issues and viability of the vendor are addressed.
				Provide a listing of recently completed projects that have been created or acquired within the past 18 months.	Select a significant project(s) to verify that documentation supports the process defined by the company. Gain an understanding of the process and verify

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
					whether it appears reasonable. Verify that the company's process requires cost/benefit analyses be adequately reviewed by project stakeholders and senior management. For a selected significant development project(s), verify the completeness, timeliness and reasonableness of the cost justification and related project approval.
		BAI 02.04	Senior management and other stakeholders approve project plans before work commences on each significant phase of the development process used for all automated solutions.	Provide evidence of management approval for project plans.	From the project(s) selected above, verify that senior management and other stakeholders approved work prior to commencement of each significant phase of the development process.
BAI 03	Project deliverables fail to meet business objectives due to inadequate design and/or ineffective oversight of implementation.	BAI 03.01	Design specifications translate proposed solutions into business processes, supporting services, applications, infrastructure and information repositories capable of meeting business and enterprise architecture requirements. Quality assurance, project stakeholders and the sponsor/business process owner approve final designs, based on	For significant programs and projects selected by the examiner, provide copies of design specifications.	Review the significant programs and projects selected by the examiner and determine whether the design specifications are approved by management and whether business and enterprise architecture requirements are addressed. Review the quality assurance support for appropriate approval, based on agreed-upon criteria. Verify that the system design includes specification of transaction types and business processing rules, automated controls, data definitions/business objects, use cases, external interfaces, design constraints and other

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
			agreed-on criteria.		requirements. Verify that the tools used to monitor costs are effective and properly used. Verify that the cost-monitoring process is adequately comparing actual hours and expenses to budgeted amounts.
		BAI 03.02	Programs and projects are designed to address system redundancy, recovery and backup, and provide for the ability to audit transactions and identify root causes of processing errors.	Provide documentation to evidence the existence of adequate business continuity, recovery and backup plans.	Determine if the company has adequate business continuity, recovery and backup plans. Select a sample of significant programs and projects and verify that the ability to audit transactions and identify the root cause of processing errors exists.
		BAI 03.05	Business and IT solution components and information repositories are integrated and configured in line with detailed specifications and quality requirements. The role of users, business stakeholders and process owners are considered in the configuration of business processes. Audit trails are implemented during configuration and	Provide a listing of automated controls that provide for accurate, complete, timely, authorized and auditable processing.	Determine if programs and system are configured to allow for accurate, complete, timely, authorized and auditable processing.
				Provide the company's data classification, information architecture, information security architecture and risk tolerance guidelines.	Review the company's data classification, information architecture, information security architecture and risk tolerance guidelines. Assess if system configuration provides for availability and integrity.
				Provide the company's development procedures and standards guidelines that address items such as procurement process and	Validate that IT procurement procedures address the services needed by the business, while also meeting security requirements.

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Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
			integration of hardware and infrastructural software to protect resources and ensure availability and integrity. Acquired application software is configured to meet business processing requirements.	acquisition strategy, hardware, software and services, etc.	
		BAI 03.06	The company has a quality assurance (QA) process to review software to ensure that business requirements are met.	For a sample of significant programs and projects selected by the examiner, provide evidence and documentation of the QA function.	Review the software QA practices relative to program and system development to ensure related processes align with the organization's QA practices. Review documentation of the software QA process for appropriateness. Review the detail QA testing for adherence with company standards.
		BAI 03.07–BAI 03.08	Integrated test plans and practices are commensurate with the enterprise environment and strategic technology plans. The company has secure pre-production development environments to maintain security	Provide evidence that would support the use of integrated testing and strategic technology plans. Provide a copy of the company's policies and procedures, including security, for pre-production environments.	Validate that integration test plans and practices enable the creation of suitable testing and simulation environments. Validate that the pre-production environments adequately support the application requirements and mirror real-world conditions, including the business processes and procedures, range of users, transaction types and deployment conditions. Review completed test work to determine if security test plans were followed in accordance with standards.

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			throughout the software development life-cycle.		
		BAI 03.08	The company performs testing in accordance with its defined plan, prior to migration to the production environment. Testing outcomes are recorded and the results communicated to stakeholders in accordance with the test plan.	For a sample of the significant programs and project selected by the examiner, provide evidence that supports the completed test plans and related stakeholder communications.	Review the completed test documentation to ensure that plans were followed and that business process owners and end users participated in the testing.
BAI 04	Systems fail to meet current and future business needs due to inadequate planning for capacity, cybersecurity events, performance and availability.	BAI 04.01	The company has established a planning and review process for continuous performance and capacity monitoring of IT resources. Management ensures that contingency plan procedures are in place to properly address availability, capacity, cybersecurity events, and performance of individual IT resources.	Provide a copy of the policies and procedures regarding performance and capacity management.	Review policies and procedures and interview key staff members involved in the development of the performance and capacity plan to verify that the appropriate elements (e.g., customer requirements, business requirements, cost, application performance requirements and scalability requirements) were considered during the development of the plan. Inquire of key staff members as to whether emergency problems have occurred in the recent past and, for those instances (if any), verify compliance with the contingency plan procedures and verify that they were effective.
		BAI 04.02	Solutions and services that are critical in the availability and capacity management process are evaluated as part of	Provide evidence to support the completion of business impact analysis procedures for key business units.	Verify that business impact analysis procedures for critical systems have been recently performed. Assess the results of these procedures to determine if business needs (performance and capacity) are being

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			business impact analysis procedures. Scenarios are defined and evaluated to address the likelihood that the systems' availability performance objective will not be achieved. The business line, function and regional leaders evaluate the impact of recovery scenarios on the business performance measures (e.g., revenue, profit, customer services).		adequately addressed.
				Provide copies of the company's business continuity plan, disaster recovery and IT contingency plans.	Review the company's business continuity and disaster recovery plans. Verify that the IT continuity framework provides for: 1) Continuity management. 2) Defined roles, tasks and responsibilities of management, and internal and external service providers. 3) The ability to document, test and execute the disaster recovery and IT contingency plans. 4) Identification of critical resources, noting key dependencies. 5) Monitoring and reporting of the availability of critical resources, alternative processing. 6) The principles of backup and recovery.
		BAI 04.03	Capacity and performance plans are updated and reviewed by management periodically, and define current and forecasted performance, and are used for service trend analysis.	Obtain capacity and performance plans, including modeling techniques that define current and forecasted performance, capacity and throughput of the IT resources. Obtain evidence of periodic update and review by management.	Determine if a review of capacity and performance plans is performed. Assess if the review considers cost-justifiable capacity and performance based upon agreed-upon workloads, as determined by the SLAs.
		BAI 04.04	The IT operations team performs trend analysis reporting and provides management with	Provide trend analysis reports that identify any significant issues and variances.	Validate the effectiveness of continuous monitoring efforts through the review of IT management's use of trend analysis reports.

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			monitoring and reporting information for availability, performance and capacity workload of all information-related resources.		
		BAI 04.05	The company maintains vendor product manuals that define: 1) an appropriate level of performance availability for peak processing and workloads; 2) corrective actions (e.g., shifting workload, prioritizing tasks or adding resources, when performance and capacity issues are identified); and 3) escalation procedures for swift resolution in case of emergency capacity and performance problems.	Provide capacity and performance reports and vendor manuals that take into account aspects such as normal workloads, contingencies, storage requirements and IT resource life cycles.	Review and assess items obtained for definition of corrective actions, appropriate level of performance availability and adequacy of escalation procedures.
BAI 06 & 07	A lack of proper change management threatens system stability and/or integrity.	BAI 06.01, BAI 06.03–BAI 06.04	The company has a process in place to record, authorize, manage, monitor and implement requests for changes. Procedures exist to ensure documentation is	Provide documentation regarding the company's change-management process, including copies of any forms used in this process. Provide documentation of how management	Verify that the company's procedures require a change request to be evaluated, authorized and tested. Review evidence of management's monitoring of open change requests. Select a sample of completed changes to verify that documentation of such items as requests,

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			appropriately updated and distributed to affected users and IT staff upon completion of change.	monitors open change requests. Provide a current list of completed change requests, during the period under review.	authorizations, business objectives, areas impacted, prioritizations, deliverable dates, change descriptions, deliverables, testing, back-out plans, closures and documentation are properly included in accordance with company standards.
		BAI 06.02	The company has a separate process in place to handle emergency changes.	Provide documentation regarding the company's process to handle emergency change requests. Provide a copy of any forms used in this process.	Verify that access to make emergency changes is revoked in a timely manner. Verify that the company completes a post-implementation review on all emergency changes.
		BAI 07.01	The company has established standards for an implementation and backout plan.	Provide procedures and guidelines for implementation. Provide procedures in the event of implementation failure.	Select a sample of completed projects and verify that the company has documented implementation and backout procedures that meet company standards.
		BAI 07.02	The company has a defined process to ensure data is converted accurately and completely.	Provide procedures detailing system and data conversion. Provide a listing of data conversion projects.	Verify that the conversion procedures ensure that data is converted accurately and completely and can be recovered. Select a sample of conversion projects and confirm that data was validated and converted accurately.
		BAI 07.04	The company has established a test environment that is representative of the production environment and takes into	Provide a description of the development, test and production environments.	Verify that production, test and development environments are appropriately segregated. Verify that the test environment has appropriate physical and logical access controls.

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			consideration security, workloads and data quality.		Verify that changes cannot be made to the code in the test environment. Verify that the data used in the testing environment meets the company's security requirements. Verify that there are required approvals to move objects from the development environment to the test environment.
		BAI 07.05	The company performs testing in accordance with its defined plan, prior to migration to the production environment.	Provide evidence of standard testing documentation, including copies of any forms used.	Select a sample of completed projects and verify that test plans and other testing evidence complied with testing standards and guidelines and were appropriately approved and review Verify that all relevant stakeholders are involved in the testing process and that changes were not implemented until the relevant stakeholders approved the testing results. Verify that testing performed considers security and performance (stress testing).
		BAI 07.06	The company has controls in place to ensure that changes are released into production in accordance with the implementation plan.	Provide evidence of controls that ensure production release in accordance with the implementation plan	Review the company's implementation process. Select a sample of completed projects and verify that changes were released into production in accordance with the implementation plan.
		BAI 07.08	The company conducts a post-implementation review as outlined in its standards and as detailed in an individual implementation plan.	Provide evidence of post-implementation review procedures, including copies of any forms utilized in the process.	Review procedures to verify that a review is performed to address positives, negatives and lessons learned. Select a sample of completed projects and verify that the post-implementation review

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					process is performed in accordance with company standards and the individual implementation plan.
BAI 08	Systems cannot be properly managed and optimized due to inadequate documentation and training.	BAI 08.01–BAI 08.04	The company has policies and procedures in place that require technical, operational and user documentation and training to be available for all significant systems The company provides training as part of system development, implementation or modification projects.	Provide evidence that appropriate technical, operational and user documentation and training is available for new system implementations or changes to existing systems.	For a sample of new or changed significant systems, verify that a training plan is incorporated into the project plan and that technical, operation and user documentation and training is provided by appropriate personnel.
BAI 10	A lack of configuration management threatens system stability, integrity and recovery.	BAI 10.01–BAI 10.05	The company has procedures in place over configuration management, which includes establishing and monitoring baselines for every system and service, in addition to the logging of any changes.	Provide a copy of policies, procedures and guidelines for configuration management.	Verify that senior management sets scope and measures for configuration management functions and assesses performance. Verify that a tool is in place to enable the effective logging and monitoring of configuration management information. Verify that configuration baselines for components are up-to-date, as defined and documented. Verify that configuration management data match the procurement records. Verify that a policy is in place to ensure that all configuration items are identified, maintained

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					and in accordance with policy.
			Installed software is periodically compared to the policy for software usage to determine compliance with software licensing agreements or to identify use of unauthorized software.	Provide information regarding the policies and procedures for, and results of, periodic reviews of software usage to the company's software policy and actual software licensing agreements.	Verify that periodic reviews are performed comparing software used to the company's policy for software usage to detect exceptions and the resolution of any discrepancies.

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PART TWO – EVALUATION OF CONTROLS IN INFORMATION TECHNOLOGY (IT) WORK PROGRAM – DELIVER, SERVICE AND SUPPORT (DSS)

Risk Stmt #	Risk Statement	Ctrl #	Common Controls	Preliminary Information Request	Possible Test Procedures
DSS 01	The quality, timeliness and availability of business data is reduced due to an ineffective data-management process.	DSS 01.01	All data expected for processing is received and processed completely, accurately and in a timely manner, and all output is delivered in accordance with business requirements.	Provide evidence of the controls that ensure all data expected for processing is available and processed completely and in a timely manner.	Interview company personnel to verify the process controls over data management to determine whether there is responsibility over the availability and completeness of data and the timeliness and accuracy of data processing.
			Procedures are defined, implemented and maintained for IT operations.	Provide a copy of the policy and procedures for IT operations.	Review the standard IT operational procedures and verify the propriety and effectiveness of the procedures for abnormal operating system termination, the inclusion of a callout list in the case of emergency, etc. Verify that batch job duties and responsibilities for each computer operator exist along with shift schedules.
			Claims and policy admin data is stored in a format that allows it to be transferred and utilized, if necessary (e.g., in the event of a receivership, audit or changing vendors, etc.)	Provide documentation regarding the accessibility and transferability of company claims and policy admin data.	Review the claims and policy admin data and determine if there would be any accessibility or transferability issues if the company needed to move its data.
			The scheduling and completion of jobs is organized into a sequence, maximizing	Provide a copy of the job run log showing batch job execution.	Verify that the log is reviewed on a routine basis and on a timely manner.
				Provide a copy of	Verify that procedures include points of contact

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			throughput and utilization to meet business requirements.	documentation showing contact information and codes for job failures.	in the case of job failures, along with a running list of job failure codes.
	The operation of outsourced IT services is not managed to maintain the protection of enterprise information and reliability of service delivery.	DSS 01.02	The company has a well-defined vendor-management process to ensure adherence to policies for security of information, operational business and IT processing requirements and integration of critical processes.	Provide a copy or description of the company’s vendor-management process.	Review the company’s vendor-management process and verify that it adheres to best practices and company policies for information.
				Provide copies of SLA and SSAE 18 SOC 2 reports for each key or critical outsourced service provider.	Review the SLA for key or critical outsourced services and verify that the contracts include a right-to-audit provision. Interview personnel and verify that the company monitors SSAE 18 SOC 2 reports for its critical outsourced processes and services. Review a sample of SOC 2 reports and verify that the effectiveness of controls was attested to by the auditor. If key control failures were identified by the auditor in the SOC 2 report, discuss with personnel how the control failure is being compensated at the company.
	Lack of infrastructure monitoring may result in the inability to detect and/or recognize security incidents.	DSS 01.03	IT infrastructure activity is logged with sufficient detail to reconstruct, review and examine operational activities; this activity is monitored on a regular basis.	Provide a copy of reports used to monitor the IT infrastructure.	Verify that the infrastructure assets that need to be monitored are identified based on service criticality and the relationship between configuration items and services that depend on them. Verify that automated tools are used to monitor IT infrastructure and whether alerts, reports and logs are generated for significant events.
	Inadequate physical and environmental controls may result in	DSS 01.04–DSS 01.05	The data center contains proper physical and environmental controls to protect the equipment, data and personnel	Provide information regarding the physical and environmental controls in place at the company’s data center	Tour the data center, inspect documents and interview the appropriate personnel to verify that physical security and environmental controls are in place and monitored.

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	unauthorized access and inadequate protection of data.		located within.	and other sensitive IT sites.	Verification may include the following: Physical sites for IT equipment have been selected through consideration of such issues as geographic position, neighbors, infrastructure and risks (e.g., theft, temperature, fire, smoke, water, vibration, terrorism, vandalism, chemicals and explosives). A process is defined and implemented that identifies and monitors the potential risks and threats to the organization's IT sites and assesses the potential business impact on an ongoing basis, taking into account the risks associated with natural and man-made disasters. A policy is defined and implemented for the physical security and access control measures to be followed for IT sites and that the policy is regularly reviewed to ensure that it remains relevant and up-to-date. Access to information about sensitive IT sites and their design plans are restricted to essential personnel. External signs and other identification of sensitive IT sites are discreet and do not obviously identify the site from outside. Organizational directories/site maps do not identify the location of sensitive IT sites. A process supported by the appropriate authorization is defined and implemented for

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					the secure removal of IT equipment. IT facilities are situated and constructed in a way to minimize and mitigate susceptibility to environmental threats. Suitable devices are in place to detect environmental threats. Evaluate the effectiveness of continuous monitoring performed through these devices. Alarms or other notifications are raised in case of an environmental exposure, procedures in response to such occurrences are documented and tested, and personnel are adequately trained. A process exists that examines the IT facilities' needs for protection against environmental conditions and power fluctuations and outages, in conjunction with other business continuity planning procedures. Verify that a policy and procedure exists for recording, monitoring, managing, reporting and resolving physical security incidents, in line with the overall IT incident management process. Uninterruptible power supplies (UPS) are available, regularly tested and meet business continuity requirements. In facilities housing sensitive IT systems, more

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					than one power supply entry is available and the physical entrance of power is separated. A process is in place to ensure that IT sites and equipment are maintained per the supplier's recommended service intervals and specifications. IT sites and server rooms are kept clean and in safe condition.
DSS 02	Inadequate or ineffective response and resolution to user requests and incidents could result in interruption of services or inefficient usage of technology solutions.	DSS 02.01	The company has a defined security incident response plan process that clearly communicates characteristics of potential security incidents, so they can be properly classified, treated, and addressed. The incident response plan outlines resources available and responsibilities for addressing security incidents. The incident response plan also considers and addresses third parties, including vendors and service providers.	Provide a copy of the company's security incident response plan including escalation procedures.	Verify the existence and completeness of a cybersecurity incident response plan, including whether it addresses third party service providers (backup vendors and other contingency plans). Verify that an appropriate level of resources is in place to recognize and effectively manage security emergencies. The following areas should exist as part of an effective incident response process: 1) Incident handling – General and specific procedures and other requirements to ensure effective handling of incidents, including prioritization, and reported vulnerabilities. Determine if there are procedures related to handling of cyber-security incidents. 2) Communications – Requirements detailing the implementation and operation of emergency and routine communications channels amongst key members of management.
				Provide a list of security incidents during the period under review.	Select a sample of incidents to verify that the security incident management process includes: 1) Event detection and containment.

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					2) Correlation of events and evaluation of threat/incident. 3) Resolution of threat, or creation and escalation of an appropriate work order. 4) Criteria for initiating the organization's incident response process. 5) Verification and required levels of documentation of the resolution. 6) Post-remediation analysis. 7) Work order/incident closure.
				Provide evidence of the company's security incident tracking process.	Verify that the security incident management process appropriately interfaces with key organizational functions, including the help desk, external service providers and network management.
			Response and recovery activities are coordinated with internal and external stakeholders, including affected external parties or business associates (e.g., vendors or service providers), and law enforcement agencies, as appropriate.	Provide a copy of the company's incident response plan and procedures.	Review the company's incident response plan and procedures and verify whether: • Personnel know their roles and order of operations when a response is needed. • Events are reported consistent with established criteria. • Information is shared consistent with response plans. • Coordination with stakeholders occurs consistent with response plans. Voluntary information sharing occurs with external stakeholders in accordance with the organization's data classification criteria to achieve broader cybersecurity situational awareness.
			The company has established procedures	Provide a copy of the company's computer	Review and confirm whether the company's procedures follow a process of identifying,

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			for performing a forensic investigation of the security incident or crime (if deemed necessary). Investigations are performed by a qualified professional trained in incident detection and management (e.g., certified forensic computer examiner, certified ethical hacker, etc.).	forensic investigation procedures.	preserving, analyzing and presenting digital evidence in a manner that is acceptable in any legal proceedings (i.e., a court of law).
			The company incorporates lessons learned from ongoing incident handling activities into incident response procedures, training and testing (including sharing with affected external parties), and implements the resulting changes into the risk management controls (APO 12).	Provide information regarding lessons learned from current and previous incident response activities and how they are incorporated into the organization's response activities.	Verify that lessons learned are incorporated into the security incident response plan and verify, where appropriate. Verify the communication of the results of post-remediation analysis to management and the board of directors or board committee, thereof, as appropriate.
		DSS 02.02–DSS 02.03	The company has a service function to record, classify and prioritize requests and incidents (e.g., service desks).	Provide a copy of the policy and procedures for the service function.	Verify that the processes and tools are in place to register incidents, status and actions for resolution. Review the standards for communication of incidents and verify that they were complied

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					with.
				Provide a listing of open and closed user reported incident records.	Review a sample of open and closed customer incidents to verify compliance with the process and service commitments. For the sample selected, verify that all resolved incidents are described in detail, including a detailed log of all steps taken to resolve the incident.
				Provide documentation on the workflow used to handle incidents	Review procedures for reporting significant incidents to management. Verify with management that significant incidents are reported to them.
		DSS 02.05	The company has a formal recovery process in place that documents, applies and tests the identified solutions or workarounds for recovery. The process includes recovery actions to restore all critical IT-related services.	Provide documentation on the workflow used to handle recovery.	Review the company’s documented recovery process for completeness and verify it is reviewed and updated regularly. Verify that recovery processes include: • Ensuring all other elements of incident response plan have been fulfilled prior to proceeding with recovery • Proper communication to internal/external stakeholders prior to and following restoration of services • Checking restoration assets for indicators of compromise, file corruption, and other integrity issues before use • Verification of the correctness, integrity and adequacy of the restoration actions taken before placing a restored system online • Defined criteria for declaring the recovery processes complete

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					If applicable, select from a sample of recent security incidents to verify documented processes related to recovery were appropriately followed. Otherwise, request documentation regarding recent testing of recovery processes.
		DSS 02.07	A reporting function has been established to monitor and measure service performance, service response times and user satisfaction with the service function.	Provide information on how the performance of the service function is monitored.	Verify that a process is in place to evaluate the performance of the service function in the areas of response time and user satisfaction.
DSS 03	The company has an ineffective problem-management process that increases operating costs and reduces system availability, service levels and customer satisfaction.	DSS 03.01	The company maintains problem-management policies and procedures, including escalation triggers, with adequate audit trails and analysis to identify, report and classify incidents by category, impact, urgency and priority.	Provide a copy of the policy and procedures used to identify, classify and track incidents.	Verify that adequate processes supported by appropriate tools are in place to identify and monitor incidents. For TPA problem management, review SLAs, SSAE 18, contracts, etc.
		DSS 03.02	The company has implemented a problem-management system that identifies and initiates solutions addressing the root cause of the problem and provides adequate audit trail facilities that allow tracking, analyzing and determining the root	Provide a copy of the company's problem-management policies and procedures.	Review the company's policies and procedures to verify that problems were tracked and solutions addressed the root cause of problems.
				Provide a listing of all problem tickets for the period under review. The listing should include a ticket number, description of the problem, date the problem was reported,	Select a sample of tickets for appropriate prioritization, identification of root cause, timely completion, documentation of actions taken and any necessary approvals.

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			cause of all reported problems.	date the problem was closed and, if open, current priority.	
				Provide evidence of the company's monitoring of the problem-management system.	Review the evidence to verify that the company (ideally business management) is monitoring the timeliness and the quality of the selected problem solutions.
		DSS 03.03–DSS 03.04	Problem disposition procedures are in place to address error resolution.	Provide a listing of all problem tickets opened during the period under review.	Review the log for sequential gaps and identify the causes. Select a sample of problems and verify, through interviews with stakeholders, that they were informed completely, and in a timely manner, of problem remediation activity and closures.
		DSS 03.05	Change management is integrated with problem management to ensure effective management of problems and to enable improvements.	Provide a copy of the company's incident management policy.	Review the policy to verify that the problem-management process is integrated with the change-management process to ensure that incidents are addressed. Select a sample of problem tickets to verify that there was an associated change ticket.
DSS 04	Inadequate continuity management may result in the inability to ensure critical business functions.	DSS 04.01–DSS 04.02, DSS 04.05	The company has a defined and documented framework that provides: 1) A consistent company-wide process for IT continuity management. 2) A planning process that creates the rules and structures to document, test and execute the IT disaster recovery and business continuity	Provide copies of IT business continuity plans, including disaster recovery plan or procedures. Provide a copy of the business impact analysis (BIA) study. Provide a copy of contracts and SLAs supporting the IT continuity plan.	Verify that a company-wide business continuity plan is in place. As part of this overall plan, an IT business continuity plan should be completed to include: 1) BIA study. 2) Prioritized recovery strategy. 3) Necessary operational support. 4) Any compliance requirements. 5) Comprehensive and appropriate disaster recovery plan. 6) Cross reference to the incident response plan. Possible elements of the disaster recovery plan that need to be verified may include:

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			plans. 3) The identification of critical resources, noting key dependencies, the monitoring and reporting of the availability of critical resources, alternative processing, and the principles of backup and recovery. 4) Considerations for continuity management in the event of a cybersecurity incident. Change control procedures are in place to ensure that the IT continuity plan is kept up-to-date and continually reflects actual business requirements.	Provide the procedures and evidence for testing and periodic plan updates.	1) The conditions and responsibilities for activating and/or escalating the plan. 2) A prioritized recovery strategy, including the necessary sequence of activities. 3) Minimum recovery requirements to maintain adequate business operations and service levels with diminished resources. 4) Emergency procedures. 5) IT processing resumption procedures, subject to incident response plan conclusion. 6) A maintenance and testing schedule. 7) Awareness, education and training activities. 8) Responsibilities of individuals. 9) Regulatory considerations. 10) Critical assets, resources and up-to-date personnel contact information needed to perform emergency, fallback and resumption procedures. 11) Alternative processing facilities, as determined within the plan. 12) Alternative suppliers for critical resources. 13) Chain of communications plan. 14) Roles, tasks and responsibilities defined by SLAs and/or contracts for internal and external service providers. Verify that plans are accessible to authorized personnel. Verify that the plans are up to date and all copies of the IT business continuity and disaster recovery plans are updated with revisions and are stored on- and off-site.

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		DSS 04.04	The company tests the IT business continuity and disaster recovery plans on a regular basis to ensure that IT systems can be effectively recovered. The company has policies in place to ensure that test results and deficiencies are communicated to management and the plan is updated as required.	Provide evidence of management's review of continuity recovery test results. Provide evidence of continuity test deficiency resolutions.	Verify that IT continuity tests are scheduled and completed on a regular basis and after significant changes to the IT infrastructure or business applications. Verify that test results are reported to management and that necessary changes are made.
		DSS 04.07	All critical backup media, documentation and other IT resources necessary for IT recovery and continuity plans are stored off-site in a secure location.	Provide a copy of policies and procedures relating to the backup of systems and data, including copies of recovery procedures for off-site backups and information about off-site backup locations and/or service providers.	Inquire and verify that data is protected and secured when taken off-site and while in transit to the storage location. Inquire and verify that the backup facilities are not subject to the same risks as the primary site. Inquire and verify that there is an air gap, or other protection mechanisms, between the company's production environment and backup systems. The air gap, whether logical or physical, should be designed in a manner that if a ransomware attack infects the company's main production systems, the immutable, offline backups could be deployed to replace the infected systems.
				Provide an inventory of backups and media and	Inquire and verify that an inventory of backups and media exists and that the company verifies

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				evidence that the company periodically validates the inventory.	its accuracy. Inquire and verify that the backup media contain all information required by the IT business continuity and disaster recovery plans.
				When outsourcing significant systems of functions, provide a copy of contracts and SLAs supporting the IT business continuity and disaster recovery plans.	Verify data replication product being used and review documentation from testing the utilization of the replicated data to recover the system.
		DSS 04.08	Effective and efficient data storage, retention and archiving policies and procedures are available to meet business objectives.	Provide a copy of the data retention policy.	Review retention periods for data and verify that they are in line with contractual, legal and regulatory requirements.
			Policies and procedures are in place to maintain an inventory of stored and archived media.	Provide a copy of the media inventory and data dictionary for the warehouses supporting all financially significant systems.	Review the media inventories and, on a sample basis, verify that media on the inventory list can be identified and items in storage can be traced back to the inventory. On a sample basis, verify that external labels correspond with internal labels, or otherwise validate that external labels are affixed to the correct media.
				If the company uses third-party vendors to provide off-site media storage, provide copies of the service contracts.	Verify, through a review of contracts, that the company's access to its storage media cannot be restricted by the service provider.
			The company has procedures in place for	Provide evidence that backup and storage	Verify that critical systems, applications, data and related documents that affect business

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			backup and restoration of systems, applications, data and documentation that are consistent with its business requirements and continuity plan. The backup environment should be isolated, air gapped, and inaccessible from the internet so information cannot be accessed or changed remotely.	requirements for critical systems, applications, data and related documents are periodically reviewed and aligned with risks and the continuity plan. Provide evidence that backup and storage environments are properly isolated.	operations are periodically reviewed for alignment with the risk management model and IT service continuity plan. Verify that adequate policies and procedures for backup of systems, applications, data and documentation exist and consider factors including: 1) Frequency and age of backups. Older backups can be used in the event that a newer backup copy is infected. 2) Type of backups (e.g., disk mirroring, external media, full, incremental, air gapped, immutable, offline copy, etc.). 3) Automated online backups. 4) Data types (e.g., voice, optical). 5) Creation of logs. 6) Critical end-user computing data (e.g., spreadsheets). 7) Physical and logical location of data sources. 8) Security and access rights. 9) Encryption.
			The post-resumption review has been performed after testing or an incident and the BCP updated as a result.	Provide evidence of recent testing of backup processes or post-resumption processes to verify all components of backups were effectively restored.	Verify that sufficient restoration tests have been performed periodically to ensure that all components of backups can be effectively restored. Verify post-resumption review was performed and the BCP updated as a result.
DSS 05	The company's business is threatened by the impact of operational	DSS 05.01	Preventive, detective and corrective measures are in place (especially up-to-date security patches and virus control) across	Provide a copy of the company's policies and procedures over malicious software. Identify how the policy is	Verify that a malicious software prevention policy is established, documented and communicated throughout the organization and is included in the security policy.

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	information security vulnerabilities and incidents.		the organization to protect information systems and technology from malware (e.g., viruses, worms, spyware, spam).	communicated throughout the organization.	
				Provide an inventory of server and desktop virus protection tools, including details on the current patch level.	Select a sample of the company's servers and validate that they are updated to the current patch level. Verify that automated controls have been implemented to provide virus protection and that violations are appropriately communicated. Inquire of key staff members whether they are aware of the malicious software prevention policy and their responsibility for ensuring compliance.
				Provide a copy of the company's virus protection tool installation and update procedures including information regarding version and patch-level used.	From a sample of user workstations, verify that a virus protection tool has been installed and includes virus definition files and the last time the definitions were updated. Verify that the protection software is centrally distributed (version and patch-level) using a centralized configuration and change-management process. Verify that information on new potential threats is regularly reviewed and evaluated and, as necessary, manually updated to the virus definition files. Verify that incoming email is filtered appropriately against unsolicited information.
			A vulnerability management plan is developed and	Provide a copy of the company's vulnerability management plan,	Verify that a vulnerability management plan is in place and has the following attributes: (1) Utilizes standardized vulnerability scanning

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			implemented.	including information on scanning and vulnerability remediation.	tools. (2) Utilizes industry standard vulnerability scoring, such as the common vulnerability scoring system (CVSS). (3) Regularly scans all end-points, servers, network devices, database management systems, web applications, and internet gateways. (4) Includes appropriate service level agreements for remediation of discovered vulnerabilities. (5) Incorporates a mechanism for reporting and aging all outstanding vulnerabilities.
		DSS 05.02	Business, risk and compliance requirements are translated into an overall IT security policy/procedure that takes into consideration the IT infrastructure and the security culture.	Provide a copy of the information security policy and IT security governance documentation, including: 1) An external communications security policy. 2) A firewall policy. 3) An email security policy. 4) An agreement to comply with IT policies. 5) A laptop/desktop computer security policy. 6) An Internet usage policy.	Verify that a detailed information security policy, as well as standards and procedures exist, which may address the following: 1) Responsibilities of the board, executive management, line management, staff members and all users of the company IT infrastructure. 2) A security compliance policy. 3) Management risk acceptance (security noncompliance acknowledgement, including noncompliance to security policies with supporting policy exception waiver approved by senior management). 4) An external communications security policy. 5) A firewall policy. 6) An email security policy. 7) An agreement to comply with IT policies. 8) A laptop/desktop computer security policy. 9) An Internet usage policy. 10) Procedures to implement, monitor, update and enforce the policies and standards. 11) Staffing requirements.

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					12) Security awareness and training. 13) Investments in required security resources. 14) Cyber-security. Verify that the IT security policy considers IT tactical plans, data classification, technology standards, security and control policies, risk management and external compliance requirements. Verify that policy exceptions are authorized, tracked, aggregated and reviewed on a regular basis for appropriateness.
			Security policies and procedures are documented and communicated to stakeholders and users.	Provide evidence of user review and acknowledgement of the company's security policies.	Verify that personnel are required to periodically review and acknowledge the company's security policies. Assess the level of awareness of both the content of the security policies and the importance of compliance with policies by employees.
			Security techniques and related management procedures (e.g., firewalls, security appliances, network segmentation, intrusion detection, etc.) are used to authorize access and control information flows from and to networks.	Provide a copy of network security standards and procedures, including change-management procedures and required documentation.	Verify that a network security policy (e.g., provided services, allowed traffic, types of connections permitted) has been established and is maintained. Verify that procedures and guidelines for administering all critical networking components (e.g., core routers, DMZ, VPN switches) are established and updated regularly by the key administration personnel and changes to the documentation are tracked in the document history.

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			Sensitive data is exchanged only over a trusted path or medium, with controls to provide authenticity of content, proof of submission, proof of receipt and non-repudiation of origin.	Provide an inventory of methods of exchanging sensitive data encryption tools used by the company.	Verify that data transmissions outside the organization require encrypted format prior to transmission. Verify that sensitive data processing is controlled through application controls that validate the transaction prior to transmission.
		DSS 05.04– Logical Access	All users (internal, external and temporary) and their activity on IT systems (business application, IT environment, system operations, development and maintenance) are uniquely identifiable.	Provide a copy of the company's user access policy and procedures for adding, modifying and deleting users, including management approvals.	Verify that security practices require users and system processes to be uniquely identifiable and systems to be configured to enforce authentication before access is granted. Verify that the company's password rules are consistent with the criticality and sensitivity of the data for which they afford access.
			User identities are enabled via authentication mechanisms including multi-factor authentication for remote or privileged access, as appropriate based on the sensitivity of the information which may be accessed.	Provide a description of the company's authentication method for system and application access.	Verify that authentication control mechanisms are utilized for controlling logical access across all users, systems, processes and IT resources, for in-house and remotely managed users. Multi-factor authentication is required for remote access.
			Policies and procedures are available to classify data and protect information assets under control of the business.	Provide policies and procedures that describe the company's data classification program.	Verify the IT security policy considers IT tactical plans, data classification, technology standards, security and control policies, risk management and external compliance requirements.
			User access rights to	Provide a listing of data	If predetermined and preapproved roles are

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			systems and data are in line with defined and documented business needs. This includes access rights granted to service providers.	classification and catalogs/inventories for significant data elements.	utilized to grant access, verify that the roles clearly delineate responsibilities based on least privileges and ensure that the establishment and modification of roles are approved by process owner management. Verify that systems, applications and data have been classified by levels of importance and risk, complete data catalogs/inventories are maintained, and process owners have been identified and assigned.
			User access rights are requested by user management, approved by system owners and implemented by the security-responsible person to grant, limit and revoke access to systems, applications and data.	Provide a listing of user access roles, including systems and applications access.	Verify that procedures exist to periodically assess and recertify individual user system and application access and authorities.
				Provide a listing of hires, transfers and terminations.	Verify that logical access rights are appropriately authorized, administered and revoked.
		DSS 05.05 – Physical Access	Procedures are defined and implemented to grant, limit and revoke access to premises, buildings and areas, according to business needs, including during emergencies.	Provide a copy of the procedures for system and facility access.	Verify that physical access rights are appropriately authorized an administered. This may include the following: 1) A process is in place that governs the requesting and granting of access to the computing facilities. 2) Formal access requests are completed and authorized by management of the IT site, the records are retained, and the forms specifically identify the areas to which the individual is granted access. This may be verified by observation or review of approvals. 3) Procedures are in place to ensure that access

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					profiles remain current. Verify that access to IT sites (server rooms, buildings, areas or zones) is based on job function and responsibilities. 4) A policy exists requiring visitors to be escorted at all times by a member of the IT operations group whilst on-site, and individuals who are not wearing appropriate identification are pointed out to security personnel. 5) Access to sensitive IT sites is restricted through perimeter restrictions, such as fences/walls and security devices on interior and exterior doors. 6) Devices record entry and sound an alarm in the event of unauthorized access. Examples of such devices include badges or key cards, key pads, closed-circuit television and biometric scanners.
				Provide a copy of the facility access logs.	Verify that there is a process to log and monitor all entry points to IT sites, registering all visitors, including contractors and vendors, to the site.
		DSS 05.06	Appropriate accounting practices and inventory management over sensitive IT assets have been established.	Provide a copy of the policy and procedures for receipt, removal and disposal of special forms (e.g., check stock and other negotiable instruments or special purpose printers).	Verify that procedures governing the receipt, removal and disposal of special forms within and out of the organization are adequate and are being followed.
				Provide a copy of the last review of the access to sensitive assets.	Verify that the access log to sensitive assets is periodically reviewed. Verify that procedures to gain, change and remove access to sensitive assets are adequate

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					and are being followed.
			Procedures are in place to ensure that business requirements for protection or removal of sensitive data, software, and hardware are met.	Provide a copy of policies, procedures, and guidelines relating to the disposal or removal of IT equipment, software, data and storage media.	Verify that responsibility for the development and communication of policies on disposal of media are clearly defined. Verify that the policy includes guidance on when software or hardware is considered obsolete, how to address obsolescence in IT systems, and how variance to this policy would be managed.
				Provide documentation to show that storage media disposed or transferred have been sanitized.	Verify that equipment and media containing sensitive information are sanitized prior to reuse or disposal in such a way that data marked as “deleted” or “to be disposed” cannot be retrieved (e.g., media containing highly sensitive data have been physically destroyed).
				Provide a copy of the current media inventory and the media disposal log.	Verify that disposed equipment and media containing sensitive information have been logged to maintain an audit trail. Verify there is a procedure to remove active media from the media inventory list upon disposal. Verify that the current inventory has been updated to reflect recent disposals in the log.
			Physical devices, software platforms and applications within the organization are inventoried.	Provide a copy of the policy and procedures detailing the inventory requirements over devices, software platforms and applications. Provide an inventory,	Verify that all devices, software and applications are classified and inventoried and then tracked with such metrics as; comprehensive deployment counts and versioning. Tracking should also consider the location and responsible individuals for items listed in the inventory. Verify that connected systems are supported

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				including operating system version numbers, of server and client end-point systems, as well as network devices.	and comply with internal policies.
		DSS 05.07	The company has an established company-wide IT security baseline and periodically tests and monitors its IT security implementation for compliance with that baseline.	Provide information regarding the process in place to log security events and how information is reviewed.	Verify that the IT security management function has been integrated within the organization's project-management initiatives to ensure that security is considered in development, design and testing requirements to minimize the risk of new or existing systems introducing security vulnerabilities.
			The company has logging and monitoring functions enabled for early detection and/or prevention of abnormal activities (including individual user activities) that may need to be addressed.	Provide information regarding the process in place to log security events, including how such information is aggregated and correlated from multiple sources. Provide information regarding any network vulnerability tests and penetration tests performed during the period under examination. The information should include the findings along with the company's actions to address the findings.	Review event logs and/or reports evidencing the review of security events, including aggregated and correlated events, to ensure that network activity is being properly monitored. This should include consideration of activity generated by third-party service providers. Note that the extent of testing (and associated requests) should be focused on material events. Procedures performed may include consideration of the manner in which management classifies events to determine that material events are appropriately identified. Review the results of the vulnerability and penetration tests to identify the findings and verify that the company has addressed items with high or critical severity.
			Threat and vulnerability information received	Provide information regarding the process to	Review examples of how information received has resulted in changes to the broader security

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			from information-sharing forums and sources (e.g., Financial Services Information Sharing and Analysis Center, CISA Alerts, NIST National Vulnerability Database, etc.) is used in developing a risk profile.	integrate information received from information-sharing forums.	framework.
			The company has a process in place to integrate acquired entities/systems in a timely manner. The process includes a security assessment and threat analysis of existing IT systems at acquired entities.	Provide information regarding the process to integrate acquired entities/systems and timeline for doing so.	Verify that security assessment and threat analysis was properly executed for any entities acquired. Ensure that issues identified through this process are properly mitigated.
			The company has implemented integrity-checking mechanisms (e.g., parity checks, cyclical redundancy checks, cryptographic hashes, etc.) and associated tools to monitor the integrity of information systems and hosted applications. Exceptions and incidents are logged and investigated.	Provide information regarding integrity-checking mechanisms used by the company to verify software, firmware and information integrity.	Verify that integrity-checking mechanisms are in place for critical systems and applications. For a sample of exceptions/incidents, verify that they are properly investigated and resolved.

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			The company defines acceptable and unacceptable mobile code, establishes usage restrictions and implementation guidance for acceptable mobile code, and monitors use of mobile code within the information system.	Provide information regarding the process for detecting and preventing the execution of unauthorized mobile code.	Verify that a baseline of approved mobile code has been established and that detection mechanisms which block unauthorized mobile code execution are in place.
			Protections against data leaks are implemented.	Provide information regarding the data loss prevention (DLP) program designed to detect and prevent protected information from leaving the company.	Verify that a DLP program is in place that includes: (1) Detective and blocking technology that regularly scans network traffic for protected information and blocks the transmission and alerts security personnel. (2) Safeguards against the use of unauthorized or unencrypted portable media. (3) Safeguards against unauthorized screen capture technology. (4) Safeguards against unauthorized use of instant messaging. (5) Prohibits the use of unauthorized file transport applications. (6) Provides routine user awareness training.

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PART TWO – EVALUATION OF CONTROLS IN INFORMATION TECHNOLOGY (IT) WORK PROGRAM – MONITOR, EVALUATE AND ASSESS (MEA)

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MEA 01	The company does not properly identify and address IT performance and conformance deficiencies.	MEA 01.01– MEA 01.04	The company has adopted and implemented a formalized monitoring framework to define the scope, methodology and process to be followed for measuring IT's solution, service delivery and contribution to the company, including tracking corrective actions to address anomolies.	Provide evidence of the policies and procedures over IT performance monitoring including key performance metrics (KPIs). Provide a listing of the reports used to monitor IT performance.	Evaluate whether the company's IT monitoring framework: 1) Is consistent with key IT processes and business goals and objectives. 2) Establishes a balanced set of performance targets that are approved by the business and other relevant stakeholders. 3) Defines benchmarks and targets to be used for comparison. 4) Requires periodic reviews of performance against targets. 5) Analyzes the cause(s) of any deviations, and initiates remedial action to address the underlying causes. Select a sample of the monitoring reports to evaluate whether the company is effectively monitoring and addressing IT performance.
MEA 02	The company does not identify and address internal control deficiencies related to IT systems.	MEA 02.01	A process has been implemented to continuously monitor benchmark and improve the IT control environment and control framework to meet organization objectives and cybersecurity expectations.	Provide a copy of internal control monitoring activities including control self-assessments, SOX-related control reviews, independent controls reviews by consultants/contractors (including SOC reporting if the organization provides outsourced	Review internal control monitoring activities for identification of control deficiencies, remediation and reporting.

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				services, penetration testing, and vulnerability scanning) and internal audit.	
				Provide a copy of the internal audit charter, mission statement and reporting relationships.	Review a copy of the internal audit charter, mission statement and reporting relationships to verify independence and objectivity of the internal audit function.
				Provide a listing of all internal audit reports, projects and reviews conducted (completed or not) during the examination period.	Review the listing of all internal audit reports, projects and reviews conducted (completed or not) during the examination period to ascertain the breadth and depth of the function.
				Provide a copy of all IT internal audit reports for the period under review.	Review all IT internal audit reports covering the examination period to ascertain the breadth and depth of the function. Verify that appropriate senior management attention was given to all significant IT findings and that issues were appropriately resolved.
				Provide a copy of the internal audit organizational chart.	Verify that the staffing of the internal audit unit is sufficient to accomplish the corporate mission.
				Provide a listing of IT specialists in the internal audit unit including background information such as education, certifications and experience.	Verify that the education, certifications and experience of the IT specialists in the internal audit unit enable the accomplishment of the corporate mission.
MEA 03	IT processes and IT-supported business	MEA 03.01– MEA 03.02	A review process has been implemented to identify on a continuous	Provide a copy of procedures to verify that legal (e.g., Insurance Data	Verify that procedures are in place to ensure that legal, regulatory and contractual obligations impacting IT are reviewed. These

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	processes are not compliant with applicable laws, regulations and other contractual requirements.		basis the changes in local and international laws, regulations and other external requirements that must be complied with for incorporation into the organization's IT polices, standards, procedures and methodologies.	Security Model Law (#668)), regulatory and contractual obligations impacting IT are reviewed.	regulatory compliance procedures should: 1) Identify and assess the impact of the applicable legal or regulatory requirements relevant to the IT organization. 2) Update the associated IT policies and procedures affected by the legal and regulatory requirements. 3) Include areas such as laws and regulations for electronic commerce, data flow, privacy, internal controls, financial reporting, industry-specific regulations, intellectual property copyright, and health and safety.
				Provide evidence that the company's IT policies and procedures have addressed all relevant legal, regulatory and contractual obligations.	Verify that the company's evidence documents its process to ensure that external obligations are addressed in IT policies and procedures.
		MEA 03.03–MEA 03.04	A procedure has been implemented to review and report compliance of IT policies, standards, procedures and methodologies with applicable legal and regulatory requirements.	Provide a copy of the position description for the chief compliance officer, including IT compliance officer if in place.	Verify that the organization has a chief compliance officer or equivalent, and review a copy of the job description for this position for adequacy.
				Provide a copy of the IT organization policies, standards, regulatory review plan and procedures.	Verify that a review of the IT organization policies, standards and procedures is conducted periodically to address any non-compliance (legal and regulatory) gaps identified (this can be included in the risk assessment process).
				Provide a copy of compliance documentation from all financially significant third-party service	Verify that policies and procedures are implemented to ensure that contract with third-party service providers require regulator confirmation of compliance (e.g., receipt of assertions) with applicable laws, regulations

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				providers.	and contractual commitments.

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