NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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Virtual Meeting

FINANCIAL ANALYSIS SOLVENCY TOOLS (E) WORKING GROUP
Thursday, September 26, 2024
11:30 a.m. – 12:30 p.m. ET / 10:30 – 11:30 a.m. CT / 9:30 – 10:30 a.m. MT / 8:30 – 9:30 a.m. PT

ROLL CALL

Greg Chew, Chair	Virginia	Lynn Beckner	Maryland
Amy Garcia, Vice Chair	Texas	Judy Weaver/Kristin Hynes	Michigan
Richard Russell/Todrick Burks	Alabama	Debbie Doggett	Missouri
Dave Lathrop/Kurt Regner	Arizona	Olga Dixon	New Jersey
Michelle Lo	California	Victor Agbu	New York
Jack Broccoli	Connecticut	Dwight Radel/Tim Biler	Ohio
N. Kevin Brown	District of Columbia	Ryan Keeling	Oregon
Carolyn Morgan/Nicole Crockett	Florida	Liz Ammerman/Ted Hurley	Rhode Island
Amanda Denton	Indiana	Kristin Forsberg	Wisconsin

NAIC Support Staff: Rodney Good/Bill Rivers/Ralph Villegas

AGENDA

1. Consider Adoption of Exposed Revisions to the *Financial Analysis Handbook* (Handbook)—*Greg Chew (VA)*
   - A. Property/Casualty (P/C) Catastrophe Reinsurance Program — Attachment 1
   - B. Credit Risk Assessment — Attachment 2
   - C. Health Pricing/Underwriting Risks — Attachment 3

2. Discuss Comments Received on Exposed Revisions to the Handbook —*Greg Chew (VA)*
   - A. Form A and Disclaimer of Control/Affiliation
     - i. Comment Letters from:
       - a. American Council of Life Insurers (ACLI) — Attachment 4
       - b. Investment Company Institute (ICI) — Attachment 5
       - c. National Alliance of Life Companies (NALC) — Attachment 6
       - d. Securities Industry and Financial Markets Association (SIFMA) — Attachment 7
       - e. The Capital Group Companies, Inc. — Attachment 8
     - ii. Revised Handbook Guidance — Attachment 9
   - B. Own Risk and Solvency Assessment (ORSA) Guidance and Form F Exemptions
     - i. Comment Letter from UnitedHealthcare (UHC) — Attachment 10
     - ii. Handbook Guidance — Attachment 11

3. Consider Exposure of Draft Handbook Guidance—*Greg Chew (VA)*
   - A. Recovery and Resolution Planning Referred by the Group Solvency Issues (E) Working Group — Attachment 12
   - B. Surplus Notes and Capital Maintenance Agreements — Attachment 13
   - C. Combined Guidance and Repositories for the Following Risk Categories:
     - i. Market Risk Assessment — Attachment 14
     - ii. Pricing/Underwriting Risk Assessment — Attachment 15
     - iii. Reputational Risk Assessment — Attachment 16
     - iv. Strategic Risk Assessment — Attachment 17

4. Discuss Any Other Matters Brought Before the Working Group —*Greg Chew (VA)*

5. Adjournment

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.

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~~ed~~~~ing factor in~~to 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~~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 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~~Determin~~e~~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)

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

Additional ~~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:
  - Planned asset mix and diversification strategies.
  - 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 d~~D~~etermine~~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

~~The procedure assists analysts in d~~Determin~~ing~~e 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 w~~When interest rates decline, prepayments will rise, forcing investors to reinvest at the lower rates which~~. This will affect~~ impacts the value of bonds o~~i~~n 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~~,~~. ~~which~~This 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 e~~Estimated prepayment speeds on its RMBS. Several standardized forms of calculating the rate of prepayments of a mortgage security exist in the market. Historically, the constant prepayment rate (CPR) and the standard prepayment model of the Bond Market Association (PSA curve) are simple methods used to measure prepayments. Numerous other methods have evolved. Analysts should consider further analysis in those instances that prepayment risk appears high.
  - There are many different types of RMBS, each of which have different characteristics and inherent risks. Therefore, consider requesting information from the insurer regarding the percentage distribution and amounts of each type of 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 g~~RBC C-3 Interest Rate Risk Component and the Actuarial Opinion cash flow testing ask the insurer to break down its RMBS portfolio by general definitional classes, each of which has its own relative level of prepayment and cash flow volatility risk. Individual insurers may use different measures and monitoring techniques. If an insurance company cannot supply this data with reasonable ease, analysts may want to look more closely at the management and monitoring systems in place for the RMBS portfolio.

Default, 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 d~~Determine~~ing~~ 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 ~~i~~important consideration~~s~~ in thi~~e~~s 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 ~~c~~Category 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 d~~Determin~~ing~~e 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~~Identify~~ing~~ and assess~~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~~inge~~ 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*~~

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

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

Procedures / Data

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

Additional Review Considerations

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

~~**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 Insurers~~FOR HEALTH INSURERS~~:

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

that have been recorded on that policy to also be non-admitted. The *de minimus* over 90-day balance itself would be non-admitted and the entire current balance would be subject to a collectability analysis.

The balance for uncollected ~~premium~~premiums may also result from amounts due from the Centers for Medicare and Medicaid Services or other government plans. Although coverage periods ~~on~~for this type of business are usually the same as comprehensive group business, the payment cycle can be much different due to the longer settlement 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 to~~Recoverables for High-Deductible Policies ~~(~~for P/C Insurers~~)~~

Large deductible programs for workers' compensation insurance marketplace create added risk. Credit quality and poor financial strength of a professional employer organization (PEO), for example, may result in future collectability risk, which may result in ongoing credit risk and future liquidity issues. Large deductible programs~~They~~ 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 c~~Consider requesting and reviewing a copy of the insurer's formal adopted investment plan. This should be evaluated to determine if the plan appears to result in investments that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs and to determine whether the insurer appears to be adhering to its plan. For example, the insurer's plan for investing in non-investment grade bonds should be reviewed for guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location.

Two possible credit risks associated with Investment Stategy include:

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

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

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

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

Examination Findings

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

Identify any examination findings regarding credit risks associated with:

- Investment concentration.
- Exposure to riskier asset classes.
- Climate change, transition, and asset devaluation.
- 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 c~~Consider requesting the NAIC's Capital Markets Bureau (CMB) to assist with investment portfolio or investment management agreement analysis. The CMB has different levels of analysis that can be arranged to assist the state.

Consider requesting the following analytical reviews:

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

Third-Party ~~INVESTMENT~~Investment Advisors

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

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

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

- 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 to~~Collectabilty of ~~r~~Reinsurance ~~r~~Recoverables 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 a~~Collectability of Affiliated ~~r~~Receivables; 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 to~~Collectability of ~~u~~Uncollected ~~p~~Premium and ~~a~~Agents' ~~b~~Balances 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 ~~r~~Relating to ~~u~~Uninsured ~~p~~Plans ~~and health care~~for Health Insurers

Procedures/Data

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

Collectability of Health Care Receivables for Health Insurers

Procedures/Data

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

Additional Procedures

For additional guidance on in~~i~~dividual procedure steps, please see the corresponding annual procedures ~~dicussed~~discussed above.

III.B.6. Pricing/Underwriting Risk ~~Repository~~Assessment ~~–~~

Health - ~~Annual~~ Additional Review Considerations~~Procedures~~

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,

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.

ACLI
Financial Security for Life

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 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

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

[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.

[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.

NATIONAL ALLIANCE OF LIFE COMPANIES
An Association of Life and Health Insurance Companies

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:

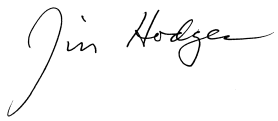
1. Permitting consideration of whether a disclaiming party "may exert influence or control over the insurer …" conflicts with the definition of Control stated in the Model Act. The handbook is an interpretive tool, efforts to use the Handbook to amend this or any other Model Act are inappropriate. This 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.

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

sifma
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);

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

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

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

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

CAPITAL
GROUP®

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.

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.

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

[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.

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

[5] Schedule 13G, Item 10.

[6] Proposal at 21.

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

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

[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).

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-~~6~~7 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 #12~~1~~-17~~6~~ provides steps for completion of the approval or denial of the Form A application and developing an overall conclusion regarding the Form A.

POST-APPROVAL PROCEDURES #18~~7~~-~~29~~34 provide administrative steps for the conclusion of the Form A approval process as well as analytical steps for post-acquisition financial solvency analysis and compliance review. It is important for the department to conduct follow-up analysis and/or examination to ensure that stipulations or conditions of the acquisition approval have been met, that actual results are in line with the financial projections, business operations and strategy of the insurer that were provided with the Form A, and if not, to understand the reasons for variances.

General Statutory Standards and Risk Assessment for Form A Review

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

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

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

Analysts are already required in other areas of this handbook to consider the prospective risks of any domiciled insurer as they perform their annual analysis and ongoing financial solvency oversight of the insurer. This also 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

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 passively monitoring their investment, 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]: 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 [Staff7]: Deleted in response to Capital Group and Sifma and ICI comment letters.

Commented [Staff8]: 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 [Staff9]: 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.

United Healthcare

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."

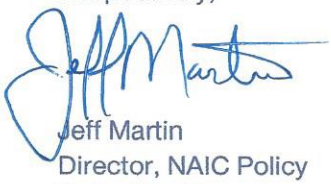
Additionally, the Handbook suggests that an insurer is expected to focus on risks it sees as material to its business instead of focusing on risks that are not material to its business. The following excerpt guides the analyst in this regard, including suggesting that the analyst consider if there are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

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.

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.

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.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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).

Washington, DC 444 North Capitol Street NW, Suite 700, Washington, DC 20001-1509 p | 202 471 3990

Kansas City 1100 Walnut Street, Suite 1000, Kansas City, MO 64106-2197 p | 816 842 3600

New York One New York Plaza, Suite 4210, New York, NY 10004 p | 212 398 9000

www.naic.org

**********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 ~~each~~the group's organization, capital structure, characteristics, and financial condition.
    - ~~Regardless of whether a formal recovery plan is required, t~~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.
    - 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 16.1~~5~~6 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.

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,

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.

State insurance departments may establish rules for when a state must complete its approval/disapproval (i.e., deemer date) for a capital or surplus note request. The review of a surplus note should be completed within [days set forth by the state's insurance department rules, e.g., 30 days].

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 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 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."

j. The note includes the following terms:

    i. Surplus floor, as determined by the insurance department policy. The purpose of a floor is to ensure that policyholders are protected against hazardous financial conditions that could develop if the floor is too low to provide for the maintenance of adequate capital and surplus.

    ii. Repayment. Provisions for repayment should be clearly set forth in the agreement.

    iii. Receivership. In the event of liquidation any payment of interest or repayment of principal under the agreement shall be in accordance with the department's Insurer Receivership Act. The written agreement should include specific language as required by the insurance department. For example:

        - "This surplus note is subject to the provisions of [insert state law], which binds the company and its successors and assigns. If action is taken against the company or its assets under the [insert state law], this surplus note shall be paid in accordance with the applicable [chapter or provision of the law]."

    iv. For a note with a sinking fund. If the subordinated indebtedness includes a provision for the payment or repayment only out of a sinking fund established by the insurer by setting aside a specified amount during a specified period, all payments must be made from the established sinking fund subject to the minimum surplus stated in the written agreement, and such amount accumulated and held in the sinking fund shall be a legal liability and financial statement liability of the insurer.

k. The agreement must state that there are no conditions placed on the insurer.

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. 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 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. Make certain that any older notes do not contain a lower surplus floor and payment dates that could trigger the insurer to pay out the surplus obtained from the new note.
    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.

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.

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 #1-196 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 #178ix – 178xiii 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.

VI.C. Group-Wide Supervision – Insurance Holding Company System Analysis Guidance (Lead State)

**********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?

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.

Commented [Staff1]: Additional edits in this section III.B.9 represent the merge of the Risk Repository and the ARG for this procedure.

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

~~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 i~~If the level of concern warrants further review, ~~as determined by analysts~~consider:

- Review and discuss with the company and evaluate the potential effect of capital notes or surplus notes on the insurer's surplus position.
- If the insurer is subject to ORSA reporting requirements, there may be a great deal of information on the insurer's capital/surplus position to be reviewed and evaluated in the ORSA Summary Report~~, 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 r~~Review~~ing~~ 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~~ determine~~ing~~ that these transactions were approved by the domiciliary state insurance department.
- ~~In addition, i~~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 r~~
- Review ~~of~~ the detail of unrealized gains (losses)~~.~~.
- ~~assessment of any parental guarantees in place and the review of~~Gain 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 #1-186 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.

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 InvestmentsDerivatives

Refer to IV. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations for general information and a primer on derivatives.

Discussion of Annual ProceduresGeneral 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 chapterand 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 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 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 a~~Analysts should ~~review the results~~complete 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 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 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 Procedures~~Annual 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 d~~Determin~~e~~ing 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 v~~Various types of investments to total net admitted assets (excluding separate accounts for Life/A&H) are a measure of the diversity of the insurer's investment portfolio by type of investment. The results of these ratios may also provide some indication of the insurer's liquidity. In addition, the ratio of the investment in any one issuer to total net admitted assets (excluding separate accounts for Life/A&H) is a measure of the diversity of the insurer's investment portfolio by issuer.

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 secuirities 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 dDetermineing 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

- 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 de~~De~~termine~~ing whether the fair value of common stock is significantly greater than or less than the actual cost. ~~The analyst should r~~Review the Annual Financial Statement, Schedule D – Part 2 – Section 2, to compare the aggregate fair value position to the aggregate actual cost of common stock. ~~The analyst should a~~Also review individual stock issues to determine if the fair value is significantly above or below actual cost. If the fair value of a stock issue is significantly below cost (unrealized loss), the insurer may incur a loss upon disposition. If the fair value of an individual stock issue is significantly greater than actual cost (unrealized gain), the insurer may be reflecting an unrealized gain that will not be realized at disposition.

Procedures/Data

- Determine if the fair value of common stock is significantly greater than or less than the cost [Annual Financial Statement, Schedule D – Part 2 – Section 2].
  - Determine if the aggregate fair value of common stocks is below the actual cost and if the difference is greater than 10% of surplus (P/C) or capital and surplus (Life/A&H, Health).
  - Determine if the aggregate actual cost of common stocks is below the fair value and if the difference is greater than 10% of surplus (P/C) or capital and surplus (Life/A&H, Health).
  - Determine the fair value to actual cost, when an investment in one issue of common stock is greater than 5% of invested assets.

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

- ~~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.
- Request~~ing~~ 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 dDetermineing whether concerns exist due to the value of investment in real estate. The analystThere 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 Rreview cConsiderations

- 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 dDetermineing 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 rReview Cconsiderations

- 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 dDetermineing whether concerns exist due to the level of investment in collateral loans. The analyst should rReview 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~~Determine~~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 d~~Determin~~eing~~ 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 r~~Review the Annual Financial Statement, Notes to the Financial Statements, Exhibit of Capital Gains (Losses) and Investment Schedules to determine the amount of other-than-temporary impairments (OTTI) that have been taken in the current period and to determine if OTTI appear to be in compliance with statutory accounting guidelines.

Procedures/Data

- Ratio of net unrealized capital gains/(losses) to prior year-end surplus.
- Ratio of net realized capital gains to net income, where the absolute value of net realized capital gains or losses is material surplus.

Additional Review Considerations

- Review Annual Financial Statement, Notes to Financial Statements, the Exhibit of Capital Gains (Losses) and Investment Schedules to assess the amount of OTTI have been taken in the current period for reasonableness.
- If concerns exist that OTTI are not properly written down, request information on the insurer's investment policy for recording OTTI to determine if it aligns with statutory accounting requirements

~~**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 r~~Review investment yields, interest rate spreads and trends in investment returns. ~~. The analyst should use the available information to d~~Determine if the investment returns appear adequate to meet the business plans of the insurer. Economic conditions, such as a low interest rate environment or change in investment markets, may result in a reduced returns on investments compared to expectations. Additionally, the insurer's actual investment portfolio and/or portfolio performance may vary significantly from projections if the insurer is not adhering to the strategy in place (i.e., higher actual credit, market or liquidity risk compared to the plan).

Procedures/Data

- Investment yield ratio
- Adequacy of investment income ratio (IRIS Ratio #4 – Life/A&H only)
- 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~~eing~~ 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

Determineing 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 cConsider 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 dDetermine 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 dDetermine 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 doubleoverlapping 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?

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 ASSESSMENTPROCEDURES

The Qquarterly Mmarket Rrisk Repository procedures are designed to identify the following.

Significant Investment Concentration by Asset Class

Determine Wwhether 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 Cconcerns 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.

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 ~~C~~concerns 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.

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 ProceduresGeneral Guidance

Using the Repository

To assessThe pricing and underwriting risk, risk 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 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 infor 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 Pprocedure #2 aalso 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.

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.

- 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.

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 AssessmentQuantitative 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 determiningReview 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 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 Lines – Life/A&H

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 – Life/A&H

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 AssessmentAnalyst 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~~Determine~~ing~~ 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.

- 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 determinge 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 d~~Determine~~ing~~ 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.
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- If the insurer has entered a new region or has significantly increased the business written in an existing region, request information on how the insurer establishes product prices in those regions, the provider contracts used by the insurer in that region and a discussion of the insurer's future expected changes in the region. Compare this information with information available from the insurer's competitors.
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High Health Writings Leverage [or Trend] - Health

PROCEDURE #6 assists analysts in dDetermineing 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 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.

Financial Impact of the Federal Affordable Care Act [Health]

PROCEDURE #7A–F assists analysts in Determine whether there are concerns reviewingregarding the impact theof 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 iIdentifying any risks or concerns withregarding 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.

- Explanations of negative results (high MLR, rebates, risk sharing payments, line of business [LOB] operating losses, etc.).
- Planned changes in market focus for ACA business (entering or exiting exchanges, entering or exiting states/regions, etc.).
- Status of recent and pending rate increases.

- Determine if there are concerns regarding recent rate filing requests:
  - Contact internal state insurance department staff responsible for the rate review and request information on any recent rate reviews. Determine whether any concerns were noted by the rate review staff (e.g., were rate adjustment requests disapproved or modified)?.
  - Review the trend in rate filing requests. Determine whether there are any concerns with the frequency or amount of the requests.
  - Review the Financial Profile Report's PMPM premium data and compare it to rate increases.

Additional Analysis and Follow-UpADDITIONAL ProceduresPROCEDURES APPLICABLE TO PRICING AND UNDERWRITING RISK

Examination Findings

EXAMINATION FINDINGS direct the analsyt to cConsider a review of the most recent examination report, sSummary rReview mMemorandum (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 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 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 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.

- 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 Assessment~~Procedures~~

The ~~Q~~quarterly ~~P~~pricing and ~~U~~underwriting ~~R~~risk ~~Repository~~ procedures are designed to identify the following:

Poor Overall Underwriting Performance – P/C~~Concerns 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 ~~C~~concerns exist ~~with the~~regarding changes in volume of premiums written, changes in the insurer's mix of business (lines of business and/or geographic location) and changes in writing leverage

Procedures/Data

- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis.
- Change in direct premiums written (DPW) for any line of business
- Ratio of DPW for new lines of business to total DPW
- 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.

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

completionthe 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, aAnalysts 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 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 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 ProceduresANNUAL REPUTATIONAL RISK ASSESSMENT

Reputational Impact of Other Risks

Reputational Impact of Other Risks

PROCEDURE #1 directs analysts to iIdentify 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 procedurepossible considerations references 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 asincluding 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 rReview of the most recent examination report, sSummary rReview mMemorandum (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.

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Own Risk and Solvency Assessment (ORSA) Summary Report

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 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 oObtain 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.

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 responddocument every 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 completionthe 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, aAnalysts 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 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 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 ASSESSMENTQuantitative 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 iIdentify 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 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 c~~Consider how recent and pending merger and acquisition activity may affect the current and prospective solvency position of the insurer. Merger and acquisition activities have the potential to move the company into new lines of business and new geographical areas, and may result in significant staffing turnover and integration activities. Failure to adequately conduct due diligence in evaluating the financial condition and compatibility of 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-up~~post-acquisition procedures comparing projections to actual results and evaluating the effectiveness of system integration and cost-cutting measures may help identify prospective risks and concerns that merit ongoing monitoring.

Procedures

- Determine whether the insurer has been a party to a merger or consolidation as indicated in General Interrogatories, Part 1, #5.1 of the Annual Financial Statement.

Additional Review Considerations

- If the insurer has been a party to a merger or consolidation, note any observations or concerns, ensure Form A or additional filings have been approved, and assess if the insurer is meeting the expectations set forth in the Form A business plan, consider the following additional procedures (as necessary):
  - If regulatory approval of the merger or acquisition was subject to ongoing conditions or restrictions, verify compliance with those requirements.
  - Compare actual results to pre- and post-transaction projections to determine whether results are meeting expectations. If not, gain an understanding of why projections have not been achieved and the company's planned actions to address issues.
  - Request and review information regarding the integration of the new business into the company's processes and systems (systems transition plan), the insurer's process and controls over integration, as well as the steps taken to ensure that adequate cybersecurity precautions are taken during the integration process.
  - Gain an understanding of and consider the impact of planned cost-cutting activities, including the nature and magnitude of cuts and their potential impact on risk exposures.
- Inquire as to whether the company is actively investigating or pursuing merger and acquisition opportunities. If "yes," consider the following additional procedures (as necessary):
  - Obtain an understanding of and consider the company's motivation for pursuing acquisition opportunities (e.g., gain market share, increase producer fees/commissions, diversification, etc.) and how that motivation may affect strategic planning and prospective risk exposures.
  - Gain an understanding of and evaluate the company's processes to perform due diligence when investigating mergers and acquisitions.

~~**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:
  - ~~a~~A 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~~
  - A~~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~~
- ~~c~~Consider having the insurer's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.

- If concerns related to the investment strategy or portfolio are identified, consider requesting and reviewing a preliminary portfolio analysis from the NAIC's Capital Markets Bureau.

~~**Reinsurance Strategy**~~

Adequaqcy of the Reinsurance Strategy

Reinsurance Cost and Availability

~~***PROCEDURE #7*** relates to the reinsurance levels maintained by t~~Determine whether the insurer has established and maintained ~~whether they are adequate~~appropriate levels of reinsurance to support the insurer's business plan and strategy~~.~~, in consideration of its capital and surplus position and risk exposure. As risks related to reinsurance strategy may vary somewhat according to business type, the procedures in this area include both considerations applicable to all business types and those specifically associated with Property/Casualty (P/C), Life and Health business.

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.

- 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 dDetermine 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 d~~Determine how any significant or unusual third-party reinsurance transactions, including loss portfolio transfers and commutations, as well as relationships with reinsurance intermediaries may affect the insurer's business plan and strategy. As risks related to unusual reinsurance transactions may vary somewhat according to business type, ~~the procedures in~~ this area include~~s~~ 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:** I~~dentify~~ing and assess~~ing~~ 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

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**: Determin~~e~~ing 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. The~~e~~is ~~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~~e~~ing 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~~e~~inge 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~~e~~ing 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.

- 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 the If 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.
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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.

- 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.

- 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.
- If surplus notes represent a significant portion of surplus, analysts should consider recalculating important ratios, excluding the surplus notes, to determine their effect on the ratio results. Other steps to consider include the review of the detail of unrealized gains (losses), assessment of any parental guarantees in place and the review of other components of surplus.

Concerns with Parental Guarantees and/or Capital Maintenance Agreements

Procedure #11X assists analysts in aAssessing 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 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.

- 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 Assessment~~Procedures~~

The ~~Q~~quarterly ~~S~~strategic ~~R~~risk ~~Repository~~assessment procedures are designed to identify the following:

Impact of News, Press Releases and Industry Reports on Insurer's Strategy

Determine if ~~C~~concerns 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 ~~the~~officers, directors or organizational ~~chart~~structure may have on the ~~potential to affect the~~strategic 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 Plannings / 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 ~~W~~whether the current updated business plans and projections result in new or emerging strategic risks;

Procedures

- Review previous business plans and financial projections filed with the state insurance department, and determine the following:
  - Have significant changes in business plan or philosophy occurred? If "yes," explain.
  - Assess if initiatives outlined in the business plan have been accomplished.
  - Compare actual with projected financial results to determine whether actual results are consistent with management's expectations.
  - Request an explanation for the variance including an explanation of whether management believes it has achieved its goals for the period and if any noted risks or challenges were not considered in the business plan.
  - Request a revised business plan.
  - Describe any events, transactions, market conditions and/or strategic management decisions that have occurred (or are planned) that may cause a significant positive or negative variance from projections, including new product development or enhancements, changes in sales volume, product mix, or geographical locations.
  - Determine whether there are any internal and/or external prospective risks that have the potential to impact the overall business plan.
- If necessary, request and review an updated strategic business plan, note any areas of concern and if necessary, request additional explanations from the insurer.
  - Determine whether the new business plan reflects significant changes in the strategic goals or philosophies compared to the prior plan. If so, provide an explanation.
  - Describe the insurer's strategic and annual planning process.
  - Describe the board of directors' involvement in developing and implementing the business plan.
  - Assess the insurer's ability to attain the expectations of the business plan and projections. Determine whether the business plan reflects changes that appear unrealistic for the current market environment, financial position of the insurer or other circumstances. If so, provide an 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 ~~W~~whether any significant changes may have been made ~~in~~to the insurer's reinsurance program or how any significant new reinsurance transactions may affect the insurer's strategic risk~~;~~.

Procedures/Data – P/C

- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis
- Gross writings leverage (rolling year)
- Net writings leverage (rolling year)
- Change in leverage ratios from prior year-end

- Gross writings leverage (rolling year)
- Net writings leverage (rolling year)
- Paid reinsurance recoverables to surplus
- Reserve leverage
- Change in ceded premiums earned from prior year-to-date

- Change in ceded premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- Change in assumed premiums earned from prior year-to-date
- Change in assumed premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- If the company is a member of a pooling arrangement, determine whether there was any change in agreement or the company's participation as indicated in General Interrogatories, Part 2, #1 of the quarterly financial statement.
- Ascertain whether there were any new reinsurers added since the prior quarter as indicated on Schedule F of their respective quarterly financial statements.
- If so, determine whether any were unauthorized.
- Determine whether there has been a change in provision for reinsurance from prior year-end

Procedures/Data – Life/A&H

- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis
- Change in ceded premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- Change in assumed premiums to gross premiums written
  - From prior quarter
  - From prior year-end
- Ascertain whether there is a balance sheet liability for reinsurance in unauthorized and certified companies.
- Change in balance sheet liability, reinsurance in unauthorized and certified companies
  - From the prior quarter
  - From prior year-end
- Change in capital and surplus account line item relating to the change in liability for reinsurance in unauthorized and certified companies
  - From the prior quarter
  - From the prior year-end
- Ascertain whether there were any new reinsurers added since the prior quarter as indicated on Schedule S of their respective quarterly financial statements.
- If so, determine whether any were unauthorized.

Procedures/Data – Health

- Change in writings from prior year-to-date on a direct, assumed, ceded and net basis
- Ascertain whether there were any new reinsurers added since the prior quarter as indicated on Schedule S of their respective quarterly financial statements.
- If so, determine whether any were unauthorized.

Additional Review Considerations – All Statement Types

- If new reinsurance is reported, obtain a copy of the new reinsurer's A.M. Best Supplemental Ratings Questionnaire, and review the reinsurance section to identify any risks or concerns.

Concerns with Reinsurance Transactions

Determine ~~W~~whether any unusual reinsurance transactions were completed during the quarter~~;~~.

Procedures/Data – P/C

- Ascertain whether there were any agreements to release reinsurers from liability during the quarter as indicated in the General Interrogatories, Part 2, #2 of the quarterly financial statement.] [P/C only]
- Determine whether there were any cancellations of primary reinsurance contracts during the quarter as indicated in the General Interrogatories, Part 2, #3.1 and #3.2 of the quarterly financial statement. [P/C only]
- Determine whether the insurer experienced any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile as required by the Model Act as indicated in the General Interrogatories, Part 1, #1.1 of the quarterly financial statement.
  - 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 Cconcerns exist regarding with the insurer's Risk-Based Capital (RBC) position; and the Aadequacy 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.