Draft date: 9/24/2024
Virtual Meeting

RISK-FOCUSED SURVEILLANCE (E) WORKING GROUP
October 10, 2024
11:00 a.m. – 12:00 p.m. ET / 10:00 – 11:00 a.m. CT / 9:00 – 10:00 a.m. MT / 8:00 – 9:00 a.m. PT

ROLL CALL

Amy Malm, Chair	Wisconsin	Andrea Johnson/Tadd Wegner	Nebraska
Johanna Nickelson, Vice Chair	South Dakota	Paul Lupo	New Jersey
Sheila Travis/Blase Abreo	Alabama	Mark McLeod	New York
Laura Clements/Michelle Lo	California	Jackie Obusek/Monique Smith	North Carolina
Jack Broccoli/William Arfanis	Connecticut	Dwight Radel/Tracy Snow	Ohio
Carolyn Morgan/Jane Nelson	Florida	Eli Snowbarger	Oklahoma
Cindy Andersen	Illinois	Ryan Keeling	Oregon
Roy Eft	Indiana	Diana Sherman	Pennsylvania
Daniel Mathis	Iowa	John Tudino/Ted Hurley	Rhode Island
Melissa Gibson	Louisiana	Amy Garcia	Texas
Vanessa Sullivan	Maine	Jake Garn	Utah
Dmitriy Valekha	Maryland	Dan Petterson	Vermont
Judy Weaver	Michigan	Jennifer Blizzard/Greg Chew	Virginia
Debbie Doggett/Shannon Schmoeger	Missouri	Tarik Subbagh/Steve Drutz	Washington

NAIC Support Staff: Bruce Jenson/Jane Koenigsman

AGENDA

1. Discuss Comments Received and Updated Drafts of Proposed Guidance on Run-Off Insurer Monitoring—*Amy Malm (WI)* — Attachment A
2. Discuss Referral Received on Contractor Oversight in Solvency Monitoring and Consider Exposure of Proposed Guidance—*Amy Malm (WI)* — Attachment B
3. Discuss Referral on Pandemic Risk—*Amy Malm (WI)* — Attachment C
4. Consider Adoption of Examiner Per Diem Salary Recommendations—*Amy Malm (WI)* — Attachment D
5. NAIC/SOFE Memorandum of Understanding—*Joie Nickelson (SD)*
6. Discuss Any Other Matters—*Amy Malm (WI)*
7. Adjournment

ACLI
Financial Security for Life

August 30, 2024

Amy Malm, Chair
Risk-Focused Surveillance Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1000
Kansas City, MO 64106-2197

RE: Proposed Edits to the *Financial Analysis Handbook* for Run-Off Insurers
Proposed Edits to the *Financial Condition Examiners Handbook* for Run-Off Insurers

Dear Madam Chair:

The American Council of Life Insurers (ACLI)[1] has reviewed the Risk-Focused Surveillance Working Group's (RFSWG) proposed edits to the *Financial Analysis Handbook* and the *Financial Condition Examiners Handbook* with respect to run-off insurers, both of which were exposed for comments on July 11.

The proposed edits heighten standards for, and oversight of, insurers in run-off and respond to the Financial Analysis Working Group's (FAWG) request to incorporate guidance for customized solvency monitoring procedures for run-off insurance companies for use in both financial analysis and examination processes as set forth in the Handbooks.

ACLI appreciates the opportunity to provide comments on the RFSWG's exposure with respect to the appropriate application of the guidance.

I. Interaction with Receivership Proceedings and Rehabilitation/Liquidation Laws and Guidance

We believe that all necessary actions should be taken to ensure that any run-off plan guidance does not supersede any receivership proceedings and/or related rehabilitation and liquidation laws and guidance, including the *Receiver's Handbook*. We encourage the RFSWG to refer these documents to the Receivership and Insolvency Task Force (RITF) and the Receivership Law Working Group (RLWG) for feedback in order to avoid any potential conflicts.

II. Importance of a Tailored and Flexible Application of Principles

As currently drafted, the proposed edits broadly apply to all insurers in run-off, which the Handbooks generally describe as follows: "either a voluntary or state mandated course of action *where the insurer ceases writing new policies on a portion of business or all business written*" (emphasis added).

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

ACLI understands the RFSWG's desire to develop additional and/or heightened guidelines for regulating certain companies that are not writing new business and have diminishing resources. However, the description of "insurers in run-off" (or "run-off insurers") in the proposed edits would include companies that, despite voluntarily ceasing to write new policies, have access to adequate capital, are growth-oriented and remain actively engaged in the insurance business through the acquisition of additional blocks of insurance. These growth-oriented insurers have a significantly different business and risk profile than those insurers who are not writing new business and have diminishing resources. The considerations outlined in the proposed edits are tailored to the latter group of companies (those with diminishing resources); but as currently drafted, the proposed edits would apply to both categories of companies (those with and without diminishing resources). The result is a set of monitoring procedures that are not tailored to many of the companies to which they would apply (those without diminishing resources).

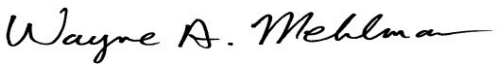
The general approach adopted by insurance regulators with respect to financial examinations is a risk-focused approach. Indeed, the Introduction to the *Financial Condition Examiners Handbook* states that risk-focused examinations "allow flexibility for procedures to be added, modified, supplemented or reduced, in accordance with the overall risk assessment of the insurer." The blanket application of the proposed edits, however, would run counter to this risk-focused approach and result in an inefficient use of both regulator and insurer resources.

ACLI, therefore, believes that the proposed edits should be revised to (i) acknowledge the diverse and wide range of companies that fit within the definition of "run-off insurer" in the Handbooks and (ii) clarify that, given this diversity, particular care should be taken to ensure that the Handbooks are applied to individual insurers in a risk-based manner that takes into account the particular characteristics and risk profile of the individual insurer.

In particular, analysts and examiners should consider whether the relevant insurer has access to capital, is growth-orientated and remains actively engaged in the insurance business through the acquisition of additional blocks of insurance. This insurer-specific application of the proposed edits would allow for closer alignment between the regulatory principles and the risk and business profiles of the individual insurance companies to which they are applied. We also believe that such an approach is consistent with the considerations identified by the FAWG to ensure that the solvency monitoring procedures and considerations are appropriately customized and provide the necessary flexibility considering the overall risk assessment of a particular insurer.

Thanks again for the opportunity to share our views and we look forward to discussing them with you if you have any comments and/or questions.

Respectfully submitted,



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Leveraging Legacy Liabilities

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August 30, 2024

Re: Exposure Drafts issued by the Risk-Focused Surveillance (E) Working Group: Proposed Edits to the Financial Analysis Handbook for Run-Off Insurers and Proposed Edits to the Financial Condition Examiners Handbook for Run-Off Insurers

To: Amy Malm (WI), Chair and Johanna Nickelson (SD), Vice Chair

AIRROC (the Association of Insurance and Reinsurance Run-Off Companies) is pleased to offer comments in response to two exposure drafts issued the Risk-Focused Surveillance (E) Working Group – the Financial Analysis Handbook for Run-Off Insurers and the Financial Condition Examiners Handbook for Run-Off Insurers. As a non-profit association AIRROC and its Board do not advocate for any specific position but provide resources and information.

AIRROC is the only US based non-profit association focusing on the legacy or run-off sector of the insurance and reinsurance industries. Corporate members include major US and international insurance and reinsurance companies, legacy acquirers, well-known rehabilitations, receiverships and liquidations, brokers, run-off managers and state insurance departments. AIRROC also benefits from its associate members, comprised of law firms and legacy service providers, such as the Big 4 accountancy firms, which support the organization with invaluable knowledge and expertise.

We have two main points for consideration for the Working Group as outlined below:

1. Concept of Run-Off

Run-off or legacy can encompass involuntary or INSOLVENT run-offs as well the business of voluntary or SOLVENT legacy portfolios. We ask that the Working Group keep this distinction clearly in mind as an overarching drafting issue in the drafts under review. There are many different models for run-off. AIRROC's members see run-off as part of their business and growth strategy and actively seek to acquire run-off and legacy business.

The legacy sector is an important and growing part of the insurance and reinsurance industries. The 2024 PwC Non-Life Global Runoff Survey estimates that there is over $1 Trillion dollars in cumulative legacy labilities worldwide. Nearly half of these are in the US. This survey was first released in 2018 – the total has increased 38% since then. The full survey can be accessed at http://www.airrocupdate.org/wp-content/uploads/2024/04/Global-Insurance-Survey-2024-FINAL-8-4-2024.pdf

Accordingly, we caution against applying the same assumptions to all forms of run-off and suggest that the guidance make clear that the domestic regulator always maintains the discretion to tailor the guidance to the circumstances of that run-off company or group.

AIRROC suggests that language be pulled from the above paragraphs and added to the introduction paragraph "J. Insurers in Runoff" in the Financial Analysis Handbook and to paragraph "H. Considerations for Insurers in Run-Off" in the Financial Condition Examiners Handbook.

2. Insurance Business Transfers (IBT's) and Corporate Divisions (CD's)

AIRROC recently submitted comments to an exposure by the Restructuring Mechanisms (E) Working Group of its drafts of a White Paper and Best Practices Procedures for IBT/Corporate Divisions. The comment period ended on July 12, 2024 and all comments have been posted to the NAIC website at: https://content.naic.org/committees/e/restructuring-mechanisms-wg

Although the draft examination and analysis procedures for Insurers in Run-Off are separate from the draft best practices for Insurance Business Transfers (IBT's) and Corporate Divisions (CD's) which the Restructuring Mechanisms Working group is working on, AIRROC recommends that there should be some cross-reference made in this new guidance since solvent insurers in run-off may consider such a transaction. Adding a section regarding IBT's/CD's will at least prompt the analyst or examiner to ask the insurer if this has been considered.

We suggest that the following be added to both the Financial Analysis Handbook for Run-Off Insurers and to the Financial Condition Examiners Handbook for Run-Off Insurers.

> **Insurance Business Transfers (IBT's) and Corporate Divisions (CD's)**
>
> Over the past few years, states have begun enacting statutes which provide opportunities for solvent insurers considering run-off of certain lines or their entire book of business to restructure their run-off with finality. These processes can be broken down into two categories generally referred to as insurance business transfer ("IBT") and corporate division ("CD").

An insurance business transfer (IBT) represents a transaction designed to transfer existing insurance obligations of one insurer (transferring insurer) to a second insurer (assuming insurer) without policyholder consent, subject to approval regulatory approval and court approval. While policyholder consent is not required, notice to policyholders, key stakeholders and the general public is required, and concerns regarding the transaction will be considered in the regulatory and/or court approval process. Following an IBT, the assuming insurer becomes directly liable to policyholders and the transferring insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the transferring insurer.

A corporate division (CD) is a division of one dividing insurer into two or more resulting insurers. The dividing insurer's assets and liabilities are allocated between or among the resulting insurers without requiring affirmative policyholder consent. Following a CD, the resulting insurer(s) becomes directly liable to policyholders and the dividing insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the dividing insurer.

AIRROC looks forward to a continued dialogue with the NAIC and more specifically the Risk-Focused Surveillance (E) Working Group. We would be pleased to act as a resource for the Working Group as these drafts are finalized.

Respectfully Submitted,

Executive Director, AIRROC

ENSTAR (US) Inc.

Comments to the Risk-Focused Surveillance (E) Working Group

August 30, 2024

Dear Chair Malm and Vice Chair Nickelson:

Thank you for your oversight and coordination of comments to the Proposed Edits to the Financial Analysis Handbook for Run-Off Insurers and the Proposed Edits to the Financial Condition Examiners Handbook for Run-Off Insurers and thanks to the many regulators who have worked to prepare these documents for review.

Enstar is a global insurance group that has been operating in the run-off space for over 30 years, headquartered in Bermuda and with operations in seven countries. During this time the company has completed 118 acquisitive transactions and acquired over $45 billion USD in assets, from which approximately $25 billion of reserves and liabilities has been run-off. Enstar's business model is to acquire and manage run-off insurance and reinsurance liabilities, creating value by better managing these run-off portfolios.

We understand that the amended guidance is not primarily intended to address the small number of insurers that are focused on acquisitive run-off insurance. However, we would appreciate the consideration of the members in noting and distinguishing as appropriate that for acquisitive run-off insurers the same considerations as to limited duration and assets may not apply.

Furthermore, the Restructuring Mechanisms (E) Working Group has also recently exposed a white paper and best practices document which is more directly focused on insurers looking to transfer run-off and other liabilities through regulatory frameworks specifically suited to such transfers and business plans. We would encourage the members to consider whether it would benefit the readers to provide cross references within these resources to aid regulators who are seeking guidance on the subject and may not frequently encounter run-off operations.

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St. Petersburg, FL 33701

ENSTAR (US) Inc.

We appreciate the work invested in these exposure drafts and believe that they provide important guidance to regulators. We thank you for your consideration of our interests in recognizing that the differences between a traditional and an acquisitive run-off insurer may require more regulatory consideration and flexibility.

Sincerely,

Robert Redpath
Senior Vice President
Regulatory & Technical Director

James Mills
Vice President, Corporate Counsel
Regulatory Relations

150 2nd Ave N, 3rd Floor
St. Petersburg, FL 33701

J. Insurers in Run-Off

Run-off may be either a voluntary or state mandated course of action where the insurer ceases writing new policies on a portion of business, or all business written. A company in run-off should prepare a run-off plan outlining how it will manage its resources in this stage of its operations. During run-off, the insurer typically continues collecting premiums on mandatory policies for a statutorily mandated period and ~~to~~ through policy expiration dates. The degree and timing of the reduction in premiums should be closely monitored through the projections provided within the run-off plan. The specific content of the run-off plan may vary depending upon the line and nature of business in run-off and the financial condition of the insurer; however, at minimum, the plan should include the size of the operations during run-off, employee retention plans, consideration of key decision points (such as when employees may be terminated, whether loss portfolio transfers may occur, or whether companies be merged or sold), and key performance indicators and metrics for the run-off (e.g., cashflow projections and Asset Liability Management plans). The run-off of claims becomes the focus of attention until the last dollar of exposure is paid. The risk exposures for insurers in run-off are likely to be different than that of an insurer writing new business; therefore, it may be necessary for an analyst to narrow the focus of the annual analysis and ongoing oversight of the insurer. Insurers that are no longer actively writing new business but continue to service policies and run-off long term claim liabilities often require customized solvency monitoring procedures and considerations. In addition to analysis outlined in the branded risk assessments, ~~T~~the focus of the analysis of a run-off insurer may include, but not be limited to, the following:

Run-Off Plan (ST, OP)~~:~~

- Analysts should obtain a copy of the run-off plan at the beginning of the run-off process and determine whether the plan is reasonable. The evaluation may include:
  - ~~-~~Consider the overall planning process and related assumptions built into the run-off projections.
  - ~~e~~Evaluate the effectiveness of the insurer's run-off plan by tracking the company's progress against its plan. ~~and determine whether the plan is determined to be reasonable. While reviewing the plan, analysts should:~~ Analyze and document any variances in projected exposures, claims counts, and cash flow needs.
  - ~~o~~
  - ~~Consider the overall planning process and related assumptions built into the run-off projections.~~
  - Review the plan to ensure it covers size of operations during the run-off, employee retention plans, consideration of key decision points, and key performance indicators and metrics for the run-off, including cashflow projections and Asset Liability Management plans.
  - Assess the management team and its retention of staff to determine if they possess the expertise to achieve a successful run-off.
  - Gain an understanding of the insurer's record-keeping processes, with special attention paid to claims records and data sources, including the ability to transfer claims data as needed in a timely manner.
  - Gain an understanding of the insurer's use of service providers and third-party administrators, including plans for continuity of services as operations shrink over time.
  - ~~Analyze and document any variances in projected exposures, claims counts, and cash flow needs.~~
  - Consider expense reduction, reinsurance, plans for collection of outstanding premium and reinsurance recoverables, potential recovery of statutory deposits, policy buy-back, novation, and claim settlements.
  - The insurer's investment portfolio should reflect a conservative strategy to preserve invested assets to meet runoff obligations. Any aggressive strategies may require analysts to discuss the insurer's investment philosophy to ensure that the matching of assets and liabilities are maximized given available capital.

Corporate Governance and Operations (OP, ST)

- Employee Retention: Insurers in run-off are faced with unique challenges in maintaining effective oversight and staffing in circumstances of decreasing resources. Some areas of corporate governance that may be more critical for an insurer in run-off include employee compensation and retention, succession planning, and adequate oversight of critical functions by the Board of Directors and senior management. Evaluating the suitability of key management becomes of increased importance in an environment of high turnover and changing responsibilities. Employee retention may be more difficult for a run-off insurer to manage, it is important to ensure that the company maintains qualified officers with sufficient knowledge and experience throughout the course of the run-off.
  - Closely monitor employee turnover and request additional reporting on any changes in senior officers throughout the run-off period.

Capital and Liquidity Management (LQ, ST, OP)~~.~~

- The ability to manage capital and liquidity risk can be of heightened importance to run-off insurers given limited resources and flexibility. An objective of an insurer in run-off is to manage its assets and liabilities and maintain sufficient cash flow to ensure claim payments are met. Ideally, the insurer will reduce liabilities over time while ensuring its balance sheet maintains liquid assets to pay claims. An insurer in run-off would generally be expected to maintain a conservative strategy in order to preserve the ability of invested assets to meet run-off obligations. An aggressive strategy may warrant additional scrutiny.
  - To assess liquidity and surplus adequacy, ~~analysts should~~ evaluate the insurer's liquidity ratio and surplus to asset ratio.
  - ~~Analysts should d~~Document any material fluctuations in the liquidity and surplus to asset ratio and apply stress testing to assess the capital needs of the insurer.
  - ~~Analysts should also c~~Consider the allocation of long v. short tail lines of business in run-off ~~in order~~ to gain a sense of the length of tail ~~in order~~ to assess future cash flow needs.
  - Monitor investment income in relation to operating expenses, using pro forma projections and reconciling differences. If operating expenses exceed investment income, the resulting losses could quickly erode policyholder surplus and create liquidity issues.
  - Inquire of the insurer:
    - Information regarding the insurer's analysis performed to determine future cash flow needs and stress testing to assess its capital needs.
    - Request pro forma projections.
- **Loss and Loss Adjustment Expense (LAE) Reserves** (RV, ST). Loss reserves are the largest liability reported by an insurer and one of the most critical pieces of data in assessing an insurer that has entered run-off. Many run-off insurers are thinly capitalized. Given the materiality of this liability, a slight variance in reserves can have a significant impact on the insurer's ability to continue as a going concern. As a result, there is increased importance placed on highly accurate reserve estimations as well as close monitoring of loss reserves.
  - For property/casualty (P/C) insurers, much of the analytical work is done by a review of Schedule P. Loss reserve accuracy can be assessed by analyzing reserve development by line of business and accident year. In addition, it's critical to review claims counts and assess the trending and severity by reviewing this data within Schedule P.
  - Life insurers at times enter run-off, however, more frequently a block of business will enter run-off. Typically, with regard to Life run-off blocks, another life insurer will manage that run-off while managing other active blocks of business, closely monitor~~ing~~ asset adequacy.

- Given the importance of reserve estimations, consider conducting independent reserve estimations and reviews more frequently or calling a targeted exam before the next full scope exam would be scheduled to have the examiner conduct independent reserve estimations.

- **Legal Risk** (LG) – Legal risks have the potential to be more significant to run-off insurers given their limited ability to adjust pricing or take other actions to address legislative changes, changes in case law, or litigation activity with the ability to significantly impact loss reserves. Therefore, it may be appropriate to:
  - Require regular legal risk update reports.
  - Involve those with legal knowledge and expertise in monitoring the company.
  - Monitor the impact of legal risks more closely on run-off companies.

- **Reinsurance Risks** (ST & CR) – Run-off insurers can benefit from carefully monitoring and applying reinsurance coverage in place to ensure that covered losses are identified and collected. In addition, reinsurance recoverable amounts and the credit risk associated with reinsurance can often be material to the solvency position of run-off insurers. Therefore, regulators should closely monitor insurer operations in this area.

- **Regulatory and Stakeholder Communications -** As the run-off plan proceeds and the block of business shrinks, the domiciliary regulator should establish a plan to effectively and timely communicate its analysis of the run-off insurer.

  - Identify key stakeholders in the run-off process, including other state regulators and receivership/guaranty fund contacts[1].
  - Ensure that sufficient confidentiality measures are in place to govern and protect communications with other stakeholders.
  - Develop a plan to communicate appropriate information in a timely and effective manner throughout the course of the run-off.

[1] The optional memorandum of understanding with P/C guaranty funds template is available on the NAIC website at: https://content.naic.org/sites/default/files/committee_related_documents/2022_PreLiquidation_PC_MOU.docx

National Conference of Insurance Guaranty Funds

NCIGF COMMENT LETTER
ON NAIC'S RISK-FOCUSED SURVEILLANCE WORKING GROUP'S
ENHANCED GUIDANCE FOR RUN-OFF COMPANIES

August 30, 2024

The National Conference of Insurance Guaranty Funds ("NCIGF") is writing to comment on the Risk-Focused Surveillance Working Group's (the "Working Group") July 2024 draft of its Enhanced Guidance for Run-Off Companies in the Financial Analysis Handbook and Financial Condition Examiners Handbook (the "Run-Off Guidance"). We appreciate the opportunity to provide feedback on this exposure. We also appreciate the Working Group's recognition of the importance of a company being able to transfer claims data in a timely and usable manner. We also note and support the importance of confidentiality measures, including reference to the optional memorandum of understanding ("MOU"). This continues the NAIC's emphasis on the importance of these items, which is reflected in recent changes to the Financial Analysis Handbook, Financial Condition Examiners Handbook, and the Troubled Insurance Company Handbook.

For your consideration, we offer a few suggested revisions to the Run-Off Guidance to incorporate some best data readiness practices in the event that a run-off company is ultimately put into liquidation.

1. The first proposed change relates to an analyst's review of a run-off plan. We would propose the following change to the new language:

   Gain an understanding of the insurer's record-keeping processes, with special attention paid to claims records and data sources, including the ability to transfer claims data as needed in a timely manner. For property and casualty companies, analysts should review data sources to ensure that they are in either UDS format or in a form that easily can be transformed into UDS format (i.e. csv file that retains all the required elements). The data should be made available for transfer timely and in a usable manner (the UDS format). For more information on UDS, please see the NAIC Uniform Data Standard Operations Manual.

   This language will provide additional detail regarding the form of a property and casualty Run-Off Insurer's data.

2. The next proposed change relates to Employee Retention. We encourage analysts to consider the necessity to retain IT staff for various purposes, including the potential need to transfer data. We suggest the following language for the "Employee Retention" section:

   An analyst may want to consider the need for an insurer in run-off to retain essential IT staff.

3. In the "Other Considerations" section of the proposed changes to the Financial Condition Examiners Handbook, we would suggest the addition of the following language:

   Developing an understanding of the insurer's use of service providers and/or third-party administrators and continuity of service plans as the company operations shrink over time. If service providers or third-party administrators are utilized for claim records and data sources, consider reviewing the ability to transfer usable claims data in a consistent and timely manner in the event of an insolvency.

4. Finally, we propose the following clarification in the "Pre-Receivership Considerations" section:

If receivership or liquidation is triggered, and assets are transferred to the receiver or guaranty fund to settle obligations, it is important that the company's data be maintained in such a format to ensure that policies can continue to be maintained and claims can continue to be paid. For example, the company should have the ability to export its claims data through a defined format either in (Uniform Data Standards [UDS]) format or in a form that easily can be transformed into UDS format (i.e. csv file that retains all required elements) that would allow the data to be received and utilized by a third-party guaranty fund. It is imperative that the data be able to be transferred in a consistent, timely, and usable manner on the date that the Order of Liquidation is signed.

This language reflects the fact that claims data in csv file can easily be transformed into UDS format.

Thank you for the opportunity to share our perspective on the Run-Off Guidance, and we look forward to ongoing engagement with you as this project moves forward.

National Conference of Insurance Guaranty Funds
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Roger H. Schmelzer
President & CEO
E-Mail: rschmelzer@ncigf.org

J. Insurers in Run-Off

Run-off may be either a voluntary or state mandated course of action where the insurer ceases writing new policies on a portion of business, or all business written. A company in run-off should prepare a run-off plan outlining how it will manage its resources in this stage of its operations. During run-off, the insurer typically continues collecting premiums on mandatory policies for a statutorily mandated period and ~~to~~ through policy expiration dates. The degree and timing of the reduction in premiums should be closely monitored through the projections provided within the run-off plan. The specific content of the run-off plan may vary depending upon the line and nature of business in run-off and the financial condition of the insurer; however, at minimum, the plan should include the size of the operations during run-off, employee retention plans, consideration of key decision points (such as when employees may be terminated, whether loss portfolio transfers may occur, or whether companies be merged or sold), and key performance indicators and metrics for the run-off (e.g., cashflow projections and Asset Liability Management plans). The run-off of claims becomes the focus of attention until the last dollar of exposure is paid. The risk exposures for insurers in run-off are likely to be different than that of an insurer writing new business; therefore, it may be necessary for an analyst to narrow the focus of the annual analysis and ongoing oversight of the insurer. Insurers that are no longer actively writing new business but continue to service policies and run-off long term claim liabilities often require customized solvency monitoring procedures and considerations. In addition to analysis outlined in the branded risk assessments. ~~The focus of the analysis of a run-off insurer may include, but not be limited to, the following:~~

Scope: Please note that the following guidance pertains to *solvent* run-off insurers, as the Handbook guidance is not applicable to those companies in receivership[1]. In particular, the below guidance most directly applies to insurers whose entire company is in run-off. Some elements of the guidance may be applicable in other run-off situations (e.g., one block of business is in run-off), and the examiner/analyst should use judgment in determining which elements may be relevant and in applying them to the risk-focused process.

The focus of the analysis of a run-off insurer may include, but not be limited to, the following:

Run-Off Plan (ST, OP)~~:~~

- Analysts should obtain a copy of the run-off plan at the beginning of the run-off process and determine whether the plan is reasonable. The evaluation may include:
  - Consider the overall planning process and related assumptions built into the run-off projections.
  - ~~e~~Evaluate the effectiveness of the insurer's run-off plan by tracking the company's progress against its plan. ~~and determine whether the plan is determined to be reasonable. While reviewing the plan, analysts should:~~ Analyze and document any variances in projected exposures, claims counts, and cash flow needs.
  - ~~o~~
  - ~~Consider the overall planning process and related assumptions built into the run-off projections.~~
  - Review the plan to ensure it covers size of operations during the run-off, employee retention plans, consideration of key decision points, and key performance indicators and metrics for the run-off, including cashflow projections and Asset Liability Management plans.
  - Assess the management team and its retention of staff to determine if they possess the expertise to achieve a successful run-off.

[1] For further guidance on run-off of insurers deemed to be financially troubled, refer to the NAIC *Troubled Insurance Company Handbook* (regulator only publication). For further guidance on insurers in receivership, refer to the NAIC *Receiver's Handbook for Insurance Company Insolvencies*.

Commented [BJ1]: MO proposed edit

Commented [BJ2]: Language added in response to ACLI and Enstar comment letters.

Commented [BJ3]: MO proposed move of text from below.

Commented [BJ4]: MO proposed move of text from below.

Commented [BJ5]: MO proposed edit

- Gain an understanding of the insurer's record-keeping processes, with special attention paid to claims records and data sources, including that the data is in a usable format and that the insurer has the ability to transfer claims data to guaranty funds in the event of receivership, as needed in a timely manner.[2]
- Gain an understanding of the insurer's use of service providers and third-party administrators, including plans for continuity of services as operations shrink over time.
- ~~Analyze and document any variances in projected exposures, claims counts, and cash flow needs.~~
- Consider expense reduction, reinsurance, plans for collection of outstanding premium and reinsurance recoverables, potential recovery of statutory deposits, policy buy-back, novation, and claim settlements.
- The insurer's investment portfolio should reflect a conservative strategy to preserve invested assets to meet runoff obligations. Any aggressive strategies may require analysts to discuss the insurer's investment philosophy to ensure that the matching of assets and liabilities are maximized given available capital.

Corporate Governance and Operations (OP, ST)

- Employee Retention: Insurers in run-off are faced with unique challenges in maintaining effective oversight and staffing in circumstances of decreasing resources. Some areas of corporate governance that may be more critical for an insurer in run-off include employee compensation and retention, succession planning, and adequate oversight of critical functions by the Board of Directors and senior management. Evaluating the suitability of key management becomes of increased importance in an environment of high turnover and changing responsibilities. Employee retention may be more difficult for a run-off insurer to manage, it is important to ensure that the company maintains qualified officers with sufficient knowledge and experience throughout the course of the run-off.
  - Closely monitor employee turnover and request additional reporting on any changes in senior officers throughout the run-off period.
  - An analyst may want to consider the need for an insurer in run-off to retain essential IT staff.

Capital and Liquidity Management (LQ, ST, OP)~~.~~

- The ability to manage capital and liquidity risk can be of heightened importance to run-off insurers given limited resources and flexibility. An objective of an insurer in run-off is to manage its assets and liabilities and maintain sufficient cash flow to ensure claim payments are met. Ideally, the insurer will reduce liabilities over time while ensuring its balance sheet maintains liquid assets to pay claims. An insurer in run-off would generally be expected to maintain a conservative strategy in order to preserve the ability of invested assets to meet run-off obligations. An aggressive strategy may warrant additional scrutiny.
  - To assess liquidity and surplus adequacy, ~~analysts should~~ evaluate the insurer's liquidity ratio and surplus to asset ratio.
  - ~~Analysts should d~~Document any material fluctuations in the liquidity and surplus to asset ratio and apply stress testing to assess the capital needs of the insurer.
  - ~~Analysts should also c~~Consider the allocation of long v. short tail lines of business in run-off ~~in order~~ to gain a sense of the length of tail ~~in order~~ to assess future cash flow needs.

Commented [BJ6]: From NCIGF comment letter.

Commented [BJ7]: From NCIGF comment letter.

[2] For further guidance on data transfer formats, such as Uniform Data Standards (UDS) for property and casualty insurers in receivership, refer to the NAIC *Receiver's Handbook for Insurance Company Insolvencies*.

- Monitor investment income in relation to operating expenses, using pro forma projections and reconciling differences. If operating expenses exceed investment income, the resulting losses could quickly erode policyholder surplus and create liquidity issues.
- Inquire of the insurer:
  - Information regarding the insurer's analysis performed to determine future cash flow needs and stress testing to assess its capital needs.
  - Request pro forma projections.

Loss and Loss Adjustment Expense (LAE) Reserves (RV, ST).

- Loss reserves are the largest liability reported by an insurer and one of the most critical pieces of data in assessing an insurer that has entered run-off. Many run-off insurers are thinly capitalized. Given the materiality of this liability, a slight variance in reserves can have a significant impact on the insurer's ability to continue as a going concern. As a result, there is increased importance placed on highly accurate reserve estimations as well as close monitoring of loss reserves.
  - For property/casualty (P/C) insurers, much of the analytical work is done by a review of Schedule P. Loss reserve accuracy can be assessed by analyzing reserve development by line of business and accident year. In addition, it's critical to review claims counts and assess the trending and severity by reviewing this data within Schedule P.
  - Life insurers at times enter run-off, however, more frequently a block of business will enter run-off. Typically, with regard to Life run-off blocks, another life insurer will manage that run-off while managing other active blocks of business, closely monitor~~ing~~ asset adequacy.
  - Given the importance of reserve estimations, consider conducting independent reserve estimations and reviews more frequently or calling a targeted exam before the next full scope exam would be scheduled to have the examiner conduct independent reserve estimations.
  - ~~o~~

Legal Risk (LG)

- Legal risks have the potential to be more significant to run-off insurers given their limited ability to adjust pricing or take other actions to address legislative changes, changes in case law, or litigation activity with the ability to significantly impact loss reserves. Therefore, it may be appropriate to:
  - Require regular legal risk update reports.
  - Involve those with legal knowledge and expertise in monitoring the company.
  - Monitor the impact of legal risks more closely on run-off companies.

Reinsurance Risks (ST & CR)

- Run-off insurers can benefit from carefully monitoring and applying reinsurance coverage in place to ensure that covered losses are identified and collected. In addition, reinsurance recoverable amounts and the credit risk associated with reinsurance can often be material to the solvency position of run-off insurers. Therefore, regulators should closely monitor insurer operations in this area.

Regulatory and Stakeholder Communications

- As the run-off plan proceeds and the block of business shrinks, the domiciliary regulator should establish a plan to effectively and timely communicate its analysis of the run-off insurer.
  - Identify key stakeholders in the run-off process, including other state regulators and receivership/guaranty fund contacts[3].

[3] The optional memorandum of understanding with P/C guaranty funds template is available on the NAIC website at: https://content.naic.org/sites/default/files/committee_related_documents/2022_PreLiquidation_PC_MOU.docx

- Ensure that sufficient confidentiality measures are in place to govern and protect communications with other stakeholders.
- Develop a plan to communicate appropriate information in a timely and effective manner throughout the course of the run-off.

Insurance Business Transfers (IBT's) and Corporate Divisions (CD's)

Over the past few years, states have begun enacting statutes which provide opportunities for solvent insurers considering run-off of certain lines or their entire book of business to restructure their run-off with finality. These processes can be broken down into two categories generally referred to as insurance business transfer ("IBT") and corporate division ("CD").

An insurance business transfer (IBT) represents a transaction designed to transfer existing insurance obligations of one insurer (transferring insurer) to a second insurer (assuming insurer) without policyholder consent, subject to approval regulatory approval and court approval. While policyholder consent is not required, notice to policyholders, key stakeholders and the general public is required, and concerns regarding the transaction will be considered in the regulatory and/or court approval process. Following an IBT, the assuming insurer becomes directly liable to policyholders and the transferring insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the transferring insurer.

A corporate division (CD) is a division of one dividing insurer into two or more resulting insurers. The dividing insurer's assets and liabilities are allocated between or among the resulting insurers without requiring affirmative policyholder consent. Following a CD, the resulting insurer(s) becomes directly liable to policyholders and the dividing insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the dividing insurer.

Refer to the work of the Restructuring Mechanisms (E) Working Group, including the draft "Restructuring Mechanisms White Paper" and the draft regulatory "Best Practices Procedures for IBT/Corporate Divisions" currently proposed, for additional information specific to IBTs and CDs that may warrant consideration in the analysis and solvency oversight of these entities.

Commented [BJ8]: Language added based on AIRROC and Enstar comment letters.

III. GENERAL EXAMINATION CONSIDERATIONS

This section covers procedures and considerations that are important when conducting financial condition examinations. The discussion here is divided as follows:

A. General Information Technology Review
B. Materiality
C. Examination Sampling
D. Business Continuity
E. Using the Work of a Specialist
F. Outsourcing of Critical Functions
G. Use of Independent Contractors on Multi-State Examinations
H. Considerations for Insurers in Run-Off
I. Considerations for Potentially Troubled Insurance Companies
J. Comments and Grievance Procedures Regarding Compliance with Examination Standards

H. Considerations for Insurers in Run-Off

Run-off may be either a voluntary or state mandated course of action where the insurer ceases writing new policies on a portion of business or all business written. During run-off, the insurer typically continues collecting premiums on mandatory policies for a statutorily mandated period and to policy expiration dates. The degree and timing of the reduction in premiums should be closely monitored through projections, which are often provided within a run-off plan. The run off of claims becomes the focus of attention until the last dollar of exposure is paid. The risk exposures for insurers in run-off are likely to be different than that of an insurer writing new business; therefore it may be necessary for an examiner to narrow the focus of the financial condition examination and ongoing solvency oversight of the insurer. For example, when examining a company in run-off, the examiner may be able to reduce testing performed in traditional areas, such as underwriting. The focus of the examination of a run-off insurer may include, but not be limited to, the following:

Run-off Plan

Please note that the following guidance pertains to solvent run-off insurers, as the Handbook guidance is not applicable to those companies in receivership[1]. In particular, the below guidance most directly applies to insurers whose entire company is in run-off. Some elements of the guidance may be applicable in other run-off situations (e.g., one block of business is in run-off), and the examiner should use judgment in determining which elements may be relevant and in applying them to the risk-focused process.

Commented [EK1]: ACLI and Enstar comment letters

A company in run-off should ~~will typically~~ prepare a run-off plan outlining how it will manage its resources in this stage of its operations. The specific content of the run-off plan may vary depending upon the line and nature of business in run-off and the financial condition of the insurer; however, at minimum, the plan should include the size of the operations during run-off, employee retention plans, and key performance indicators and metrics for the run-off (e.g., cashflow projections and ALM plans). If the company has prepared a run-off plan, the examiner should obtain, from the analyst, the plan that was received at the beginning of the run-off process (and any adjustments between its receipt and the beginning of the examination) ~~and~~ to gain an understanding of the process the company has chosen for winding down its business and the primary risks that remain. In addition, the examiner should track the company's progress against its plan to assist in evaluating the effectiveness of the run-off. If the company has entered into run-off since the prior exam, the department analyst may have already obtained the run-off plan. Therefore, the examiner should consult with the analyst prior to requesting the run-off plan from the company.

[1] For further guidance on run-off of insurers deemed to be financially troubled, refer to the NAIC *Troubled Insurance Company Handbook* (regulator only publication). For further guidance on insurers in receivership, refer to the NAIC *Receiver's Handbook for Insurance Company Insolvencies*.

Corporate Governance

Insurers in run-off are faced with unique challenges in maintaining effective oversight and staffing in circumstances of decreasing resources. Some areas of corporate governance that may be more critical for an insurer in run-off include employee compensation and retention, succession planning, and adequate oversight of critical functions by the Board of Directors and senior management. Evaluating the suitability of key management becomes of increased importance in an environment of high turnover and changing responsibilities. As such, it may be appropriate to closely monitor employee turnover and request additional reporting on any changes in senior officers throughout the run-off period. The examiner may also consider the need for an insurer in run-off to retain essential IT staff, and whether the company's decreasing resources create segregation of duties issues that limit the effectiveness of the company's internal control structure. .

Commented [EK2]: NCIGF Comment letter item #2

Capital and Liquidity Management

An objective of an insurer in run-off is to manage its assets and liabilities and maintain sufficient cash flow to ensure claim payments are met. Ideally, the insurer will reduce liabilities over time while ensuring its balance sheet maintains liquid assets to pay claims. When assessing liquidity and surplus adequacy, the examiner should evaluate the appropriateness of the insurer's investment portfolio, including proper asset/liability matching. An insurer in run-off would generally be expected to maintain a conservative strategy in order to preserve the ability of invested assets to meet run-off obligations. An aggressive strategy may warrant additional scrutiny by the examiner. The examiner may also evaluate whether the insurer has performed analyses to determine further cash flow needs and stress testing to assess its capital needs. One metric to be considered in evaluating both liquidity and capital adequacy would be to monitor investment income in relation to operating expenses, using pro forma projections and reconciling differences. If operating expenses exceed investment income, the resulting losses could quickly erode policyholder surplus and create liquidity issues. In some circumstances, the examiner may consider involving an actuarial specialist to assist in evaluating the adequacy of the insurer's capital.

Loss and Loss Adjustment Expense (LAE) Reserves

Loss reserves are the largest liability reported by an insurer and one of the most critical pieces of data in assessing an insurer that has entered run-off. Many run-off insurers are thinly capitalized. Given the materiality of this liability, a slight variance in reserves can have a significant impact on the insurer's ability to continue as a going concern. As a result, there is increased importance placed on highly accurate reserve estimations as well as close monitoring of loss reserves. Therefore, the exam team may consider suggesting, through the SRM, the analyst consider performing more frequent independent reserve estimations or calling a targeted exam before the next scheduled full scope exam. When examining an insurer in run-off, the examiner should consider focusing procedures on the company's processes for determining loss reserves, reviewing loss reserve development trends, and involving an actuarial specialist in evaluating the overall adequacy of the reserves held.

Loss reserves of run-off insurers can be significantly impacted by litigation activity, or changes in legislation or case law that impact claims liabilities. Therefore, it may be appropriate to require the insurer to provide regular legal risk update reports, involve those with legal knowledge and expertise in monitoring the company, or take other actions to monitor the legal and regulatory risks more closely on run-off companies.

Other Considerations

Given the nature of run-off insurers, there are a number of other considerations to take into account during an examination. In addition to the above areas, the exam of a run-off insurer may have greater focus on the following:

- Gaining an understanding of a run-off insurer's record keeping process, particularly in regard to claims records and data sources, including the ability to transfer claims data as needed in a timely

manner. For property and casualty companies, examiners should review data sources to ensure that they are in either UDS format or in a form that can easily be transformed into UDS format (i.e. CSV file that retains all the required elements). The data should be made available for transfer timely and in a usable manner (the UDS format). For more information on UDS, please see the NAIC Uniform Data Standard Operations Manual.

- Developing an understanding of the insurer's use of service providers and/or third-party administrators and continuity of service plans as the company operations shrink over time. If service providers or third-party administrators are utilized for claims records and data sources, consider reviewing the ability to transfer usable claims data in a consistent and timely manner in the event of an insolvency.
- Developing a plan to communicate necessary information to other key stakeholders (e.g., other state regulators and/or receivership/guaranty fund contacts, if applicable—see "Pre-Receivership Considerations" below) in a timely and effective manner throughout the course of the run-off. Ensure appropriate confidentiality measures are in place to protect these communications, such as the memorandum of understanding highlighted in the guidance below.
- Reviewing the run-off insurer's IT systems to ensure that they are kept up to date and secure, while also ensuring cost effectiveness. While the IT systems are reviewed during full-scope examinations, it may be pertinent to consider targeted exams in between full-scope exams to assess the IT systems more frequently.
- Closely monitoring the company's reinsurance operations, as reinsurance recoverable amounts and the associated credit risk can be material to a run-off insurer's solvency.

Insurance Business Transfers (IBT's) and Corporate Divisions (CD's)

Over the past few years, states have begun enacting statutes which provide opportunities for solvent insurers considering run-off of certain lines or their entire book of business to restructure their run-off with finality. These processes can be broken down into two categories generally referred to as insurance business transfer ("IBT") and corporate division ("CD").

An insurance business transfer (IBT) represents a transaction designed to transfer existing insurance obligations of one insurer (transferring insurer) to a second insurer (assuming insurer) without policyholder consent, subject to approval regulatory approval and court approval. While policyholder consent is not required, notice to policyholders, key stakeholders and the general public is required, and concerns regarding the transaction will be considered in the regulatory and/or court approval process. Following an IBT, the assuming insurer becomes directly liable to policyholders and the transferring insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the transferring insurer.

A corporate division (CD) is a division of one dividing insurer into two or more resulting insurers. The dividing insurer's assets and liabilities are allocated between or among the resulting insurers without requiring affirmative policyholder consent. Following a CD, the resulting insurer(s) becomes directly liable to policyholders and the dividing insurer's obligations under the insurance policies and contracts are extinguished thereby achieving legal finality for the dividing insurer.

Refer to the work of the Restructuring Mechanisms (E) Working Group, including the draft "Restructuring Mechanisms White Paper" and the draft regulatory "Best Practices Procedures for IBT/Corporate Divisions" currently proposed, for additional information specific to IBTs and CDs that may warrant consideration in the examination and solvency oversight of these entities.

Commented [EK3]: NCIGF comment letter item #1

Commented [EK4]: NCIGF comment letter #3

Commented [EK5]: AIRROC comment letter

Commented [BJ6]: Reference from Enstar comment letter.

I. Considerations for Potentially Troubled Insurance Companies

A troubled insurance company is broadly defined as an insurance company that is either in or is moving towards a financial position that subjects its policyholders, claimants and other creditors to greater-than-normal financial risk, including the possibility that the company may not maintain compliance with the applicable statutory capital and/or surplus requirements (*Troubled Insurance Company Handbook*). The "Prioritization Framework" as discussed in the NAIC's *Financial Analysis Handbook* identifies troubled companies as Priority 1.

In situations in which an examination is being planned for a troubled insurance company (i.e., Priority 1 company), the NAIC's *Accreditation Program Manual* (Part B3: Department Procedures and Oversight) indicates that "the department should generally follow and observe procedures set forth in the NAIC *Troubled Insurance Company Handbook*." However, regulators may also consider leveraging the insights in the Troubled Insurance Company Handbook for Priority 2 companies, which are defined in the *Financial Analysis Handbook* as "high-priority insurers that are not yet considered troubled but may become so if recent trends or unfavorable metrics are not addressed."

The following guidance provides an overview of key elements to consider during an examination. Additional insights to assist in enhancing a state's monitoring and surveillance of troubled insurance companies, including regulatory actions available to Departments of Insurance (DOIs), can be found in the *Troubled Insurance Company Handbook*.

Communication Expectations

If an examination is planned or ongoing for a troubled or potentially troubled company, or through the course of the examination that the domestic regulator elevates the priority level of the company to troubled or potentially troubled, it is critical that the domestic regulator communicates proactively and timely with other impacted state insurance regulators. It is also important that the non-domiciliary state communicates with the domestic regulator prior to taking any action against the insurer. This can be particularly important if the corrective action plan implemented by the domestic regulator depends on continued operations of the insurer in other states. Depending on the circumstances, it may also be appropriate to communicate certain information with other parties, such as other regulatory bodies, company management, and state guaranty funds. Establishing a coordinated communication system among the relevant parties will help facilitate the domestic regulator's surveillance of the troubled company.

The timeliness of communication with other regulators should be commensurate with the severity of the event, and it should include information about the troubled company's situation and the proposed corrective action. It may also include a request for other jurisdictions to assist in the implementation of the plan. When determining which states to notify, the department may consider those in which the company: 1) has a significant amount of written, assumed or ceded insurance business; 2) has significant market share; 3) is licensed; 4) has affiliates; 5) utilizes fronting entities; 6) has pooled companies; and 7) is seeking to write business or obtain a license. If it is reasonably anticipated that corrective plans will not prevent a finding of insolvency or insolvency is reasonably possible, advance communication to the guaranty funds is critically necessary for a successful transition to liquidation. If the guaranty funds are notified in a timely manner, they may be able to provide additional guidance and assistance in preparing the company for liquidation. The memorandum of understanding, which is maintained on the Receivership and Insolvency (E) Task Force web page, is an optional tool available to state insurance regulators that can help facilitate this communication and information sharing, as well as transitional planning and preparation.

Pre-Receivership Considerations

Depending on the circumstances of the troubled company's situation, the department may determine that the appropriate course of action is to place the company in receivership. There are several steps that the department can take to ensure a smooth transition to receivership, should that be necessary. Having a thorough understanding of the company's rights and ownership of its assets, as well as its liabilities and obligations can help the

department manage the possible transactions that could occur if the company is placed in receivership. It may also help the regulator understand if inappropriate transactions occur in anticipation of receivership, such as preferential payments to related entities and payment of management bonuses or expense reimbursements. As part of the corrective plan, the department may consider requesting the implementation of controls surrounding the troubled company's operations. For instance, it may be necessary for management to establish controls around acceptance of new business or new commitments by the company, as well as recordkeeping requirements if the insurer is involved with reinsurance.

If an examination is planned or ongoing for a troubled or potentially troubled company, the examination should increase its review of risks and controls surrounding financial reporting processes in the areas discussed above. For example, the exam may have a greater focus on the following areas:

- Gaining an understanding of the location (i.e., bank accounts, deposits, custodial accounts, letters of credit, etc.) and ownership (i.e., funds held with reinsurers, intermediaries, MGAs/TPAs, etc.) of company assets.
- Gaining an understanding of possible encumbrances on company assets that may be triggered if the financial position of the company continues to deteriorate.
- Gaining an understanding of the provisions within various agreements that the company has entered into (i.e., reinsurance agreements, agreements with service providers, investment advisors, etc.) that could be impacted by being placed into receivership.
- Reviewing transactions involving the movement of company assets.
- Identifying primary responsibility for obligations and liabilities, such as tax payments, pension plan contributions, pledges of assets, etc.
- Additional testing to ensure the completeness of policy and claims data.

If receivership or liquidation is triggered, and assets are transferred to the receiver or guaranty fund to settle obligations, it is important that the company's data be maintained in such a format to ensure that policies can continue to be maintained and claims can continue to be paid. For example, the company should have the ability to export its claims data through a defined format, either in ~~(~~Uniform Data Standards [UDS]~~)~~ format or in a form that easily can be transformed into UDS format (i.e. CSV file that retains all required elements) that would allow the data to be received and utilized by a third-party guaranty fund. It is imperative that the data be able to be transferred in a consistent, timely, and usable manner on the date that the Order of Liquidation is signed. Therefore, the examination may include additional procedures as part of the IT review to identify and locate data storage and processes, understand the format of the data, and ensure that proper functionality exists for timely and efficient export of policy and claims data in the event of a receivership.

Commented [EK7]: NCIGF comment letter item #4

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: Amy Malm, Chair of Risk-Focused Surveillance (E) Working Group

FROM: Financial Regulation Standards and Accreditation (F) Committee

DATE: July 26, 2024

RE: Use of Independent Contractors for Analysis and Examinations

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Financial Analysis & Department Oversight of Contractors

As states continue to face challenges with staffing and resources, more and more states are turning to the use of independent contractors to assist in the completion of financial analyses. This is a recent, yet growing, trend that accreditation review teams are encountering while conducting accreditation reviews. When a state utilizes the services of an independent contractor for analysis, the only guidance that is afforded a review team member when a state questions appropriate oversight is under the process-oriented guidelines for the Appropriate Supervisory Review standard in the Accreditation Program Manual that states:

- If the department utilizes a contractor to perform the primary supervisory review of financial analysis, an additional level of review is required on the IPS and/or Group Profile Summary (GPS) by a qualified department employee.

Unlike the Financial Condition Examiners Handbook, the Financial Analysis Handbook does not appear to provide guidance for the use of independent contractors in conducting analysis.

While the use of independent contractors for analysis is a newer development, the question is raised whether having just a process-oriented guideline is appropriate, or should there be consideration for a results-oriented guideline that focuses on the depth or level of understanding expected of a qualified department employee that reviews the IPS and/or GPS.

Additionally, should there be defined timeliness requirements for the department oversight review? In practice, review teams have been following the overall timeliness guidelines for the review of independent contractor work by a department qualified employee, regardless of when the initial supervisory review occurred. In other words, review teams do not expect the department's oversight to be performed within a certain timeframe, but rather, by the overall review dates, which are:

- Annual review of a priority company: April 30
- Annual review of a non-priority company: June 30 (or July 31 if a preliminary review is performed)
- Quarterly review of a priority company: within 60 days from receipt of filing

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- Quarterly review of a non-priority company: within 90 days from receipt of filing
- Holding company filings: by October 31/December 31, accordingly

The above timing guidelines are currently considered a best practice for when the department oversight review of the IPS and/or GPS occur; however, because there is not a direct accreditation guideline, the team would generally not be reporting on any deficiencies that exceed these best practices.

Financial Examinations & Department Designee

The *Financial Condition Examiners Handbook* (FCEH) provides some requirements and guidance on the role of the department designee, indicating it should be a person who is certified by the Society of Financial Examiners (SOFE) as a Certified Financial Examiner (CFE) or a person with substantially similar experience, qualifications and background, and who is employed by and conducting work solely on behalf of the state. Additionally, the guidance requires that the department designee participate by reviewing and approving various work papers and documents (i.e., Examination Planning Memorandum, Exhibit CC-Issue/Risk Tracking Template, Exhibit DD-Critical Risk Categories, Exhibit V-Prospective Risk Assessment, status and budget updates, risks identified, and planned test procedures prior to beginning Phase 3 and Phase 5 fieldwork). In events where the entire examination, including supervisory review, is to be conducted by contract examiners, review teams often have questions about assessing the role of the department designee.

There is currently just one process-oriented accreditation guideline pertaining to the department designee role:

- If a department elects to utilize contract examiners, the department should demonstrate involvement of appropriate department personnel during the course of the examination in accordance with the Examiners Handbook and the department's policies and procedures.

Questions often arise around whether the department designee should be able to demonstrate their level of overall understanding of the examination and its risks and findings at a broad/high level. Currently, there is no process-oriented guideline specific to the qualifications of the department designee, nor a results-oriented guideline that focus on the depth or level of understanding expected of a department designee and the question is, should there be?

Lastly, the FCEH states the department designee's review should be timely; however, it is not clear what timely means.

Additional guidance in these areas would be helpful for review teams to be able to reference when states under review ask questions or when states may not be following intended expectations.

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September 27, 2024

Ms. Amy Malm, Chairperson
NAIC Risk-Focused Surveillance (E) Working Group
Via e-mail to Bruce Jenson, NAIC, at bjenson@naic.org

Comments on Exposure of Proposed Changes to Accreditation Review Team Guidelines and to Self-Evaluation Guide Updates for Contractor Use in Analysis

Dear Ms. Malm:

On behalf of a large and diverse group of industry interested parties, we submitted earlier today the attached letter to the Chair of the Financial Regulation Standards and Accreditation (F) Committee in response to the above-captioned exposure of that committee.

The topic of the exposure – the use of contractors by state insurance departments to support or assist the financial analysis function – raises issues and concerns for interested parties. The attached comment letter lists some of those issues and concerns but does not delve into them in detail. Rather, interested parties believe that the proper forum to address them is the NAIC's Risk-Focused Surveillance (E) Working Group (RFSWG). Our hope is that the F Committee will amend and expand the referral to RFSWG that it approved at the NAIC's 2024 Summer National Meeting to include these issues and concerns. Regardless, by bringing these issues and concerns directly to your attention, interested parties hope that the RFSWG will consider them as well as the use of appropriate guidance and guardrails to ensure that the work of contractors in a state's financial analysis function is well supervised and avoids unintended consequences and risks.

It does not appear that the agenda for RFSWG's call on October 10 has been finalized and posted yet although the NAIC's website says that the purpose of that call includes to "discuss referrals received from other NAIC groups." We assume that will include the referral from F Committee. Regardless, we encourage you to add this to the agenda for that call. We would be glad to take that opportunity to share more detail with RFSWG members about Interested Parties' concerns about the need for a range of guardrails over the use of contractors in the analysis function, as

well as to discuss how interested parties can assist the RFSWG as it considers any new guidance over the use of contractors.

Thank you for considering our request with respect to the issues and concerns of interested parties regarding the use by states of contractors in the financial analysis function. Please let us know if you have any questions or would like to discuss these matters ahead of the October 10 RFSWG meeting.

Sincerely,

D. Keith Bell Rose Albrizio

cc: Interested parties
NAIC Staff

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September 27, 2024

Lori K. Wing-Heier, Chair
Financial Regulation Standards and Accreditation (F) Committee
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Exposure on Proposed Changes to Accreditation Review Team Guidelines and to the Self-Evaluation Guide Updated for Contractor Use in Analysis

Dear Ms. Wing-Heier:

Interested parties appreciate the opportunity to comment on the above-captioned item that was exposed for comment by the Financial Regulation Standards and Accreditation (F) Committee (the "F Committee") during the NAIC's 2024 Summer National Meeting with an extended comment deadline of September 27th.

We understand that the subject exposure was issued by the F Committee to clarify guidance in the NAIC Accreditation Program's Review Team Guidelines ("Guidelines") and Self-Evaluation Guide ("Guide") pertaining to the use of independent contractors to support the financial analysis function of state insurance departments. We note that the current Guidelines and Guide already recognize that independent contractors may have a role in assisting state insurance departments with the analysis of insurers. The changes that are proposed, to our understanding, only further clarify the application of the Guidelines and the Guide in the case of independent contractors for the benefit of accreditation reviewers. The proposed revisions also include details about information to be gathered during the accreditation process and on a somewhat more granular basis than is currently gathered, about the extent of resources provided to a state by independent contractors supporting the analysis function. In that regard, we have no comments about those proposed revisions contained in the subject exposure.

That said, the exposure, taken together with the referral that was made by the F Committee to the Risk Focused Surveillance (E) Working Group (RFSWG) at the NAIC's 2024 Summer National Meeting, raises some concerns about related matters which we want to bring to the attention of the F Committee. We believe these matters should also be taken into account in the Accreditation

Manual, not necessarily as part of the current exposure, but in due course once RFSWG has addressed the F Committee's referral.

Our primary concern is the apparent increased involvement in recent years of independent contractors in the state regulatory financial analysis function, a trend which is acknowledged in the F Committee's referral to RFSWG.

We understand and have experienced the resource constraints that state insurance departments are experiencing in the current environment to attract and retain qualified personnel, a phenomenon that is impacting both the public and private sectors in various ways. Balancing the need to address the shortage of qualified personnel with the issues associated with the use of contractors, any use of contractors – whether in the private or public sector – calls for the use of appropriate guardrails. The referral to RFSWG should include developing guardrails to assure the quality of work performed and avoid unintended consequences and risks. Indeed, and as the NAIC's Financial Condition Examiner Handbook states, "it is the responsibility of management [of the insurer] to determine whether processes which have been outsourced are being effectively and efficiently performed and controlled." The same is true of any entity outsourcing key functions – including state insurance departments. Having proper oversight of the use of contractors will ensure consistency and mitigates the risks to insurers and the state regulatory system.

We note that the Guidelines and Guide, in their current form without the proposed revisions included in the F Committee's current exposure, recognizes a key guardrail over the use of contractors, i.e., the responsibility of states to oversee and supervise their work, which we believe should also include all phases of the contractor's delegated authority from setting the scope to finalizing the review. The proposed changes strengthen that to some degree by requiring that reviews by state employees of certain documents prepared by contractors be evidenced in supporting documentation. We agree with that suggested revision and emphasize the importance of the respective state insurance department oversight.

There are other aspects involving the use of independent contractors that are not covered currently in the NAIC's Financial Analysis Handbook, the current Guidelines and Guide or the proposed revisions to those materials. These include guardrails which address not just the supervision and review of work performed, but also matters such as the independence of the contractor (and/or his/her firm); any potential conflicts of interest they may have and the ongoing responsibility to report any changes promptly; the confidentiality of insurer-specific information or proprietary processes with which the contractor may come into possession or knowledge in the course of their work on behalf of the state; the security and data governance over that information including in electronic format and transmissions; and compliance with state laws and regulation pertaining to the due process protections that limit the delegation of regulatory authority, including to outside parties. We do not represent this brief list of potential guardrails to be all-inclusive, but they are representative of the matters that are of concern to interested parties relating to the increased use of contractors in a state's analysis function.

We also believe that the use of contractors for financial analysis should only be undertaken on a temporary basis until such time as the state insurance department is able to hire qualified personnel.

Full-time personnel provide a continuity of involvement with the insurers that are the subject of their analyses and the departments, as well as insurers, benefit from their in-house knowledge and experience with insurers over time. Having the analysis performed by state insurance department personnel provides that continuity of involvement and resolves most of the above concerns and should be the long-term goal of the department.

In short, the F Committee's referral to RFSWG addresses only a subset of the potential guardrails noted above and which interested parties believe should be in place, in the Financial Analysis Handbook, and then addressed in the Accreditation Manual and its Guidelines and Guide. We believe the process should begin with work at the RFSWG because of the subject matter expertise its members have in both the analysis and examination areas. Concurrent with this submission to you and for the F Committee, we are submitting a letter to the chair of the RFSWG to bring these concerns to their attention. We would appreciate your support and that of the F Committee in that regard, for example, by expanding the topics included in your referral to RFSWG to address the concerns about guardrails that interested parties have now brought to your attention.

Once RFSWG has completed its work and it has been adopted up the line through the NAIC's committee structure, interested parties believe that the F Committee should consider at its earliest opportunity the incorporation of additional standards in the Accreditation Manual that relate to the totality of guardrails necessary for a state insurance department to take responsibility so that states that need to utilize independent contractors in the analysis function do so in a manner that is consistent with the authority given the department by its state statutes, ensures the work is well supervised, and also avoids unintended consequences and risks.

Thank you for the opportunity to provide comments. We will reach out to the RFSWG to discuss our concerns raised in this letter in more detail and offer assistance in addressing those issues.

* * *

Thank you again for this opportunity to comment. Please feel free to contact either one of us if you have any questions or would like to discuss further.

Sincerely,

D. Keith Bell Rose Albrizio

cc: Interested parties
NAIC staff

NAIC FINANCIAL REGULATION STANDARDS AND ACCREDITATION PROGRAM

REVIEW TEAM GUIDELINES

Part B1: Financial Analysis

a. Sufficient Qualified Staff and Resources

Standard: The department should have the appropriate staff and resources to effectively and timely review the financial condition of all domestic insurers.

Results-Oriented Guidelines:

1. The department should have qualified analysts (including department reviewers) or contractual resources with appropriate skill sets, abilities, knowledge and experience levels to satisfactorily and effectively perform analysis tasks and procedures. Such experience should match the sophistication and complexity of the domestic industry. When assessing whether a department has qualified staff and resources, consideration should be given to the following:
   - The quality of the work performed by the financial analysis staff as documented in the financial analysis files.
   - The financial analysis staff's knowledge and comprehension of the insurance industry and its domestic insurers, as demonstrated during interviews with the staff.

2. The analysis of various financial filings should be completed timely, as discussed in the process-oriented guidelines. If the analysis tasks and procedures were not completed timely, consideration should be given to the size and complexity of the department's multistate insurers and the insurance holding company systems for which the department acts as the lead state. If the analysis tasks and procedures were not completed timely, the department should document the reasons for such, and the review team may take extenuating circumstances into consideration.

Process-Oriented Guidelines:

1. The financial analysts and supervisors, including contractors (if applicable), as well as those reviewing contract supervisor work, should have an accounting, insurance, financial analysis and/or actuarial background, and insurance backgrounds should be financial in nature. College degrees should focus on accounting, insurance, finance, business or actuarial science. Professional designations and credentials may also demonstrate expertise in insurance and/or financial analysis.

2. The analysis of priority insurers should be completed by the analyst and reviewed by the supervisor (including department review of contract supervisor work) by:
   - Annual statements and actuarial-related filings: End of April.
   - Quarterly statements: Within 60 days from receipt of filing.
   - Supplemental filings (excluding holding company filings): Within 60 days from receipt of filing.
   - Holding company filings: by Oct. 31st for analysis conducted by the lead state; by Dec. 31st for analysis conducted by the domestic state.

3. The analysis of non-priority insurers should be completed by the analyst and reviewed by the supervisor by:
   - Annual statements and actuarial-related filings: End of June or if a preliminary analysis, as outlined in the NAIC *Financial Analysis Handbook* (Analysis Handbook), indicates no immediate concerns, then by the end of July.
     - Preliminary analysis performed and relied upon for analysis completion dates should be completed within two weeks from receipt of filing.
   - Quarterly statements: Within 90 days from receipt of filing.
   - Supplemental filings (excluding holding company filings): Within 120 days from receipt of filing.
   - Holding company filings: by Oct. 31st for analysis conducted by the lead state; by Dec. 31st for analysis conducted by the domestic state.

c. Appropriate Supervisory Review

Standard: The department's financial analysis process should provide for appropriate supervisory review and comment. Supervisory review may be conducted by the analyst's supervisor or a senior-level analyst whose job functions include such review duties.

Results-Oriented Guidelines:

1. The supervisory review should be an in-depth and challenging review of the analyst's findings. An in-depth and challenging review should ensure the financial analyses performed are thorough and substantive. When assessing whether the supervisory review is in-depth and challenging, consideration should be given to the following:
   - Substantive review notes provided by the supervisor. Although supervisory review notes may assist the accreditation review team in assessing the supervisory review, they are not required to be created or maintained.
   - The overall quality of the analysis work as documented in the analysis file, including whether all material matters have been identified and adequately discussed.
   - Why issues with the quality of the analysis were not identified and resolved by the supervisor.

2. If a department elects to utilize a contractor to perform the primary supervisory review of financial analysis, an additional level of review is required on the IPS and/or Group Profile Summary (GPS) by a qualified department employee. This review should result in the department employee understanding and assessing the overall quality of the analysis work performed.

Process-Oriented Guidelines:

1. There should be evidence of at least one level of supervisory review on the financial analysis. This does not include scenarios when the company "passed" an automated review, such as the Quarterly Assessment of Non-Troubled Insurers. The supervisory review should be evidenced by sign-off and dating.

2. If the department uses an automated review such as the Quarterly Assessment of Non-Troubled Insurers, and the company did not "pass" the automated review but the analyst documented the rationale that no further documented analysis was necessary, a supervisor should approve the conclusion.

3. The supervisory review should include a review of the risk assessment and significant supporting documentation, and include at least some review of the source documents, the level of which should be based on the experience of the analyst.

4. The supervisory review should be performed within two to three weeks of completion of the original analysis.

5. The supervisory review should include a review of any written responses from the company received by the primary analyst that contain significant information.

6. The supervisory review should include a review of any change in an insurer's priority rating.

7. If the department utilizes a contractor to perform the primary supervisory review of financial analysis, an additional level of review is required on the IPS and/or Group Profile Summary (GPS) by a qualified department employee. This department review should be completed within three weeks of the primary supervisory review, or prior to the overall analysis timeliness deadlines (whichever is sooner).

Part B2: Financial Examinations

a. Sufficient Qualified Staff and Resources

Standard: The department should have the resources to effectively examine all domestic insurers on a periodic basis in a manner commensurate with the financial strength and position of each insurer.

Results-Oriented Guidelines:

1. The department should have qualified examiners (including department designees) or contractual resources with appropriate skill sets, abilities, knowledge and experience levels to satisfactorily and effectively perform examination tasks and procedures. Such experience should match the sophistication and complexity of the domestic industry. When assessing whether a department has qualified staff and resources, consideration should be given to the following:
   - The quality of the work performed by the financial examination staff and/or contractors as documented in the financial examination files.
   - The financial examination staff's and/or contractor's knowledge and comprehension of the insurance industry and the company under examination, as demonstrated during interviews with the staff.

2. The department should have sufficient examination staff and/or contractual resources to appropriately perform necessary target and limited scope examinations.

Process-Oriented Guidelines:

1. The financial examiners and supervisors (including department designees) should have an accounting, insurance, financial analysis, financial examination, information technology (IT) and/or actuarial background, and insurance backgrounds should be financial in nature. College degrees should focus on accounting, insurance, finance or actuarial science. Professional designations and credentials may also demonstrate expertise in insurance and/or financial examinations.

2. The department should perform a full-scope examination on each domestic company in accordance with the respective state law or at least once every five years, whichever is less.

d. Appropriate Supervisory Review

Standard: The department's procedures for examinations should provide for supervisory review of examination workpapers and reports to ensure that the examination procedures and findings are appropriate and complete and that the examination was conducted in an efficient and timely manner.

Results-Oriented Guidelines:

1. The supervisory review should be an in-depth and challenging review of the examiner's findings and the concepts applied in performing the work. When assessing compliance with this guideline, consideration should be given to the following:
   - Depth and challenging nature of supervisory review notes, although maintenance of review notes is not required.

- The overall quality of the work performed, including whether the examination procedures appear to be complete and appropriate and no material matter remains unaddressed.
- Discussions with department staff that verify occurrence and sufficiency of supervisory review, including, but not limited to, the EICs.
- Why issues with the quality of the examination were not identified and resolved by the supervisor.

2. If a department elects to use contractors to complete the supervisory review of the examination, the department should demonstrate involvement of appropriate department personnel (i.e., department designees) during the course of the examination in accordance with the Examiners Handbook and the department's policies and procedures. This should result in the department designee providing effective contractor oversight (e.g., status updates, budget oversight), as well as understanding and assessing the overall quality of the work performed.

Process-Oriented Guidelines:

1. All workpapers, including work performed by the EIC, should receive at least one level of supervisory review evidenced by sign off and dating by the reviewer.

2. The work of specialists should be reviewed by the EIC for familiarity and understanding.

3. The supervisory review (including department designee review) of planning (Phase 1 and Phase 2), including the Examination Planning Memorandum and risk matrices, should be done before work has begun in Phase 3. The review of planning should include each of the following:
   - Identification of key activities.
   - Identification and assessment of inherent risks.

4. The supervisory review (including department designee review) of Phase 3, Phase 4 and the first part of Phase 5 should be documented by a review of the risk matrices and any associated coaching notes or correspondence before any applicable substantive test work has begun. The review of Phase 3, Phase 4 and the beginning of Phase 5 should include each of the following:
   - Identification and evaluation of risk mitigation strategies/controls.
   - Determination of residual risk.
   - Established detail examination procedures.

5. The primary supervisory review of workpapers should occur within a reasonable period after completion of the item being examined (generally two to four weeks).

6. Upon the conclusion of examination fieldwork, the insurance department's designee should complete the general review outlined in the Review and Approval Summary exhibit of the Examiners Handbook (or substantially similar document) to ensure an appropriate depth of review has been performed.

~~6.~~7. The examination report should be reviewed by at least one person other than the preparer.

~~7.~~8. The examination report should be approved by the commissioner or the commissioner's designee prior to final issuance.

e. General Examination Procedures

Standard: The department's policies and procedures for the conduct of examinations should generally follow those set forth in the Examiners Handbook. Appropriate variations in methods and scope should be commensurate with the financial strength and position of the insurer.

Results-Oriented Guidelines:

1. The examiner should utilize a risk-focused approach and prepare examination documentation in sufficient detail to provide a clear understanding of the work performed. The content and organization of the documentation should support conclusions reached and effective execution of the risk-focused approach. When assessing compliance with this guideline, consideration should be given to the following:
   - Utilization of a risk-focused approach in establishing priority of accounts or operational areas.
   - The clarity and accuracy of the documentation used to support examination conclusions.
   - Extent of involvement with contract examiners if utilized.
   - Utilization of audit work when relied upon to support an identified risk.
   - Fulfillment of coordination efforts as determined by the state in Exhibit Z – Examination Coordination, and consistent with their role as described in the Examiners Handbook, for companies that are part of a holding company group with insurers domiciled in multiple states.

Process-Oriented Guidelines:

1. The examiner should prepare a Risk Assessment Matrix, or substantially similar document, that addresses each of the seven phases.

2. The examiner should prepare a planning memo that includes a discussion of each of the following:
   - Scope and objective of the examination.
   - Materiality assessment.
   - Results of the analytical review.
   - Results of the IT review.
   - Corporate governance assessment.
   - Results of the audit function assessment (internal and external), including review of external auditors' workpapers and reports.
   - Summary of the key activities selected.
   - Scope of the prospective risk assessment procedures to be performed.
   - Intended reliance on work completed by auditors and accredited states (if applicable).
   - Exam staffing and time budgets.

3. If the company being examined is part of a holding company group with insurers domiciled in multiple states, the state should complete the appropriate section of Exhibit Z, Part Two (or similar document) as follows:
   - If the state is the exam facilitator conducting a fully coordinated group examination, Exhibit Z, Part Two, Section B (or similar document) should be completed.
   - If the state is a participating state in a fully coordinated group examination, the state should complete Exhibit Z, Part Two, Section C (or similar document).
   - If the state did not participate in a coordinated group examination or utilized existing work outside of a fully coordinated group examination, the state should complete Exhibit Z, Part Two, Section D (or similar document).

4. The data supplied by the company or an outside source and utilized (relied upon) by the examiners should be tested for both accuracy and completeness in accordance with the respective residual risk assessment.

5. The sampling techniques used should conform to guidance set forth in the Examiners Handbook or other appropriate authoritative guidance.

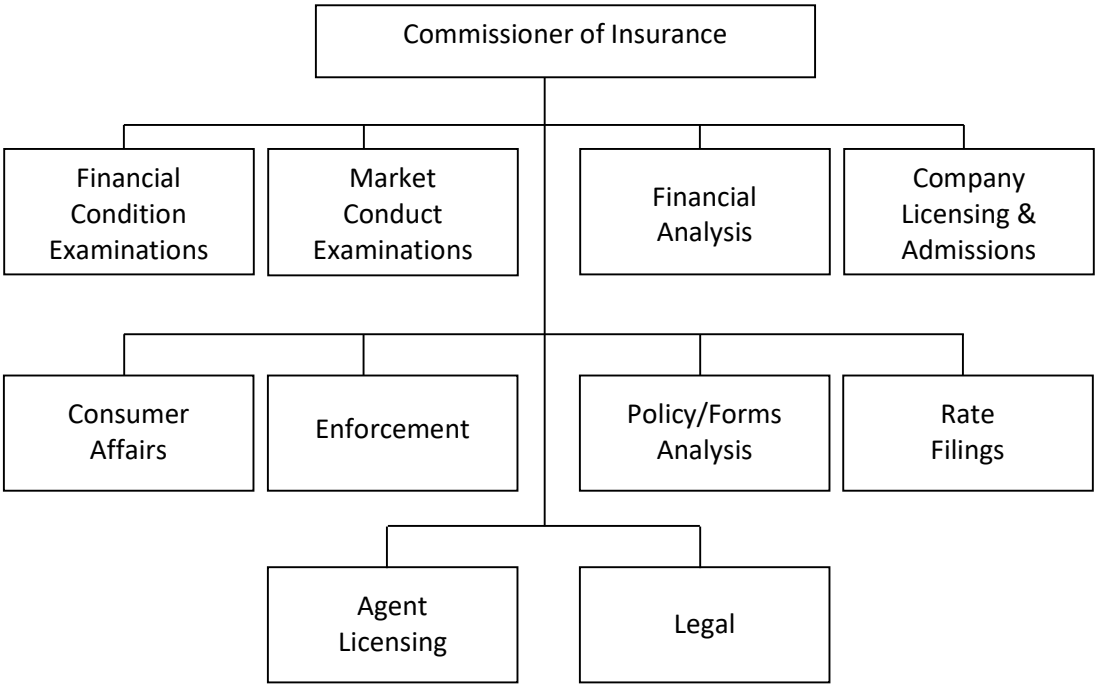
6. If a department elects to utilize contract examiners, the department should demonstrate involvement of appropriate department personnel during the course of the examination in accordance with the Examiners Handbook and the department's policies and procedures.

7. The department should utilize qualified EICs and department designees. The Examiners Handbook provides guidance on the authority, responsibilities and credentials for ~~a~~ qualified EICs and department designees. If the department utilizes an EIC who does not hold the CFE designation or is not directly supervised by someone holding the CFE designation, the department should document in the Financial Exam Electronic Tracking System (FEETS) when calling the exam how this individual is qualified to act in the capacity of an EIC on a multi-state insurer examination. Factors that may be considered include other professional designations, prior insurance experience, familiarity with the NAIC risk-focused surveillance process, etc.

Organization Chart

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

Chart of State Insurance Department Functional Units



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

Risk-Focused Financial Condition Examinations

The insurance code in most states allows the state insurance department to examine insurers as often as the insurance commissioner deems appropriate and requires that each insurer be examined at least once every three to five years (as determined by each state). Risk-focused financial condition examinations performed by the state insurance departments include full-scope periodic examinations and limited-scope or targeted examinations, which focus on the review and evaluation of an insurer's business process and controls (including the quality and reliability of corporate governance) to assist in assessing and monitoring its current financial condition and prospective solvency. Through the risk-focused financial condition examinations, the state insurance department gains knowledge about all aspects of the insurer, including its risk management practices and key business activities, which can be useful information to incorporate into the department's ongoing solvency analysis.

The results of a financial condition examination are documented in an examination report that assesses the financial condition of the insurer and sets forth findings of fact (together with citations of pertinent laws, regulations and rules) with regard to any material adverse findings disclosed by the examination. Examiners complete Exhibit AA – Summary Review Memorandum (SRM), or something similar, at the conclusion of the

exam. The SRM includes discussion of potential ongoing or prospective solvency concerns, corporate governance, examination adjustments, risk mitigation strategy issues, report findings, management letter comments, responses to issues raised by financial analysts, subsequent events, and other residual risks the examiner may want to communicate to state insurance department personnel. The SRM is a useful tool to communicate information and findings to the analyst, chief examiner, and other state insurance regulators. The final section of the SRM, prioritization level and changes to the supervisory plan, provides discussion of the examiner's overall conclusions regarding ongoing monitoring, including specific follow-up recommended to the analyst.

Additionally, key documents should be available to analysts, including examination reports and management letter comments, which may also include corrective actions required to be taken by the insurer and/or recommendations for improvements.

Market Conduct Examinations

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

Risk-Focused Financial Analysis

Risk-focused financial analysis provides continuous off-site monitoring of the state's domestic insurers' financial condition, significant internal/external changes relating to all aspects of the insurer, maintains a prioritization system, provides input into the state insurance department's priority of each insurer, works with the examination staff to develop an ongoing Supervisory Plan and updates the Insurer Profile Summary (IPS), providing department management with timely information of significant events relating to the domestic insurers in assessing prospective risks. The analyst should refer to all available information to monitor the insurer's statutory compliance and solvency on a continuous basis in coordination with the periodic on-site field examination process. As part of the analysis process and the review of the examination report and summary review memorandum, the analyst should incorporate into his/her analysis information gained about the corporate governance and risk management processes of the insurer. If desired, regulators can request the IPS, if applicable, for non-domestic insurers from the domestic or lead state.

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

Financial Analyst Qualifications

Financial analysts and supervisors (including those reviewing contract supervisor work) should generally have an accounting, insurance, financial analysis and/or actuarial background, and insurance backgrounds should primarily be financial in nature. College degrees should generally focus on accounting, insurance, finance, business, risk management or actuarial science. Professional designations and credentials (i.e., AFE/CFE, APIR/PIR, CPA, CPCU, FLMI) may also demonstrate expertise in insurance and/or financial analysis.

Financial Analyst Salary Guidelines

The compensation guidelines in this section of the Handbook were developed in recognition of the importance of compensation particularly as it affects an Insurance Department's ability to hire and retain well-qualified employees. The guidelines were developed based on surveys of analyst pay across Insurance Departments, as well as external comparisons to other similar professions, including other financial regulators, internal auditors and external auditors. In using the information below, the following are brief descriptions of the associated positions listed:

Financial Analyst

Financial analysts are responsible for conducting a risk-focused financial analysis on assigned insurers under the supervision of an analyst supervisor. The financial analyst reviews annual and quarterly insurer financial statements and all related supplemental regulatory filings to assess and monitor the current financial condition and prospective financial solvency of insurance companies.

Senior Financial Analyst

Senior financial analysts are responsible for conducting a risk-focused financial analysis on assigned insurers under the supervision of the supervising analyst. The senior financial analyst reviews annual and quarterly insurer financial statements and all related supplemental regulatory filings to assess and monitor the current financial condition and prospective financial solvency of more complex and higher priority insurance companies. Senior financial analysts may also be asked to provide guidance, support and training to financial analysts.

Supervising and Assistant Chief Analyst

A supervising or assistant chief analyst is responsible for supervising the financial analysts and senior financial analysts conducting a risk-focused financial analysis on assigned insurers. This position provides input on technical matters, acts as a reviewer of the work performed by the financial analysts and senior financial analysts, and ensures that analyst work is an appropriate execution of the risk-focused analysis approach.

Chief Analyst

This position is responsible for overall staff performance and development and should serve as the department's main point of contact for analysis and ongoing monitoring of regulated entities. This position should oversee company assignments and priority ratings. This position should work under the general direction of a commissioner or deputy commissioner and should oversee a consistent risk-focused financial analysis process across the department.

Use of Salary Tables

The salary tables included below generally require certain adjustments before being applied by a state or jurisdiction in setting analyst compensation. Factors to consider in setting analyst compensation include:

- Specific job responsibilities and expectations
- Location or market-based adjustments
- Complexity of industry
- Specialization requirements (e.g., reinsurance/investment/information technology [IT] specialist)
- Travel expectations (including consideration of amount of travel and in consideration of work from home or other similar arrangements)
- Retirement and other benefits (not included in table)

	Salary Range	
Position	**Low End**	**High End**
Financial Analyst	$52,000	$85,000

Senior Financial Analyst	$64,500	$105,000
Supervisor/Assistant Chief Analyst	$87,000	$150,000
Chief Analyst	$100,000	$170,000

Note: The data above is based on a national average and is not appropriate to be applied to all locations without consideration of market and cost of living variances.

Company Licensing and Admissions

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

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

The UCAA includes three applications. The Primary Application is for use by newly formed companies seeking a Certificate of Authority in their domicile state and by companies wishing to re-domesticate to a uniform state. The Expansion Application is for use by companies in good standing in their state of domicile that wish to expand their business into a uniform state. The Corporate Amendments Application is for use by an existing insurer for requesting amendments to its certificate of authority.

Consumer Affairs

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

Enforcement

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

Policy/Forms Analysis and Rate Filings

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

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

The NAIC's System for Electronic Rate and Form Filing (SERFF) is an electronic platform used by industry for form submittal, document management and state insurance regulatory review that accelerates the pace of market-entry for new and renewing products, while ensuring compliance with consumer protection requirements. The NAIC's Speed to Market (EX) Working Group governs the SERFF product.

Agent/Producer Licensing

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

The National Insurance Producer Registry (NIPR) is a nonprofit affiliate of the NAIC. NIPR developed and implemented the Producer Database (PDB) and the NIPR Gateway. The PDB is an electronic database consisting of information relating to insurance agents and brokers (producers). The PDB links participating state regulatory licensing systems into one common repository of producer information. The PDB also includes data from the RIRS to provide a more comprehensive producer profile. The NIPR Gateway is a communication network that links state insurance regulators with the entities they regulate to facilitate the electronic exchange of producer information.

Legal

Legal is generally involved in the review of proposed changes of control of insurers and other holding company transactions and frequently supports the other functions. Legal may also draft statutes and regulations to assist the insurance department in regulating insurers, agents, and other licensees; hold administrative hearings between the commissioner and insurers, agents, and other licensees; and represent the department in judicial and other proceedings.

Intra-Departmental Communication

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

To assist in the coordination of risk-focused financial condition examination, state insurance regulators use the NAIC's Financial Exam Electronic Tracking System (FEETS). FEETS allows state insurance regulators to call an

examination of a multistate insurer, facilitate coordination via various functionality within the program, communicate the completion of an examination, and share the completed version of the state insurance department's examination report. Use of FEETS on iSite+ is required by the NAIC when calling examinations on multistate insurers and is recommended for all examinations.

Communication from the Financial Analyst to Financial Examiners

The analyst may identify concerns as a result of the risk-focused financial analysis process that, when communicated to the financial condition examinations division, may lead to a targeted or limited scope financial condition examination. In addition, since the risk-focused analysis and examinations are interactive processes, the analyst should be familiar with the insurer's current financial condition; including any changes in its operations since the last periodic financial condition examination as well as the insurer's exposure to branded risks, which include prospective risks.

In communicating information to the examiners for examination planning, the analyst should review the examiner's Exhibit B – Examination Planning Questionnaire to note any items already accumulated and provide access to relevant information that has already been obtained by the analyst function and is available at the state insurance department.

Communication between examiners and analysts should occur for examination planning and at the conclusion of the examination. Specifically, regarding exam planning, results of ongoing analysis procedures should be shared with the financial examiners to assist in examination planning through a coordination meeting. An email exchange alone, between analyst and examiner, is not considered sufficient communication in planning an examination. During the preplanning process of each examination, the analyst should communicate areas of concern and specific issues to address during the examination. To assist in communication, the analyst should provide a current copy of the, IPS as well as other supporting analyst work papers and other documentation already on file at the department to communicate current or prospective concerns or observations and suggested procedures.

Regarding exam follow-up the financial analyst should participate in a collaborative follow-up meeting or conference call at the end of the examination to discuss the following:

- Examination results and/or findings
- Insurer's prioritization level
- Ongoing supervisory plan and the completed Summary Review Memorandum
- Re-assessment of branded risks as contained in the IPS

Such information may be shared by providing and discussing the current IPS, as well as other supporting analysis documentation necessary to support the branded risk assessment or other issues noted in the analysis. Statutory violations identified as a part of the analysis should be communicated to the enforcement division for the issuance of appropriate penalties and/or corrective orders against the insurer. Additionally, solvency related concerns, when communicated to the legal division, may result in the restriction, suspension, or revocation of an insurer's Certificate of Authority.

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

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

Refer to the III.A.4 Analyst Reference Guide for further guidance on communication between analysts and examiners.

Communication from Other Divisions or Areas to the Financial Analyst

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

1. Information from Risk-Focused Financial Examination:
    a. If recently completed, the SRM, financial condition examination reports and management letter comments that include significant adjustments to the financial information reported to the department, corrective actions required to be taken by the insurer, and/or recommendations for improvements based on examination results. (See above)
    b. If an examination is in progress, communication from examination staff should include information on the planning, progress and preliminary findings, based on the phase of the examination Risk-Focused Financial Examination.
    c. Any relevant information obtained in planning the financial examination stage.
2. Market conduct examination reports containing corrective actions required to be taken by the insurer as a result of violations in sales, advertising, rating, and/or claim practices, which might be an indication of financial problems or lead to the risk of financial losses through class action suits or regulatory fines (market conduct examinations).
3. An increase in the number or type of complaints filed by policyholders, claimants, employees, agents, or third parties that could indicate liquidity or internal control problems (consumer affairs).
4. Corrective orders and other regulatory actions taken against an insurer and fines and penalties levied (enforcement).
5. New policy form filings or expansion into new lines of business, including high-risk and long-tail lines of business, which might imply planned rapid growth to obtain premiums in order to improve liquidity or cover prior losses (policy/forms analysis).
6. Requests for significant premium rate increases, which might be an indication of insufficient rates to cover losses and expenses in the past (rate filings).
7. An increase in the licensing of agents, including managing general agents or third-party administrators, which could indicate planned rapid expansion or relaxed underwriting standards (agent licensing).
8. The use of managing general agents or third-party administrators, which might be an indication that the insurer is not in control of its operations (agent licensing).

9. Information that management personnel of an insurer (including officers, directors, or any other persons who directly or indirectly control the operations of the insurer) fail to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such a position (legal).
10. The unexpected resignation of an insurer's officer(s), director(s), or other key management personnel, which might indicate internal turmoil or dissatisfaction with the insurer's goals or operating practices (legal).

Intra-Department Communication System

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

1. Key insurance department officials should possess all relevant information to permit decisions to be made on a timely basis.
2. The department should assure that all levels of staff have the appropriate knowledge, information, and feedback to effectively perform the assigned functions.
3. Managers within various functional units or divisions should be responsible for the proper internal communications and documentation of decisions and actions taken under their authority.
4. The department should establish procedures to assure that orders and directives are effectively communicated to the appropriate staff and that the staff observes such orders and directives.

Considerations for Troubled Insurance Companies

In troubled or potentially troubled insurance company situations, proactive and timely communication to the appropriate persons within the department and with non-domiciliary state departments (for multistate companies) is critical. It is also important that the non-domiciliary state communicate with the domestic regulator prior to taking any action against the insurer. In certain circumstances, it may also be appropriate to communicate certain information with other parties (e.g., other regulatory bodies, company management, state guaranty funds, etc.). Establishing a coordinated communication system among the relevant parties will help facilitate the domestic regulator's surveillance of the troubled or potentially troubled insurance company. The *Troubled Insurance Company Handbook* (regulator only) provides additional guidance to assist in enhancing a state's monitoring and surveillance of troubled insurance companies, including communication and coordination of troubled or potentially troubled insurance companies.

At some point, the insurance department may determine that a corrective action plan cannot be implemented or completed successfully. Under these circumstances, the department may determine that the appropriate course of action is to place the troubled company in receivership. The *Troubled Insurance Company Handbook* outlines specific steps the department should take at all times during the development and implementation of a corrective action plan to prepare itself for this eventuality. This includes knowledge and control over the company's assets, determining and reviewing the company's obligations, operational considerations, information gathering, data/IT systems, other jurisdiction/regulatory considerations, etc. In addition to the

Troubled Insurance Company Handbook, the *Receiver's Handbook for Insurance Company Insolvencies*[i] provides detailed information and guidance regarding pre-receivership considerations. Both handbooks emphasize the benefits of early communication in a pre-receivership situation. The handbooks offer state insurance regulators tools and best practices for communication and coordination with other relevant parties in a pre-receivership situation, including other state insurance departments, federal and international regulatory authorities, guaranty associations, etc. Examples of tools include checklists to assist in the takeover phase of the receivership process and an optional memorandum of understanding template for advance communication with guaranty associations in a property/casualty (P/C) liquidation.[ii]

[i] The *Receiver's Handbook for Insurance Company Insolvencies* is available on the NAIC website at: https://content.naic.org/sites/default/files/publication-rec-bu-receivers-handbook-insolvencies.pdf.

[ii] The optional memorandum of understanding template is available on the NAIC website at: https://content.naic.org/sites/default/files/inline-files/2022_PreLiquidation_PC_MOU.docx.

Overview of Risk-Focused Surveillance Process

The intent of the risk-focused surveillance process is to broaden and enhance the identification of risk inherent in an insurer's operations and use that evaluation in formulating the ongoing surveillance of the insurer. Through their activities, insurers assume a variety of risks, which is the essence of an insurance transaction. The type of risk and its significance vary by activity. Investment activities may involve credit risk, market risk and liquidity risk. In product sales, insurers may assume market risk, pricing/underwriting risk, strategic risk or liquidity risk in varying degrees, depending on the product. Over the years, state insurance regulators have developed numerous tools to address the risks insurers assume. Investment laws limit the market and credit risk insurers can assume. Limitations on net retentions help reduce catastrophe risk. Risk-based capital requirements establish capital levels in recognition of a variety of risks. State insurance regulators have always considered the risk profiles of licensed insurers and the activities that may pose risk to the company in the future. The risk-focused surveillance process uses an organization-wide risk assessment process to enhance evaluation and to better coordinate the activities of financial solvency surveillance through greater consistency within the state insurance department, and with other departments.

A risk-focused surveillance process includes identifying significant risks, assessing and analyzing those risks, documenting the results of the analysis, and developing recommendations for how the analysis can be applied to the ongoing monitoring of the insurer. This increased attention by state insurance regulators to risk assessment and risk management processes used by insurers will be a positive development.

The enhancements included in the risk-focused surveillance process, including examination and analysis, intend to provide the following benefits:

1. Strengthen regulatory understanding of the insurer's corporate governance function by documenting the composition of the insurer's board of directors and the executive management team, as well as the quality of guidance and oversight provided by the board and management.

2. Enhance evaluation of risks through assessment of inherent risks and risk management processes to determine if there are weaknesses of management's ability to identify, assess and manage risk.

3. Improve early identification of emerging risks at individual insurers on a sector-wide basis.

4. Enhance effective use of regulatory resources through increased focus on higher risk areas.

5. Increase regulatory understanding of the insurer's quality of management, the characteristics of the insurer's business and the risks it assumes.

6. Enhance the value of surveillance work and establishment of risk assessment benchmarks performed by insurers and state insurance regulators, who have common interest in ensuring that risks are properly identified and that adequate, effective control systems are established to monitor and control risks.

7. For examinations, better formalize and document the risk assessment process via the use of the risk assessment matrix tool to assist in examination planning and resource assignment.

8. Expand risk assessment to provide a more comprehensive and prospective look at an insurer's risks through identification of the insurer's current and/or prospective high-risk areas.

9. For examinations, coordinate the results of the risk-focused examination process with other financial solvency surveillance functions (i.e., establishing/updating the priority score and supervisory plan).

In full, the risk-focused surveillance process provides effective procedures to monitor and assess the solvency of insurers on a continuing basis. The risk-focused approach consists of a structured methodology designed to establish a forward-looking view of an insurer's risk profile and the quality of its risk management practices. This

approach permits a direct and specific focus on the areas of greatest risk to an insurer. Through this approach, state insurance regulators can be more proactive and better positioned to identify and respond to any serious threat to the stability of the insurance company from any current or emerging risks. This regulatory approach will benefit all participants in the insurance marketplace.

ROLE OF THE FINANCIAL ANALYST

In the risk-focused surveillance approach, the financial analyst's role is to provide continuous off-site monitoring of the state's domestic insurers' financial condition, monitor internal/external changes relating to all aspects of the insurer, maintain a prioritization system and provide input into the state insurance department's priority of each insurer, work with the examination staff to develop an ongoing Supervisory Plan as well as update the Insurer Profile Summary (IPS), and provide state insurance department management with timely knowledge of significant events relating to the domestic insurers.

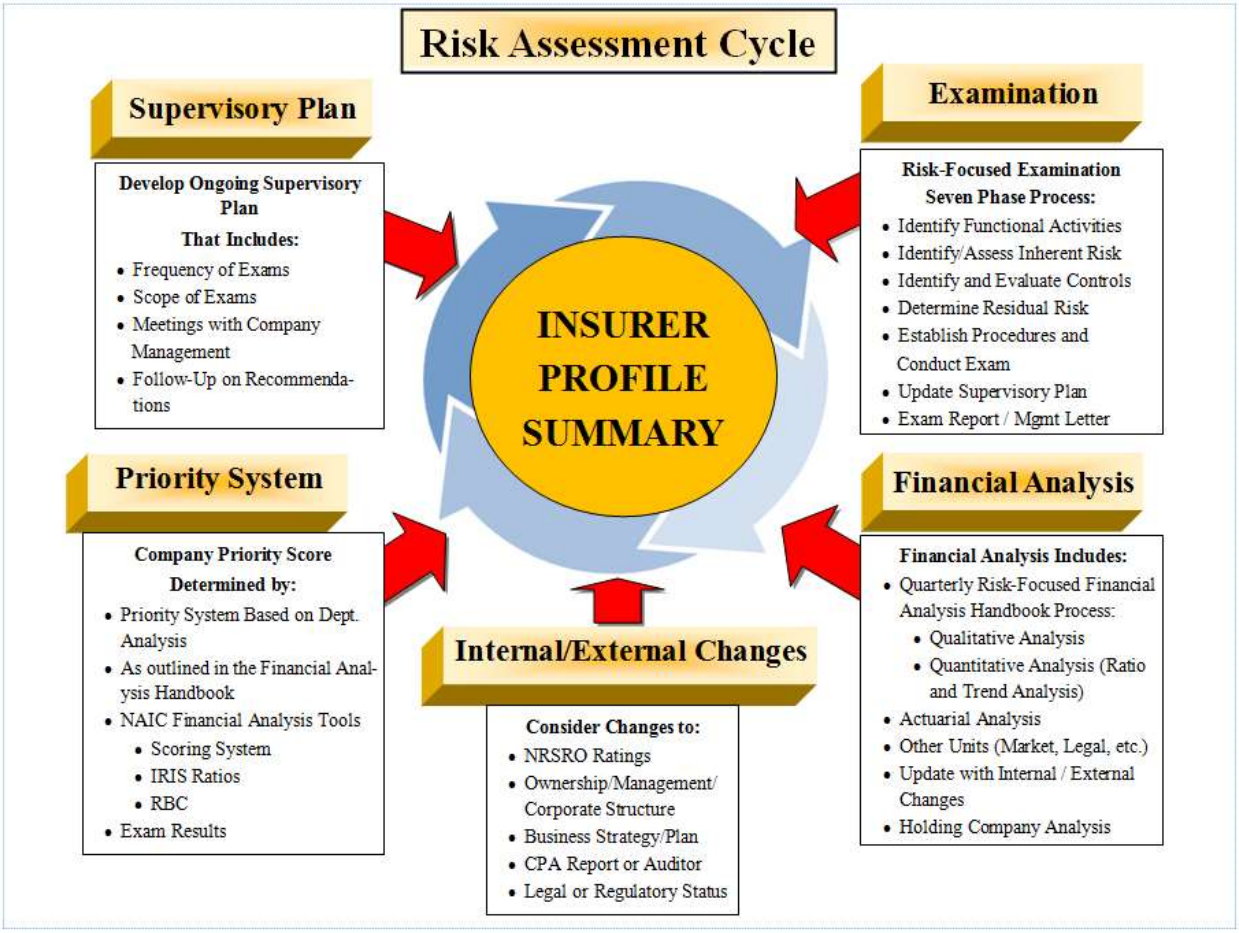
RISK-FOCUSED SURVEILLANCE CYCLE

The risk-focused surveillance framework is designed to provide continuous regulatory oversight. The risk-focused approach requires fully coordinated efforts between the financial examination function and the financial analysis function. There should be a continuous exchange of information between the field examination function and the financial analysis function to ensure that all members of the state insurance department are properly informed of solvency issues related to the state's domestic insurers.

The regulatory Risk-Focused Surveillance Cycle involves five functions, most of which are performed under the current financial solvency oversight role. The enhancements coordinate all of these functions in a more integrated manner that should be consistently applied by state insurance regulators. The five functions of the risk assessment process are illustrated within the Risk-Focused Surveillance Cycle.

As illustrated in the Risk-Focused Surveillance Cycle diagram, elements from the five identified functions contribute to the development of an IPS. Each state will maintain an IPS for its domestic companies. State insurance regulators that wish to review an IPS for a non-domestic company will be able to request the IPS from the domestic or lead state. The documentation contained in the IPS is considered proprietary, confidential information that is not intended to be distributed to individuals other than state insurance regulators.

Please note that once the Risk-Focused Surveillance Cycle has begun, any of the inputs to the IPS can be changed at any time to reflect the changing environment of an insurer's operation and financial condition.



The elements of the risk assessment process are:

- **IPS:** This profile is used to "house" summaries of risk-focused examinations, financial analyses, internal/external changes, priority scores, supervisory plan and other standard information. This profile is intended to be a "living document" and preferably shared with other state insurance regulators who have signed the NAIC *Master Information Sharing and Confidentiality Agreement* verifying that such shared information would remain confidential.
- **Risk-Focused Examinations:** These examinations consist of a seven-phase process that can be used to identify and assess risk, assess the adequacy and effectiveness of strategies/controls used to mitigate risk, and assist in determining the extent and nature of procedures and testing to be used in order to complete the review of that activity. The risk-focused surveillance process can be used to assist examiners in targeting areas of high-risk.
- **Risk-Focused Financial Analysis:** This function consists of a risk-focused analysis processes performed by state insurance regulators as outlined in the *Financial Analysis Handbook* (Handbook). This analysis process identifies and assesses risk based on the nine branded risk classifications to complete and document an overall assessment of the financial condition of the insurer.
- **Internal/External Changes:** Changes in rating agency ratings, ownership/management/corporate structure, financial condition/risk profile, business strategy or plan, external audit reports, and legal or regulatory status should be considered in developing the priority and supervisory plan.
- **Priority System:** The prioritization of the insurer, changes in priority or rationale for changes. See chapter I.F. Prioritization of Work for details.

- **Supervisory Plan:** At least once a year, a supervisory plan should be developed or updated by the domestic state for each domestic insurer. The supervisory plan should be concise and outline the type of surveillance planned, the resources dedicated to the oversight, and the consideration and communication and/or coordination with other states.

Overview of the Risk-Focused Financial Analysis Process

Financial analysis is an ongoing process that can be divided into annual cycles, each of which includes the analysis of the Annual Financial Statement, Quarterly Financial Statements and the various supplemental filings, such as the Actuarial Filings, Management's Discussion and Analysis (MD&A), Audited Financial Report and holding company filings. The financial analysis process is designed to assist the analyst in reviewing and analyzing insurers throughout the annual cycle in a logical manner, focusing on areas of concern within the nine branded risk classifications. The end result of this process is a financial analysis of each insurer specifically tailored to the concerns of that insurer as a result of its unique risks.

Procedure Description	Expectation
Risk Assessment Procedures and Insurer Profile Summary (annual and quarterly).	Complete for all domestic insurers.
Non-Lead State Holding Company Analysis (applies only to non-lead state domestic insurance regulators).	Complete for all domestic insurers that are part of an insurance holding company system.
Lead State Holding Company Analysis Documented within the Group Profile Summary (applies only to lead state domestic insurance regulators).	Complete for all insurance holding company system groups.

Annual/Quarterly Risk Assessment Procedures – Domestic Insurer

Annual and Quarterly Financial Statements

An insurer is required to file an Annual Financial Statement with its state of domicile, the NAIC and all jurisdictions in which the insurer is authorized to transact business by March 1 of each year for the 12 months ended December 31 of the previous year. An insurer is required to file Quarterly Financial Statements for the first, second and third quarters with the state of domicile, the NAIC and, in most instances, all states in which the insurer is authorized to do business by May 15, August 15 and November 15, respectively. The Financial Statement information is loaded onto the NAIC database, at which time automated financial analysis solvency tools are calculated and the Handbook's quantitative results are generated. All of this information is available to the state insurance departments via iSite+.

Scope and Depth of Risk-Focused Analysis

The depth of review will depend on the complexity, financial strengths and weaknesses, and known risks of the insurer and the priority designation established by the state insurance department. Other factors—such as the insurer's past regulatory history, accuracy of filing, age of insurer, stability of business plan, knowledge of insurer's operations, and materiality of the regulatory concerns, etc.— may affect the scope and depth of analysis. The flexibility to customize the scope and depth of the analysis is determined at the state insurance department's discretion and should include analyst and supervisor input. Therefore, the state insurance department should tailor the data and procedures used and the level of documentation to sufficiently address the specific risks of the insurer.

The Risk Assessment procedures for annual analysis consists of an overall analysis of the insurer documented in the nine branded risk classifications. Refer to section III.A.4 Risk Assessment – Analyst Reference Guide for further explanation of the risk classifications. The analyst should perform a background analysis, a current

period analysis, and a review of data and procedures within the nine branded risk classification repositories. All of these data and procedures provide the basis for the completion of a thorough review of the insurer's financial solvency.

The nine branded risk classification chapters are designed as "repositories" of data, benchmarks and procedures the analyst may select from in order to perform his/her analysis of that risk category. The analyst's review should use data relevant to each specific risk classification and customized for the insurer such that it is sufficient to perform and document his/her analysis and investigation of risks. Analysts are not expected to respond to all procedures, data or benchmark results listed in the Risk Assessment procedures or the nine branded risk repositories. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address specific risks of the insurer and document completion of analysis. Documentation of the risk assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.

At the conclusion of the risk assessment, the analyst should develop and document an overall summary and conclusion based on the results of the risk-focused analysis performed, prospective risks of the insurer, follow-up analysis or regulatory actions, any correspondence and the impact of the holding company on the insurer. The analyst should update the IPS (and supervisory plan, if applicable) to document this summary and conclusion. Note that an analyst's documentation of the risk assessment represents the *detail* of the analysis of risks, which may be more in-depth for certain material risks or complex insurers, whereas the IPS represents a *summary* of the risks of the insurer. Refer to section III.A.4 Risk Assessment – Analyst Reference Guide for further explanation on completing the IPS.

The analysis of annual statements for priority insurers (see section I.F. Prioritization of Work for definitions), including supervisory review, should be completed by the end of April. The analysis of annual statements for non-priority insurers, including supervisory review, should be completed by the end of June, unless a preliminary analysis (see section III.A.4. Risk Assessment ARG for description) indicates no immediate concerns. In that case, the analysis of non-priority insurers should be completed by the end of July.

The analysis of quarterly statements, unless the insurer passes the quarterly non-troubled qualitative review referenced below, should be completed within 60-days of receipt for priority insurers, and within 90-days of receipt for non-priority insurers.

Supplemental Filings

Other supplemental filings to the Annual Statement, including actuarial filings (titles and content vary by statement type), Management's Discussion and Analysis filings, and the Annual Audited Financial Statements and related filings, are required to be reviewed within 60-days of receipt for priority insurers, and within 120-days of receipt for non-priority insurers.

Quarterly Non-Troubled Quantitative Review

For first-, second- and third-quarter financial statement analysis, if the results for the non-troubled automated system calculation (see section III.A.4. Risk Assessment ARG for description) indicate a full quarterly risk assessment should be completed and if it is not, then the analyst should justify and document the reason(s) why. If the results indicate that a full quarterly risk assessment is not required, no quarterly analysis documentation is required to be completed.

If the insurer has been identified as troubled (i.e., Priority 1) or the results of the non-troubled automated system calculation indicate a full quarterly risk assessment should be completed and no justification for not completing one is provided, then the analysis of quarterly statements should be completed within 60-days of receipt for priority insurers, and within 90-days of receipt for non-priority insurers.

Prioritization of Analysis Work

The analyst should ensure that those insurers identified as having significant concerns will be analyzed on a priority basis for future filings. Those insurers with the highest priority should receive the most in-depth review, and are required to be analyzed more frequently, and earlier in each review period. Refer to section I.F. Prioritization of Work for further guidance.

Supervisor Input and Review
It is important for the analyst's supervisor to be actively involved in the financial analysis performed, including determination of the scope and depth of analysis. It also is important that the review and supervision be performed on a timely basis.

The branded risk repositories offer suggestions for the types of information the analyst may consider requesting. It is important that the analyst's proposed follow-up procedures be discussed with the analyst's supervisor.

Use of Contractors in Financial Analysis Work
An insurance department's decision to engage an independent contractor to assist in the completion of financial analysis work may arise due to insufficient department staff or the need for specialized expertise. While the foregoing circumstances may lead an insurance department to contract the services of an independent contractor, the department should consider the long-term effects of not maintaining an appropriate level of qualified staff.

If the department utilizes a contractor to perform the primary supervisory review of financial analysis, an additional level of review is required on the IPS and/or Group Profile Summary (GPS) by a qualified department employee in accordance with the overall timeliness expectations. This review should result in the department employee understanding and assessing the overall quality of the analysis work performed.

Captives and/or Insurers Filing on a U.S. GAAP Basis
These procedures are designed for insurers filing on a U.S. generally accepted accounting principles (GAAP) (or modified GAAP) basis, after the completion of the traditional Risk Assessment Procedures. (See section III.C.1. Special Analysis Procedures – Captives and/or Insurers Filing on a U.S. GAAP Basis Worksheet.) The procedures provide guidance on the review of a GAAP filer on a statutory blank and address the following areas:

- Management assessment
- Balance Sheet assessment
- Operations assessment
- Investment practices
- Review of disclosures
- Assessment of results from prioritization and analytical tools

Domestic and/or Non-Lead State Holding Company System Analysis

Procedures for evaluating and considering the impact of an insurance holding company system on individual insurers should be completed for all domestic insurers. For lead states, this consideration is included within the VI.C Insurance Holding Company System Analysis Guidance (Lead State). For non-lead states, this consideration is included in V.A Holding Company Procedures (Non-Lead State). The depth of the holding company analysis of an insurer in a holding company system will depend on the characteristics (e.g., sophistication, complexity and financial strength) of the holding company system, availability of information, and existing potential issues and problems found during review of the holding company filings. Non-lead states should obtain, utilize and rely on holding company analysis work performed by the lead-state, as appropriate, in fulfilling their review responsibilities. Lead state and non-lead state responsibilities are further defined in section VI.C.

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

- **FORM A**
  The Form A review is to be completed for all acquisitions, mergers or changes in control. Form A is filed with the domestic state of each insurer in the group. The analyst should review the transaction and all applicable documents and complete the Form A Procedures, when necessary.
- **FORM D**
  The Form D review is to be completed for all prior notices of material transactions. Form D must be filed with the domestic state. The analyst should review the transaction and all applicable documents and complete the Form D Procedures, when necessary.
- **FORM E OR OTHER REQUIRED INFORMATION ON COMPETITIVE IMPACT**
  The Form E or other review of competitive impact is to be completed for all pre-acquisition notifications regarding the potential competitive impact of a proposed merger or acquisition by a non-domiciliary insurer doing business in the state or by a domestic insurer. Form E or other required information must be filed with the domestic state. The insurer may also be required to file documents with the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) under the federal Hart-Scott-Rodino (HSR) Act. The analyst should review the transaction and all applicable documents and complete the Form E Procedures, when necessary.
- **EXTRAORDINARY DIVIDENDS/DISTRIBUTIONS**
  The extraordinary dividends/distributions review is to be completed for any domestic insurers planning to pay any extraordinary dividend or make any other extraordinary distribution to its shareholders. Such dividends and distributions must receive proper prior regulatory approval. The analyst should review the transaction and all applicable documents and complete V.E Extraordinary Dividends/Distributions Procedures, when necessary.

At the end of section V.A., the analyst is asked to develop and document a conclusion regarding the impact of the holding company system on the domestic insurer and update the IPS accordingly by Dec. 31 each year. In addition, the analyst is encouraged to notify the lead state of any material risks or events that the lead state may not be aware of, that should be considered in the evaluation of the overall financial condition of the holding company system.

Group-Wide Supervision

The Group-Wide Supervision procedures establish guidance for lead state use in the analysis of insurance company holding systems. This includes a risk-focused approach to group regulation where specific risks that are relevant to insurance holding company structures are addressed.

- **INSURANCE HOLDING COMPANY SYSTEM ANALYSIS DOCUMENTED IN THE GROUP PROFILE SUMMARY (GPS) (LEAD STATE)**:
  - Understanding the insurance holding company system (lead state)
  - Addressing lead state analysis considerations
  - Evaluating the overall financial condition of the holding company system by completing a detailed analysis through the group's exposure to each of the nine branded risk classifications
  - Assessing corporate governance and enterprise risk management

- Documenting material concerns or conditions in the group that affect the lead state's domestic companies
- Performing additional procedures on key risk areas, as needed
- Sharing the results of the analysis, through the GPS, with other impacted regulators on a timely basis (i.e., by October 31 for groups with entities domiciled in multiple states)

- **CORPORATE GOVERNANCE DISCLOSURE PROCEDURES**
  The *Corporate Governance Annual Disclosure Model Act* (#305) and *Corporate Governance Annual Disclosure Model Regulation* (#306) require an insurer, or an insurance group, to file a summary of an insurer or insurance group's corporate governance structure, policies and practices with the commissioner by June 1 of each calendar year. The lead state should take primary responsibility for reviewing the CGAD filing, if it is filed on a group basis, and should incorporate any takeaways or concerns into the GPS. Any concerns relevant only to a specific insurance entity in the group should be communicated to the domestic state in a timely manner.

- **OWN RISK AND SOLVENCY ASSESSMENT (ORSA) PROCEDURES**
  The *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.

- **FORM F PROCEDURES**
  The Form F is filed with the lead state commissioner of the insurance holding company system for every insurer subject to registration under the *Insurance Holding Company System Regulatory Act* (#440). The Form F review is to be completed by the lead state in conjunction with the review of Form B. The lead state analyst should identify the material risks within the insurance holding company system that could pose enterprise risk to the insurers in the group. Takeaways and concerns from the review should be documented in the GPS. Any concerns relevant only to a specific insurance entity in the group should be communicated to the domestic state in a timely manner.

- **PERIODIC MEETING WITH THE GROUP PROCEDURES**
  These procedures are intended to demonstrate the type of potential questions a lead state may want to consider when it conducts a periodic meeting with the group.

- **TARGETED EXAMINATION PROCEDURES**
  The targeted examination procedures provide examples of potential risk areas where the lead state may want to perform certain limited examination procedures as part of the continual risk assessment process.

LEAD STATE REPORT

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

III. GENERAL EXAMINATION CONSIDERATIONS

This section covers procedures and considerations that are important when conducting financial condition examinations. The discussion here is divided as follows:

A. General Information Technology Review
B. Materiality
C. Examination Sampling
D. Business Continuity
E. Using the Work of a Specialist
F. Outsourcing of Critical Functions
G. Use of Independent Contractors on Multi-State Examinations
H. Considerations for Insurers in Run-Off
I. Considerations for Potentially Troubled Insurance Companies
J. Comments and Grievance Procedures Regarding Compliance with Examination Standards

G. Use of Independent Contractors on Multi-State Examinations

When evaluating staffing needs to schedule examinations of domestic insurers licensed in multiple states, state insurance departments may find it necessary to engage an independent contractor. An independent contractor is defined as anyone employed by the state insurance department that is outside of the department's staff. Examples of independent contractors, while not inclusive, are as follows:

- Certified Public Accountants
- Contract Examiners
- Specialists

An insurance department's decision to engage an independent contractor may arise due to, among other things, insufficient examination staff or the need to meet statutory mandates. While the foregoing circumstances may lead an insurance department to contract the services of an independent contractor, the department should consider the long term effects of not maintaining an appropriate level of qualified staff. Maintaining competent examiners on examinations and during interim periods enhances the department's ability to effectively regulate domestic insurers and foreign insurers with substantial state premium writings. Through the examination process, examiners can enhance their knowledge of state laws and regulations, various types of insurance products, investment practices, loss reserving techniques, reinsurance transactions etc., that are useful in effectively and efficiently assessing a domestic company's financial condition and results of operations. This internal expertise is particularly important in handling troubled insurance companies.

The use of independent contractors requires the involvement of the state insurance department in directing and monitoring the work performed by the independent contractor. The oversight of independent contractors is primarily the responsibility of the insurance department's designee.

The role of department designee must be filled by an individual who is certified by the Society of Financial Examiners (SOFE) as a Certified Financial Examiner (CFE) or by an individual who has substantially similar experience, qualifications and background. (Include the details in examination planning memorandum.) This individual must be employed by and conducting work solely on behalf of the State Insurance Department. In general, the department designee should have an accounting, insurance, financial analysis, financial examination, information technology (IT) and/or actuarial background, and insurance backgrounds should primarily be financial in nature. College degrees should generally focus on accounting, insurance, finance, business, risk management or actuarial science. Other professional designations and credentials may also demonstrate expertise in insurance and/or financial examinations.

Depending on the scope of the engagement and extent of the work performed by the independent contractor, the following standards of examination planning, fieldwork, and examination reports are applicable:

1. Standards of Examination Planning and Field Work

a. The procedures shall be planned and developed according to the Handbook under the supervision and with the participation of the insurance department's designee. This includes review and approval of the examination planning memorandum, which may also warrant a review of workpapers supporting the conclusions reached therein.

b. The insurance department's designee shall review and approve significant examination workpapers on a timely basis. This includes, but is not limited to the following:

- Applicable risk assessment workpapers, including the examination risk tracker (Exhibit CC), prospective risk assessment (Exhibit V), key activity matrices and consideration of critical risk categories (Exhibit DD).
- Ongoing examination status and explanation of modifications to the approved time budget.

c. The insurance department's designee shall supervise all significant field work activities, including appropriate review and approval of risks identified and planned procedures prior to beginning Phase 3 and Phase 5.

2. Standards of Examination Conclusions and Reporting

a. The insurance department's designee shall review and approve key solvency monitoring and completion documents on a timely basis, including the summary review memorandum (Exhibit AA) and evidence of interdepartmental communication of significant issues and concerns.
b. The examination results and findings shall be reviewed for reasonableness and sufficiency, and accompanying workpapers shall be reviewed for adequacy of documentation by the insurance department's designee.
c. The report shall be prepared by the insurance department in accordance with the Handbook and departmental policy.
d. The report shall be signed by the examiner-in-charge (EIC). If the EIC is an independent contractor, the report shall also be signed by the insurance department's designee.
e. The insurance department's designee shall complete the general review section of the Review and Approval Summary (Exhibit Q) to ensure an appropriate depth of review has been performed.

3. Use of a CPA on an Agreed-Upon Procedures Engagement

While not very common, the use of a CPA independent contractor in an examination may be accomplished through an "Agreed-Upon Procedures Engagement." (Only CPAs can perform an Agreed-Upon Procedures Engagement.) In addition to meeting the standards of examination planning, fieldwork, and examination reports, the following establishes guidelines for engaging a CPA to perform agreed-upon procedures.

The American Institute of Certified Public Accountants (AICPA) Statement on Standards for Attestation Engagements No. 10, *Attestation Standards: Revision and Recodification* (SSAE No. 10), sets forth the standards and provides guidance to the CPA when performing and reporting on engagements to apply agreed-upon procedures. In an agreed-upon procedures engagement, the CPA performs specific procedures on specific elements, accounts or items of a financial statement and issues a report of findings based on those procedures. The insurance department and the CPA agree upon the procedures to be performed by the CPA that the insurance department believes are appropriate. Therefore, the insurance department assumes all responsibility for the sufficiency of the procedures and the risk that those procedures might be insufficient for their purposes. Because the CPA will only report on the findings of the procedures performed, any conclusions regarding the findings, and disposition thereof, must be made by the department. Additionally, the CPA has no responsibility to determine the differences between the agreed-upon procedures to be performed and the procedures that the CPA would have determined necessary had he or she been engaged to perform another form of engagement, such as an audit under generally accepted auditing standards. The department should review SSAE No. 10, and consider the CPA's professional standards prior to engaging an accounting firm to provide this type of service.

The insurance department must attain certain standards relative to the examination report, planning and field work that are in accordance with the Handbook. These standards relate to the responsibilities of the insurance department

and the utility of the examination report in achieving regulatory objectives when engaging a CPA to perform agreed-upon procedures.

4. Conflicts of Interest

   Conflicts of interest may occur if an examination of a company is performed by an independent contractor who has a significant relationship with the company, its affiliates, or their management (financial or non-financial) that may impair in fact, or appearance, the independent contractor's independence. To evaluate any such conflicts of interest, the insurance department should request a disclosure letter from the independent contractor regarding their past, present or planned relationships, both financial and non-financial, with the examined company or its affiliates. The disclosure letter should discuss the nature of the services provided by the independent contractor and the amount of fees paid to the CPA by the company over the preceding five years.

   Determining whether a potential conflict of interest exists is a matter of considerable judgment. As independent contractors provide many different types of services (e.g., accounting, auditing, actuarial, management and tax consulting), it will be necessary to evaluate the nature of services provided and the amount of fees involved when determining whether a potential conflict of interest exists.

5. Maintenance of Workpapers

   The insurance department should maintain, at a minimum, a complete photocopied set of the CPA's original workpapers.

6. Independent Contractors' Immunity Privileges

   When hiring independent contractors to perform all or portions of a state insurance examination, the state insurance department should consider the following items related to the independent contractor's immunity prior to finalizing an agreement.

   - Review the NAIC *Model Law on Examinations* (#390), Section 8 to determine if your state has adopted these provisions in its statutes. If your state has not adopted Model #390, confirm if it has adopted similar language which grants immunity to any examiner appointed by a commissioner.
   - Determine if there are any relevant court decisions or opinions, which hold that an examiner appointed by the commissioner is granted immunity from liability in the performance of his/her duties.
   - Verify if independent contractors in your state are required to carry liability insurance coverage for work performed. Determine if your state provides insurance coverage to these independent contractors in the performance of their duties.

7. Controlling Exam Costs when Utilizing Independent Contractors

   It is important to keep in mind that the use of independent contractors can lead to higher examination costs. It is the regulator's responsibility to appoint and monitor the independent contractor, and it is the insurer's responsibility to cooperate with the independent contractor and provide appropriate input to facilitate an efficient examination process. The insurer may provide factual input to the regulator based on observations of the independent contractor's work. High-level company monitoring of the examination process and ongoing two-way communication of problems on the examination (related to the cooperation of the insurer or the performance of the examination) can help ensure the effective use of independent contractors. If state legislation permits and circumstances are warranted, it may benefit the regulator to consider the following procurement procedures in order to control costs when utilizing an independent contractor.

   a. The regulator should have minimum qualification standards that the independent contractor should meet in order to be considered in the procurement process. The independent contractor should have the following:

      - Practical experience with the type of work that is out for bid;

- Qualified personnel; and
- Demonstrable success on prior contract examinations.

b. The regulator should consider having a meeting with all qualified vendors (independent contractors) and the insurer to further explain, clarify, or identify areas of concern. This meeting should address the following:

   - A detailed description/specification of the work to be performed in terms of required outcomes. Specifications should be written to encourage, not discourage, competition consistent with seeking overall economy for the purpose intended. The goal is to invite maximum reasonable competition;
   - Concerns of the insurer, independent contractor and the department of insurance; and
   - Time frame of the bidding process.

c. The potential independent contractor should describe their organizational and staff experience as well as past experience, which should be described in sufficient detail to demonstrate their ability to perform the functions outlined by the department. For long-term projects, the independent contractor should document their experience, capability, and commitment to perform project management functions.

d. The independent contractor should provide a minimum of three references who may be contacted where services similar in scope to the requirements outlined by the department have been provided. The state department should consider the independent contractor's experience with other state insurance departments.

e. Prior to selecting the independent contractor, the regulator should consider at least three competitive bids.

f. The most responsive and responsible independent contractor whose bid reflects the lowest price should be considered. "Responsible" means that the vendor has the capability, integrity, and reliability to provide the services needed. Being "responsive" means that the bid conforms in all material respects to the requirements outlined by the department.

Various types of contracts exist and each type of contract should be considered by the regulator when utilizing independent contractors. Fixed fee contacts and cost-reimbursement type contracts are two common types of contracts. Fixed fee contracts are contracts for a set amount, regardless of the expenses or hours incurred by the independent contractor. Under this scenario, the independent contractor is fully responsible for performance costs and enjoys (or suffers) resulting profits (or losses) based on the efficiency and effectiveness of their examination progress. Fixed fee contracts are typically appropriate when the work to be performed by the independent contractor can be described clearly and the regulator can write clear and detailed specifications for how the work is to be done. If a fixed fee contract is not chosen, the regulator may use a cost-reimbursement type contract. In this type of contract, the department agrees to compensate the independent contractor at a fixed hourly rate plus compensation for reimbursable expenses. If this type of contract is used, the regulator should strongly consider making it a three-party contract between the state department, the independent contractor and the insurer.

If a fixed fee contract is used, independent contractor travel expenses are irrelevant to the regulator. If a contract that allows for cost reimbursement is utilized, the regulator should consider the extent of the independent contractor's travel expenses. It is recommended that the regulator monitor the independent contractor's travel expenses. The regulator should consider the recommended per diem rates for lodging, meals and incidentals set forth within Section 1, Part II, D of this Handbook (this is also available on the NAIC Web site).

The above mentioned guidance, as it relates to procurement, contracts and travel expenses, combined with continued monitoring of the independent contractor's work may result in significant cost decreases. It is encouraged that the time budget be communicated to the insurer, however, final approval of the budget should reside with the insurance department and the work of the independent contractor should be directed by the state regulator. Consider holding frequent status meetings with the independent contractor to ensure that the adequacy and timeliness of the work being performed is meeting the department's expectations. The development of a detailed time budget for the independent contractor will allow the insurance department and the insurer to compare the actual work performed

with expectations. The time budget should estimate the time to complete examination sections, which typically are annual statement line items, system processes, related controls or the company background. The independent contractor should submit time budgets to the state insurance department on at least a monthly basis, or as often as a detailed time and expense billing report is required to be submitted. The detailed time budget should also include an estimated date of completion for all fieldwork. If any action, or lack of action, by the insurer causes the independent contractor's hours to significantly increase (i.e., a greater than 10% increase in the budgeted time for a specific examination area), the independent contractor should immediately communicate this to the state department, who would then contact the insurer. This same communication process should take place if the independent contractor becomes aware of any material transactions that took place subsequent to the balance sheet date.

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: Amy Malm, Chair of Risk-Focused Surveillance (E) Working Group

FROM: Steve Drutz, Chair of Health Risk-Based Capital (E) Working Group

DATE: June 6, 2024

RE: Referral for Pandemic Risk

In 2020, in light of the Covid-19 pandemic, the Health Risk-Based Capital (E) Working Group added into its working agenda an item to consider impact of COVID-19 and pandemic risks in the Health Risk-Based Capital (RBC) formula. During subsequent meetings held in 2023 and 2024, the Working Group evaluated whether RBC is the appropriate tool to capture pandemic risk. Some of the actions include:

- Looked into 2014 Health RBC interrogatories to analyze how companies allocated surplus or model for pandemic and biological risks.
- Received presentation by Texas Department of Insurance on "Pandemic Risk and Insurer Solvency – A Review of Personal Consumption Expenditures (PCE) on Healthcare Before, During, and After the COVID-19 Pandemic".
- Reviewed RBC trends for an extended period (2015-2021).
- Considered capital requirements for pandemic risk in other jurisdictions (e.g., Solvency II).

One specific trend noted from the Texas Department of Insurance presentation was the decrease in healthcare expenditures during the pandemic, and the return to historical norms that occurred as the pandemic subsided. This appeared to increase the difficulty in adequately pricing policies post pandemic. Based on the work and findings above, the Working Group concluded that changes, resulting from pandemic risks, to the Health RBC formula are not warranted for the time being. The Working Group would like to ask the Risk-Focused Surveillance (E) Working Group to evaluate whether the pandemic risk is being sufficiently addressed from their perspective, and if not, the need for enhancement in the financial analysis and/or financial examination process.

If you have any questions, or would like to further discuss, please contact the Health Risk-Based Capital (E) Working Group chair or vice chair (Steve Drutz, Matthew Richard), or NAIC staff Maggie Chang (mchang@naic.org).

Cc: Julie Gann, Maggie Chang, Derek Noe, Bruce Jenson, Jane Koenigsman

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Existing NAIC Handbook Guidance on Pandemic Risks

Note: This document includes excerpts from both the NAIC's *Financial Analysis Handbook* and the *Financial Condition Examiners Handbook* to which revisions are being proposed to update guidance around the review of affiliated investment management services and agreements. The proposed revisions are shown as tracked changes throughout.

Analysis 1 – III.B.5.c Operational Risk Repository – Health Annual

Operational Risk: The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events.

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Additional Analysis and Follow-up Procedures
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Enterprise Risk Management: • If concerns exist regarding potential for pandemic outbreak: o Regulators should consider performing additional procedures if significant risks/concerns are identified in this area. o Gain an understanding of and evaluate the company's processes for dealing with a potential pandemic event. o Determine whether processes address increased utilization, liquidity needs, ability for employees to work remotely, etc.

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Example Prospective Risk Considerations		
Risk Components for IPS		***Explanation of Risk Components***
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12	Lack of preparation for pandemic outbreak	The insurer does not have appropriate policies and practices in place to deal with a potential pandemic outbreak that could significantly impact operations.

Analysis 2 – III.B.5.d Operational Risk Repository – Analyst Reference Guide

Additional Analysis and Follow-Up Procedures

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ENTERPRISE RISK MANAGEMENT (HEALTH) directs analysts to conduct additional procedures if concerns exist regarding the insurer's ability to respond to a pandemic outbreak event. A pandemic is defined as an epidemic of infectious disease that has spread through human populations across a large region. The effects a pandemic may have on an insurer include, but are not limited to, significant increases in claims volume, increased loss costs and liquidity demands. Therefore, it is important to understand the processes and strategies put in place by health insurers to limit the effect of a pandemic on an insurer's operations and ongoing solvency, including the results of stress testing performed to assess and quantify the impact on an insurer. Such procedures may include gaining an understanding of the company's plans and processes for dealing with such an event and evaluating whether they address increased utilization, liquidity needs and impact on workforce.

Analysis 3 – III.B.6.c Pricing/Underwriting Risk Repository – Health Annual

Note: Similar guidance in the Pricing/Underwriting Risk Repository for Life/A&H/Fraternal has not been included in this file.

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

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Example Prospective Risk Considerations		
Risk Components for IPS		***Explanation of Risk Components***
1	Trend of poor underwriting results [indicate overall or specific line of business]	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., pandemic exposure).

Analysis 4 – III.B.9.a Strategic Risk Repository – Annual (All Statement Types)

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

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Additional Analysis and Follow-Up Procedures
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Inquire of the Insurer: If concerns exist, consider requesting information from the insurer regarding: ----------Text deleted to conserve space---------- **Business Plans/ Strategies** • Revised/updated business plans and projections • 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)

Examination 1 – Section 1-III D. Business Continuity

D. Business Continuity

Reviewing an insurer's business continuity plan is an established part of Financial Condition Examinations through testing and review performed in conjunction with the completion of the Information Technology Review. However, natural disasters, terrorism concerns and new business practices have led to a heightened need for management to plan for the prospective risks associated with business continuity including the risk to the financial solvency of the insurer. As such, business continuity planning has expanded beyond its initial information systems focus of disaster recovery plans to encompass issues, such as the impact of a wide range of relevant natural and man-made disasters on company operations. Such issues might include terrorism, climate change, a pandemic, fraud, fire, loss of utility services, personnel losses and new laws and regulations. Therefore, it is important that an insurer's business continuity plan be considered throughout all aspects of the examination and not just in the context of a review of the insurer's information systems.

For all insurers, the business continuity process consists of identifying potential threats to an organization and developing plans to provide an effective response to ensure continuation of the company's operations. The objectives of the business continuity process are to minimize financial losses; continue to serve policyholders and financial market participants; and to mitigate the negative effects disruptions can have on an insurer's strategic plans, reputation, operations, liquidity, credit ratings, market position and ability to remain in compliance with laws and regulations. The guidance below provides examiners additional information about the business continuity process a typical insurance company may use. The guidance does not create additional requirements for insurers to comply with but should be used by examiners to assess the appropriateness of the company's business continuity process.

Some of the basic steps all insurers would expect to have in their business continuity processes consist of:

1. Understanding the Organization

To develop an appropriate business continuity plan, an insurer must first understand its organization and the urgency with which activities and processes will need to be resumed in the event of a disruption. This step includes performing an annual business impact analysis and a risk assessment. The business impact analysis identifies, quantifies and qualifies the business impacts of a disruption to determine at what point in time the disruption exceeds the maximum allowable recovery time. This point in time is usually determined separately for each key function of the insurer. The risk assessment reviews the probability and impact of various threats to the insurer's operations. This involves stress testing the insurer's business processes and business impact analysis assumptions with various threat scenarios. The results of the risk assessment should assist the insurer in refining its business impact analysis and in developing a business continuity strategy.

2. Determining Business Continuity Strategies

Under this step in the process, the insurer determines and selects business continuity management strategies to be used to continue the organization's business activities and processes after an interruption. This step should use the outputs of step one above to determine what business continuity strategies the insurer will pursue. This includes determining how to manage the risks identified in the risk analysis process. The strategies should be determined at both the corporate and key functional level of the insurer.

3. Developing and Implementing a Business Continuity Plan

The purpose of the business continuity plan is to identify in advance the actions necessary and the resources required to enable the insurer to manage an interruption regardless of its cause. The plan should be a formal documentation of the insurer's business continuity strategy and should be considered a "living document." Some basic elements that should be included in a business continuity plan include:

- Crisis management and incident response
- Roles and responsibilities within the organization
- Recovery of all critical business functions and supporting systems
- Alternate recovery sites
- Communication with policyholders, employees, primary regulators and other stakeholders

The business continuity plan should be written and should include a step-by-step framework that is easily accessible and able to be read in an emergency situation.

4. Testing and Maintenance

A company's business continuity plan cannot be considered reliable until is has been reviewed, tested, and maintained. The testing should be based on a methodology that determines what should be tested, how often the tests should be performed, how the tests should be run and how the tests will be scored. It is recommended that key aspects of the plan be tested annually and that the test be based on clear objectives that will allow the results of the test to be scored to determine the effectiveness of the business continuity plan. In addition to testing the plan, the plan should be maintained and updated regularly to ensure that the organization remains ready to handle incidents despite internal and external changes that may affect the plan.

Examiner Review of Business Continuity Plans

Reviewing the insurer's business continuity plan is a vital part of assessing a company's prospective risk and should consider all parts of the business, including outsourced functions. When evaluating the business continuity plan, the examiner should first become familiar with the work completed on the insurer's business continuity plan during the review of the company's information systems, which may include reviewing the insurer's business continuity plan to determine any of the following:

- Whether the plan is current, based on a business impact analysis, tested periodically and developed to address all significant business activities;
- Whether the business impact analysis addresses a wide range of relevant natural and man-made disasters, such as terrorism, climate change, a pandemic, fraud, fire, loss of utility services, personnel losses, new laws and regulations, etc.
- Whether the business continuity plan clearly describes senior management's roles and responsibilities associated with the declaration of an emergency and implementation of the plan;
- Whether a list of critical computer application programs, data and files has been included in the plan;
- Whether a restoration priority has been assigned to all significant business activities;
- Whether user departments have developed adequate manual processing procedures for use until the electronic data processing function can be restored;
- If copies of the plan are kept in relevant off-site locations;
- If current backup copies of programs, essential documents, records and files are stored in an off-premises location;
- Whether a written agreement or contract exists for use by IT of a specific alternate site and computer hardware to restore data processing operations after a disaster occurs; and

- Whether the business impact analysis is periodically reviewed to determine the appropriateness of maximum recovery times.

After the examiner has become familiar with the work completed on the insurer's business continuity plan during the review of the information systems, the examiner should consider what additional work should be performed to determine whether the insurer has established an appropriate business continuity plan. Examples of additional procedures that may need to be performed include the following:

- Determine if the board has established an appropriate enterprise-wide business continuity planning process and if the board reviews and approves the business continuity plan on an annual basis.
- Determine if senior management periodically reviews and prioritizes each business unit, department, and process for its critical importance and recovery prioritization.
- Determine if senior management has evaluated the adequacy of the business continuity plans of its service providers and whether the capabilities of the service provider are sufficient to meet the insurer's maximum recovery times.
- Review the business continuity plan to determine whether the plan takes into account business continuity risks not related to information technology such as public relations, human resource management and other factors.
- Perform additional procedures as necessary based on the risks of the insurer being examined.

Terrorism-Specific Considerations

Under several lines of business and policy types (most notably commercial property), property/casualty (P/C) insurers can be exposed to significant losses resulting from acts of terrorism. Before the attacks of Sept. 11, 2001, insurers generally neither charged for nor specifically excluded terrorism coverage. However, these practices changed drastically due to the attacks and $46 billion estimated insured loss as the availability of commercial reinsurance dried up. To discourage insurers from excluding terrorism coverage from existing policies and ensure that sufficient coverage continued to be available, the federal government enacted the Terrorism Risk Insurance Act (TRIA) in 2002. The Act creates a federal "backstop" for insurance claims related to acts of terrorism and provides for a transparent system of shared public and private compensation for these claims. However, before this backstop can be accessed, several stipulations and limits are applied, many of which were adjusted under subsequent extensions of the Act to limit the support available to insurers. Therefore, certain insurers may be exposed to significant losses related to acts of terrorism even with the federal backstop in place. Procedures within the Capital and Surplus Repository can help state insurance regulators carefully consider the impact of terrorism exposures in assessing the solvency of relevant insurers.

Examination 2 – Section 3: Examination Repositories – Underwriting

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
Other Than Financial Reporting Risks						
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The insurer has not established and maintained appropriate catastrophic risk exposure limits that are consistent with its risk appetite. (Refer also to Examination Repository – Reinsurance Ceding.) Note: This risk is intended to address catastrophe risk exposure (natural, terrorism/man-made, casualty liability, pandemics).	ST PR/UW	AC CO	UPSQ	The insurer has established more granular concentration limits for various catastrophe risks. The limits can be set by peril as zone limits, through scenario analysis, or by using a catastrophe model, depending on the sophistication of the insurer. For example: • The PML calculated using a catastrophe model for a 1-250 loss event for earthquake risk in CA cannot exceed 2% policy-holder surplus. • Limit commercial real estate exposure to $2.5 billion for a five-square-block radius to mitigate the impact of a terrorism event. The insurer monitors the actual exposure to the	Verify that management reviews and approves concentration limits that are consistent with the risk appetite and risk tolerance levels articulated in the company's ERM process. Verify that management reviews and approves	Evaluate the appropriateness of concentration limits in comparison to the overall risk appetite, reinsurance strategy, and capital available to the insurer by considering applicable industry standards and comparison to peer groups.

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
				catastrophe risks to the concentration limits on a frequent basis and reports to management. The insurer has an escalation process to respond to the exposure to catastrophe risk approaching the concentration limits. Concentration limits established by the insurer are regularly updated to consider the direct and indirect impacts of climate change risk.	reports of actual exposure to catastrophic risk limits on a regular basis. Verify that any exposures approaching the concentration limit are subject to management review and action, if appropriate, to reduce the gross risk exposure (i.e., stop underwriting new business, non-renew certain policies, increase the limit, re-rate business, etc.). Perform a walkthrough of the underwriting process and observe how the impact of climate change risk is considered when establishing and updating concentration limits for catastrophe risk.	
The catastrophe (CAT) risk exposure calculations are not produced by a reliable process and/or data input. Note: this is for catastrophe risks only	ST PR/UW	AC CO	UPSQ	The insurer has a process to ensure that: • Data input into the CAT model is complete and timely, populated from the data sources. Input data is correctly	Verify that data reconciliations exist to ensure that inputs are loaded and transformed into the CAT model correctly. Obtain and review the documentation of the assumptions. Additionally,	Select a sample of input data and reconcile it to the data sources. Consider engaging the NAIC catastrophe modeling Center of Excellence (COE) or an independent expert to

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
(natural, terrorism/man-made, casualty liability, pandemics).				transformed into the modeling format. • The selection of the CAT model assumptions is documented. • Non-modeled risks are quantified and aggregated to the CAT model output. • Outputs of the CAT model are checked for reasonableness, and the CAT model is independently validated on a regular basis.	obtain and review the documentation of the quantification methodology of the non-modeled risks. Obtain and review the validation report produced by the independent validator. Conduct and document a walkthrough of the CAT modeling process to ensure that: inputs are complete, timely, and reconciled to the source data; assumptions are reviewed and documented; and outputs are validated and approved by management before being used for underwriting.	review the CAT modeling process for reasonableness. Consider selecting a sample of actual losses and comparing them with the estimates from the CAT model.

EXHIBIT DD
CRITICAL RISK CATEGORIES

One of the goals of a risk-focused examination is to focus on the most critical financial solvency risks facing an insurer. To assist the examination team in meeting this goal, a list of critical risk categories has been developed for consideration in reviewing the adequacy of risk statements developed for each examination. The initial identification of risks in Phase 2 should utilize the understanding of the company gained in Phase 1, as well as a consideration of branded risk classifications, exam assertions, etc. The critical risk categories can then be used at the end of Phase 2 to ensure that the risks identified through this process cover some of the most common solvency risks identified by insurance regulators. The expectation is that each critical risk category will be addressed by at least one risk statement on a key activity matrix (or Exhibit V). Alternatively, if the exam team determines that a particular category is not applicable or critical to the company being examined (i.e., the company does not have exposure in the category), an explanation may be provided within the Examination Planning Memorandum.

The critical risk categories take into consideration both financial reporting and other than financial reporting risks, which categories would be common to most insurers and the typical impact of a risk category on the current and prospective financial solvency of an insurer. Specific risk statements that are used to address the critical risk category investigation requirement should be tailored based on the company's risk profile, which may necessitate consideration of matters such as climate change, terrorism, a pandemic, cybersecurity, etc. Additional risks beyond the critical risk categories are expected to be identified and reviewed through the examination process at the discretion of each examination team as described in Section 2 of this Handbook.

To demonstrate that the examination has covered each of the relevant critical risk categories, the template below should be completed to demonstrate where in the exam file each critical risk area is addressed. This may be accomplished by providing reference to each individual risk statement that addresses each critical risk category. In situations where a particular critical risk category is not addressed by at least one risk statement, the exam team should provide reference to an explanation provided within the Examination Planning Memorandum.

Critical Risk Category Reporting Template

Risk Category	Description	Where Addressed
Appropriateness of Investment Portfolio and Strategy	This category encompasses whether the insurer's investment portfolio and strategy are appropriately structured to support its ongoing business plan. Considerations may include elements of the ongoing investment strategy such as asset diversification, quality, maturities and risk/reward considerations, which could impact the insurer's vulnerability to future market fluctuations and impairments associated with various scenarios (e.g., real-estate downtown, a pandemic, significant shift in interest rates, climate change/energy transition, etc.). For long-term lines of business in particular, these considerations would address asset adequacy testing/liability matching.	*Example Comment: See Risk 5 and Risk 6 on Exhibit V at A.7.3.*
Appropriateness/ Adequacy of Reinsurance Program	This category encompasses the overall reinsurance strategy of the insurer, whether the strategy is appropriate to support its ongoing business plan and whether adequate coverage is in place to address the insurer's risk exposures (e.g., catastrophe/climate risks, morbidity risk, etc.). Considerations may include the quality of reinsurance counterparties, types of coverage in place, associated limits, net retentions, concentration of reinsurance cessions, coverage periods, terms, affiliated agreements, etc.	
Reinsurance Reporting and Collectibility	This category encompasses whether all reinsurance amounts are properly accounted for and reported by the insurer. Considerations may include the existence and valuation (including collectibility) of reinsurance recoverable amounts and reserve credits. In addition, proper accounting and reporting/disclosure for risk transfer issues may be considered.	
Underwriting and Pricing Strategy/Quality	This category encompasses whether the insurer has appropriate underwriting, pricing and marketing practices (including premium management) to meet its financial solvency needs. Considerations may include whether the insurer has established and implemented appropriate risk exposure limits and underwriting guidelines, whether the insurer is establishing adequate rates for the risks assumed under its policies and expense structure, and whether these strategies and practices are consistently applied across the insurer's distribution channels to appropriately address exposure to a wide range of insurance risks (e.g., catastrophe/climate, pandemic, increased mortality/morbidity, etc.).	

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

To: Risk-Focused Surveillance (E) Working Group

From: NAIC Staff

Date: October 10, 2024

RE: Recommended Increases to Financial Analyst and Examiner Financial Examiner Per Diem Rates

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The Risk-Focused Surveillance (E) Working Group is charged with maintaining and updating salary range guidelines for financial analysts and financial examiners published in the *Financial Analysis Handbook* and *Financial Condition Examiners Handbook*, respectively. The Working Group expects to consider updates to the salary ranges every two years, with a salary survey conducted during 2025, and resulting recommendations to be considered for inclusion in the 2026 Handbooks. Additionally, as several states currently base examiner compensation on the salary and per diem guidelines contained in Section 1 – II (D) of the *Financial Condition Examiners Handbook* the Working Group will continue to ensure those rates are updated. The Working Group expects to update per diem rates annually. This memo outlines the recommended increases to the per diem rates along with the methodology utilized to reach the recommendation.

Daily Rate Guidelines

Adjustments to the per diem guidelines are largely based upon changes in the Consumer Price Index (CPI). The Consumer Price Index, as defined by the U.S. Bureau of Labor Statistics (BLS), is a measure of the average change in prices of goods and services purchased by households over time. The CPI is based on prices of food, clothing, shelter, fuels, transportation fares, charges for doctors' and dentists' services, drugs, and other goods and services purchased for day-to-day living. In 2008, regulators determined that because the CPI takes into consideration most costs incurred by the average household, it is reasonable that an increase in salary should be within the same parameters as the increase in the cost of living.

The following data table shows the average annual salary increases adopted in the previous four years as compared to the CPI, as well as the proposed increase for the following year. The information "as published by BLS" compares the CPI as of July of each year, consistent with the analysis performed in past years. As shown below, the rates suggested by the NAIC have been consistently comparable to those published by the BLS, regardless of method used.

	2020	2021	2022	2023	2024
As Published in the next *Financial Condition Examiners Handbook*	1.00%	4.50%	8.50%	3.20%	2.90%*
As Published by BLS	0.99%	5.37%	8.52%	3.18%	2.89%
Difference	0.01%	-0.87%	-0.02%	0.02%	0.01%

**Suggested Change*

Based upon the July 2024 CPI data, the estimated annual change in CPI is approximately 2.9%. As such, if the Committee intends to base salary increase on changes in the CPI, we recommend a 2.9% increase in all position classifications as shown below.

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Classification	2024 Daily Rates	Suggested Increase	2025 Daily Rates
Insurance Company Examiner, AFE*	$396	2.90%	$407
Automated Examination Specialist, AFE (no AES**)	$486	2.90%	$500
Senior Insurance Examiner, CFE***	$486	2.90%	$500
Automated Examination Specialist, AES	$546	2.90%	$562
Automated Examination Specialist, CFE (no AES)	$546	2.90%	$562
Insurance Examiner In-Charge, CFE	$585	2.90%	$602
Supervising or Administrative Examiner	$620	2.90%	$638

*Accredited Financial Examiner
**Automated Examination Specialist
*** Certified Financial Examiner

