MEMORANDUM

TO: Justin Schrader (NE), Chair of the Risk-Focused Surveillance (E) Working Group

FROM: Judy Weaver (MI), Facilitator of the Chief Financial Regulator Forum

DATE: November 10, 2020

RE: Affiliated Service Agreements with Market-Based Expense Allocation

On its Nov. 10, 2020 call, the Chief Financial Regulator Forum discussed the topic of affiliated service agreements. During this discussion, regulators noted an increase in the number of affiliated service agreements (Form D filings) being filed for regulator review with market-based expense allocations. While market-based expense allocations are not prohibited by the NAIC's *Insurance Holding Company Model Regulation With Reporting Forms and Instructions* (#450), the insurer is required to provide a statement regarding the cost allocation methods that specifies whether proposed charges are based on "cost or market." If market based, rationale for using market instead of cost, including justification for the company's determination that amounts are fair and reasonable, is required to be provided with the filing.

In addition to Model #450 filing requirements, the NAIC's *Financial Analysis Handbook* provides other guidance for regulators to consider in reviewing Form D filings with market-based expense allocations. Such guidance states that "compensation bases other than actual cost should be closely evaluated" and that "insurers should not use related-party transactions as a method for transferring profits of the insurance company to an affiliate or related party." In addition, the guidance references ways for regulators to evaluate the fairness and reasonability of market-based expense allocation, including: 1) Review of rates charged by the affiliated service provider to third-party clients for similar services; and 2) Review of rates charged (or quoted) by non-affiliated service providers to their clients for similar services. However, given the increasing prevalence and complexity of these agreements, the analysis handbook might benefit from additional guidance or supporting best practices tailored to specific types of services and contracts (e.g. pharmacy benefit management).

In addition, the NAIC's *Financial Condition Examiners Handbook* provides general guidance for reviewing and evaluating the appropriateness of affiliated service agreements but does not appear to directly discuss market-based allocations. As such, the Chief Financial Regulator Forum encourages the Risk-Focused Surveillance (E) Working Group to review this topic and to coordinate across analysis and exam processes to address any concerns identified. In addressing this issue, it might be appropriate to consider whether additional handbook guidance, sound practice considerations or educational/training materials should be developed to provide additional clarity.

If there are any questions regarding the proposed recommendation, please contact either me or NAIC staff (Bruce Jenson at *bjenson@naic.org*) for clarification.

Thank you for your consideration.

Proposed Revisions to Financial Analysis Handbook

III.A.6. Template for Planning Meeting with Financial Examiner

Overview

This template is intended as an optional tool highlighting items that may be discussed during a planning meeting between the assigned financial analyst and the financial examiner in support of the financial exam process. This meeting should ensure that the examiner both understands the company that will be examined and also receives details on work that has already been performed in supervising the company's operations. An effective exchange of information will promote efficiencies in the financial examination process by allowing the examiner to leverage the knowledge and work performed by the financial analyst. It may also prove useful to supplement this meeting with a discussion of the Exam Planning Questionnaire (Exhibit B) so that the analyst can review during the discussion to highlight or indicate if a document being requested has been obtained and/or reviewed by the insurance department. Although this template focuses on discussions between the assigned financial analyst and the financial examiner, the examiner may also consider incorporating this discussion into a broader planning meeting with members of department management and representatives from other areas of the department. However, if such an approach is taken, it should not reduce or diminish the level of discussion between the analyst and the examiner.

Given the importance of the Insurer Profile Summary (IPS) in communicating the results of the department's financial analyst's review of the company's operations, the planning meeting with the analyst is intended to generally follow the format of the IPS template.

Depending on the significance of operations at the group level, the examiner should consider whether additional agenda items should be added to focus on risks posed and discussed on the Group Profile Summary that are relevant for consideration during the examination.

NOTE: The exhibit was prepared to assist examiners in obtaining a general knowledge of the company through the meeting with the analyst. The examiner leading the discussion should not rely exclusively on these topics and should tailor agenda items based on knowledge of the company and based on knowledge of work that has been performed by the department.

Planning Meeting Between the Financial Analyst and Financial Examiner – Agenda Items

1. **Business Summary** – Discuss a summary of the business operations and lines of business of the insurer.
    a. Discuss whether the department has received a recent business plan from the company and has identified any significant changes in strategy/operations.
    b. Discuss any recent meetings with the company and their potential impact on the examination.
    c. Discuss the corporate governance in place at the company and any recent changes or concerns identified.

2. **Regulatory Actions** – Discuss any significant recent steps taken in supervising the company, including, but not limited to:
    a. Granting of permitted practices;
    b. Identification of issues of non-compliance;
    c. Follow-up on items from the last financial examination;
    d. Review of items filed with the department for approval and the need to verify or reevaluate approvals during the exam (e.g., Form A, Form D, Form E, etc.); and
    e. Recent or pending regulatory actions (such as forfeitures, cease & desist orders, or restrictions on the company's writings or operations).

3. **Financial Snapshot/Overview of Financial Position** – Discuss the company's recent financial results, including, but not limited to:

a. Changes in profitability trends;

b. Deterioration in asset quality, liquidity or capital adequacy;

c. Changes in investment holdings and strategy;

d. Changes in key annual statement balances;

e. Changes in reinsurance balances and program structure;

f. Significant results noted in financial analysis solvency tools; and

g. Deterioration in reserve development trend.

4. **Branded Risk Assessments** – Discuss individual branded risk assessments with a focus on moderate and significant areas of concern. For example:

   a. Discuss a summary of detailed analysis work performed to address key issues.

   b. Discuss the status of any outstanding inquiries or requests for the company.

   c. Discuss any management representations to the department that should be verified or corroborated during the exam.

   d. Discuss any recommended exam procedures and/or follow-up on key issues.

   e. Discuss any risks assessed as "minor" which appear to be escalating.

5. **Impact of Holding Company on Insurer** – Discuss the impact of the holding company system on the domestic insurer. For example:

   a. Discuss and obtain the Group Profile Summary and non-lead state holding company analysis work as necessary.

   b. Discuss whether the analyst's review of the Corporate Governance Annual Disclosure, Own Risk and Solvency Assessment (ORSA) Summary Report and/or Form F reporting indicate a need for additional follow-up and review during the exam.

   c. Discuss any developments or follow-up items resulting from recent supervisory college sessions.

6. **Overall Conclusion and Priority Rating** – Discuss the analyst's overall conclusion on the company's financial condition, strengths, weaknesses and priority rating assigned to the company.

7. **Supervisory Plan** – Discuss the analyst's plans for the ongoing supervision of the company, including any specific examination procedures identified.

8. **Access to Work Papers and Company Documents** – Discuss the best way that the analyst's work can be reviewed/obtained. As the number of files that examiners wish to review and obtain increases, they may consider obtaining access to the analyst's workpapers and receiving specific locations (i.e., workpaper references) for all requested documents.

9. **Input from Other Areas of the Department** – Discuss whether the analyst has received recent communications from other areas of the insurance department regarding issues that could affect the financial examination including, but not limited to, units in charge of:

   a. Approving rates and forms filings

   b. Legal and administrative matters

   c. Market conduct examinations/filings

10. **General Observations** – Depending on the information already provided, determine whether there are any additional topics relevant for discussion, such as:
    a. If you were going on-site to examine this company, where would you focus your time?
    b. What are your biggest concerns in terms of things that could go wrong at this company to result in a solvency concern?
    c. Are you aware of any fraud allegations or concerns at the company? Are there any fraud risk factors that the exam team should be aware of?

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

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

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

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Exposure to Affiliated / Related Party Transactions

Note: *The following procedures for the review of Corporate Structure and Affiliated Transactions should consider any analysis already completed or anticipated to be completed with regard to the Holding Company Analysis performed by the lead state, review of the Form B – Registration Statement and any review of Form D – Material Transactions to avoid duplication of analysis.*

6. Determine whether any concerns exist regarding changes in the insurer's corporate structure.

	Other Risks
a. Review the Annual Financial Statement, Schedule Y – Part 1 and additional information provided in Form B, for the current and prior year: i. Were there any significant changes to the corporate structure during the year (e.g., acquisitions, divestitures, mergers)? ii. If 6.a.i is "yes," and the change involved ownership of the insurer or a transaction with an affiliate, did the insurer fail to receive proper regulatory approval? iii. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company? iv. Does the insurer have an agency of brokerage subsidiary?	ST

7. Identify whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Management fees paid to affiliated to total expenses incurred [Annual Financial Statement, Underwriting and Investment Income Exhibit, Part 3]		>15%	[Data]	[Data]
				Other Risks
b. Review the Annual Financial Statement, Schedule Y – Part 2, Notes to Financial Statement – Note #10 and Note #13, and additional information provided in Form B and Form D: i. Are any unusual items noted, such as significant new affiliated transactions or				ST, LQ

modified intercompany agreements from the prior year or significant increases in transaction amounts? ii. Has the insurer forwarded to any affiliate funds greater than 15% of the insurer's surplus? iii. Do affiliated undertakings resulting in a contingent liability to the insurer involve financial exposure greater than 25% of surplus? iv. Review the description of management agreements and service contracts. Is an allocation basis involved other than one designed to estimate actual cost?	
c. After reviewing both the Annual Financial Statement, Schedule Y – Part 2 and Notes to Financial Statements – Note #10, identify any discrepancies in reporting between the two disclosures.	
d. Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved (e.g., Dividends – Note #13 and Structured Settlements – Note #27).	
e. **Risk Retention Groups:** Summarize the insurer's level of reliance on captive managers, TPAs, or MGAs to run its business operations (e.g., underwriting, claims, record and reporting). i. If significant reliance exists, describe the services provides, any additional relationships, whether the expense ratio is in line with industry standards, and whether those parties service other insurers.	ST

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

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Affiliated receivable to surplus	CR*	>10%	[Data]	[Data]
b. Affiliated payable to surplus	CR*	>10%	[Data]	[Data]
c. Federal income tax recoverables to surplus		>5%	[Data]	[Data]
d. Does any foreign entity control 10% or more of the insurer, either directly or indirectly, through a holding company system? [Annual Financial Statement, General Interrogatories, Part 1, #7.1 and #7.2.]		>10%	[Data]	[Data]
e. Review the Annual Financial Statement, General Interrogatories, Part 1, #20.1 and #20.2:				
i. Total amount loaned to directors, other officers, or stockholders to net income.		>10%	[Data]	[Data]
ii. Total amount of loans outstanding at end of the year to directors, other officers, or stockholders to surplus.		>5%	[Data]	[Data]
f. Has the insurer failed to establish a conflict of interest disclosure policy? [Annual Financial Statement, General Interrogatories, Part 1, #18]		=YES	[Data]	[Data]

	Other Risks
g. Review Annual Financial Statement, Schedule E – Part 1 : i. Were any open depositories a parent, subsidiary, or affiliate? ii. Based upon a review of the holding company financial statements (as filed with the Annual Holding Company Registration Statement Form B), are there any holding company lenders reported that also appear as open depositories of the insurer?	
h. Review the Annual Financial Statement, Notes to Financial Statements, Note #9 : i. If the insurer is included in a consolidation federal income tax return, note any concerns relating to how taxes are allocated to the insurer. ii. Review the tax-sharing agreement and verify whether the terms are being followed. iii. Obtain and review the financial statements of the parent of affiliate and evaluate any collectability to the insurer. iv. Verify whether the amount recoverable from the prior year-end has been collected/recovered. v. If federal income tax recoverables are greater than 5% of surplus, are federal income tax recoverables due from an affiliate?	CR, LQ
i. Review the Annual Financial Statement, Notes to Financial Statements, Note #27: i. Has the insurer acquired structured settlements from an affiliated life insurance company? ii. If 8.i.i is "yes," is the amount of loss reserved eliminated by annuities greater than 15% of surplus? iii. Determine the current rating of the affiliates from the major rating agencies, if available. iv. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups. v. Obtain and review the Statement of Actuarial Opinion of the affiliate, if available. vi. Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.	
j. Review the Annual Financial Statement, General Interrogatories, Part 2, #5. In the case of reciprocal exchange: i. Are any unusual items noted regarding compensation of the attorney-in-fact? ii. If there an approval agreement on file with the insurance department, review the Articles of Agreement.	
k. If 8.d is "yes," did the insurer fail to properly disclose the investment on the Annual Financial Statement, Schedule Y – Part 2?	
l. If 8.f is "yes," is there any evidence that activities of directors, other officers, or shareholders were in violation of state statues?	
m. Review the Financial Annual Statement, Schedule SIS, are any unusual items noted regarding transactions with, or compensation to directors and officers?	
n. Assemble a list of all affiliated and other related parties and summarize the financial	

impact of each transaction. Identify any other unusual transactions and investigate for reasonableness.	

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Additional Analysis and Follow-Up Procedures

Examination Findings:

Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding operational risks associated with:

- Operating performance
- Information Technology (IT) systems
- Cybersecurity
- Fraud
- Internal controls
- Disaster recovery
- Affiliated transactions and services

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

Overall Operating Performance:

If there are any concerns regarding the insurer's operating performance as it relates to expenses overall or by line of business:

- Compare the entity's actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
- Review the Annual Financial Statement, Insurance Expense Exhibit (IEE):
  - Investigate unusual items, especially situations where expenses were allocated to lines of business using methods not defined in the Annual Statement Instructions. The Annual Statement Instructions are included in the Supplements section and additional guidance in this regard is included in the *Financial Condition Examiners Handbook*.
- Review the IEE, Part 1 :
  - Investigate significant fluctuations in expenses by expense groups between years
  - Compare expenses by expense group for the insurer with industry averages
- Review the IEE, Part II and Part III:
  - Investigate significant fluctuations in expenses by lines of business between years
  - Compare expenses by line of business with industry averages
  - Determine whether the totals agree with financial statement line items included in the Annual Financial Statement

Corporate Governance:

If the CGAD is filed to your state as either the domestic state of a legal entity (not part of a group) or the lead state of a group and if concerns related to the corporate governance practices of the insurer or insurer group are identified:

- Consider reviewing internal resources on file related to the following, and if not on file, request the following information from the insurer:
  - For the board of directors and each committee established by the board of directors request a copy of the charter/policy, the business ethic policy, code of conduct policy, and conflict of interest policy
  - The most recent conflict of interest statement, or its equivalent, for each member of the board of directors and committees established by the board of directors including an explanation of any conflicts reported
  - Financial expertise or statutory accounting principles expertise of the audit committee
  - Reporting structure of the internal audit function
  - Copy of the company's by-laws currently in effect
  - If part of a holding company system, discussion on the level of oversight the parent company maintains over the insurer
  - Discussion of compliance with corporate governance statutes
  - Discussion of compensation policies, bonus/incentive programs, and management performance and assessment programs
  - Discussion of the board of directors' and management's responsibilities and authority
- If your state is not the lead state and the CGAD is filed to the lead state, contact the lead state with any questions, concerns or follow-ups.

Affiliated Transactions:

If concerns related to the economic substance of an affiliated/related party transaction are identified, obtain and review supporting documents.

- If the concern relates to the fair value of an affiliated transaction:
  - Obtain and review an appraisal of the asset transferred
  - Consider consulting an independent appraiser
- If the concern involves a management agreement or service contract:
  - Obtain and review the supporting contract and compare against Form D filing previously submitted to the department (if applicable)
  - Determine whether the amounts involved are reasonable approximations of actual costs
  - Determine whether the actual amounts paid are in agreement with the supporting contact
  - For any arrangement based on a cost plus formula or percent of premiums formula, request justification from the insurer for amounts in excess of the actual costs of providing the service
  - For those services being performed by/for an affiliate and that are also provided by unrelated third-party vendors (e.g., data processing, actuarial, investment management), contact such vendors or review vendor pricing schedules in order to determine the reasonableness of the intercompany transfer pricing level
  - Evaluate whether any portion of such fees in substance dividends should be evaluated in the contact of dividend regulations
  - Determine if agreements received appropriate regulatory approval in conformity with regulatory

requirements

- Consider whether additional examination procedures should be recommended to verify/validate information reported on affiliated services or to further evaluate the fairness and reasonableness of expense allocations.
  - See additional guidance regarding criteria to be considered in determining whether an affiliated agreement merits review during an onsite examination at V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide (Form D - Prior Notice of a Transaction).

- If the concern relates to federal tax recoverables from a parent or affiliate:
  - Obtain and review the financial statements of the parent or affiliate, and evaluate any collectability risk to the insurer
  - Review the tax-sharing agreement, and verify that terms of the tax-sharing agreement are being followed
  - Verify that the amount recoverable from the prior year-end has been paid

MGAs and TPAs:

For the more significant MGAs and TPAs, if further concerns exist request the following information from the insurer to evaluate:

- The comparability of the incurred loss and LAE ratios on the business written by the MGA and TPA with that written directly by the insurer (for the lines of business in which significant, but not all, direct business is written through the MGA/TPA).
- Whether the business produced by the MGA and TPA is ceded to a particular reinsurer and, if so, whether that reinsurance was arranged by the MGA or TPA. If the MGA or TPA arranged for the reinsurance, determine whether the MGA or TPA is affiliated with the reinsurer, and consider reviewing the reinsurance agreements to determine whether the terms are reasonable.
- Commission rates and any other amounts paid to the MGA and TPA. Review the information for reasonableness and compare the commission rates to those paid by the insurer to other agents.
- Whether the contracts between the insurer and MGA include minimum required provisions per Section 4 of the NAIC *Managing General Agents Act* (#225) and/or the applicable sections of the insurance code.
- Whether the contracts between the insurer and TPA include minimum required provisions per Sections 2,4,6,7 and 8 of the NAIC *Registration and Regulation of Third-Party Administrators* (#1090) and/or the applicable sections of the insurance code.
- The most recent independent CPA audit or annual report of the MGA or TPA.
- If the MGA establishes loss reserves, the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA.
- Documentation supporting the insurer's periodic (at least semi-annual) on-site review of the MGA's underwriting and claims processing operations.
- Documentation supporting the insurer's periodic (at least semi-annual) review of the operations of the TPA. (Model #225 requires at least one of the semi-annual reviews to be an on-site audit of the operations of the TPA.)

If there are concerns regarding the business placed with the insurer by an MGA or TPA, consider determining if other insurers are utilizing the same MGA or TPA and perform the following:

- Compare the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether the contracts are similar (e.g., contain the same

commission rates).

- Compare the insurer's loss and LAE ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer may be receiving a disproportionate amount of "bad" business from the MGA or TPA.

Own Risk and Solvency Assessment (ORSA) Summary Report:

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

- Did the ORSA Summary Report analysis conducted by the lead state indicate any operational risks that require further monitoring or follow-up?
- Did the ORSA Summary Report analysis conducted by the lead state indicate any mitigating strategies for existing or prospective operational risks?

Holding Company Analysis:

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

Example Prospective Risk Considerations

	Risk Components for IPS	*Explanation of Risk Components*
1	Trend of poor operating performance [indicate overall or specific line of business]	Continued trends in expense ratio, combined ratio and overall profitability may indicate ongoing solvency risks.
2	High expense structure	A high expense structure may make it difficult for the insurer to attract new business, compete with other insurers and fulfill its strategic plan.
3	Lack of effective governance/oversight of operations	The lack of an effective governance function to oversee operations may make it difficult for the insurer to fulfill its strategic plan and achieve desired outcomes.
4	Change in operations	A significant change in operations resulting from turnover or change in key board and/or senior management positions may increase operational risk.
5	Lack of asset control	Assets not under the full control of the insurer may not be available to fulfill policyholder obligations.
6	Questionable investment transactions	The insurer's investment performance or risks in its investment portfolio may be masked due to questionable investment activities (e.g., wash sales, window dressing, etc.).
7	Concerns with investment advisors	Heavy reliance on unqualified investment advisors or lack of effective oversight may lead to excessive risk taking and increases in the fraud and investment reporting risks.
8	Significant and complex affiliated services and transactions	Significant affiliated services and transactions can mask true financial performance and increase risks related to cost sharing, contingent

		liabilities, unauthorized dividends, etc.
9	Significant reliance on MGAs/TPAs	Reliance on MGAs/TPAs to produce premiums, process claims and fulfill other operational functions can increase operational risk significantly if effective oversight practices are not in place.

Operational Risk Assessment

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

The objective of Operational Risk Assessment analysis is to focus on risks inherent in the company's daily operations. As such, although operational risk encompasses overall profitability, other risks in this area may not be identified through traditional financial statement review. Therefore, analysts may require additional investigation and information requests to understand and assess the potential impact of these risks. For example, analysst may need additional information to assess the insurer's exposure to cybersecurity risks. In addition, information presented in the Enterprise Risk Report (Form F) and Own Risk and Solvency Assessment (ORSA) Summary Report (if available) may assist analysts in identifying and assessing the insurer's exposure to operational risks.

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

- Statement of income and operating performance
- Corporate governance practices
- Changes in officers and directors
- Investment operations (purchases and sales)
- Use of investment advisors
- Changes in corporate structure
- Related party transactions
- Use of managing general agents (MGAs) and third-party administrators (TPAs)
- Separate accounts (Life only)
- Risk transfer arrangements other than reinsurance (Health only)
- Provider liabilities (Health only)

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Exposure to Affiliated/Transactions

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

PROCEDURE #6 assists analysts in determining whether any concerns exist regarding changes in the insurer's corporate structure. Significant changes in corporate structure may materially impact the entity's future financial condition and generally require prior regulatory approval. Analysts should closely analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure in which the health entity operates, analysts may be able to foresee future problems and take appropriate action. For example, a common corporate structure analysts may encounter involves a holding company whose only significant asset is the stock of the insurance entity. The holding company may have financed the acquisition of the insurer through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the insurer. This type of corporate structure

warrants close attention by analysts to ensure that dividends are valid and in compliance with your state's applicable dividend restrictions, and that any other payments by the insurer to the holding company are legitimate, rather than dividends in disguise. Analysts should also be alert to a corporate structure that includes affiliated brokers or intermediaries that may be recording unusual or significant levels of commissions and fees. When a corporate structure is involved that includes multiple tiers of affiliates where significant levels of surplus are comprised of investments in affiliates, analysts should focus on the level of real surplus that exists on a consolidated basis.

Additional steps may be performed if the insurer's corporate structure elevates concerns about affiliated transactions. The primary objective is to understand the financial position of the parent company. By understanding the financial commitments of the parent, analysts will be able to better understand the parent's motivation for entering into transactions with the insurer or other affiliates. Financial statements of affiliates may reveal unauthorized transactions in progress.

PROCEDURE #7 assists analysst in determining whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines. Several types of affiliated transactions are reported in the Annual Financial Statement, Schedule Y – Part 2, and explanatory comments are provided in the Annual Financial Statement, Notes to Financial Statements, #10. In addition, information is made available in Note #13, as well as in holding company filings (Form B and Form D) that are received from insurance holding company systems throughout the year. Analysts should refer to all of these sources of information in order to develop an understanding and assessment of the underlying affiliated transactions.

The following briefly describes the key concerns to analysts for several of the major affiliated transactions. For shareholder dividends, the major concern relates to whether the level of dividends is within the regulatory guidelines and whether the dividends should be considered extraordinary, and therefore requires prior regulatory approval. For capital contributions from the insurer to another affiliate, analysts should determine that such contributions do not substantially impact the financial condition of the insurer. For non-cash capital contributions into the insurer, analysts should determine that the infusion is recorded at fair value so as to not arbitrarily inflate surplus. In the case of purchases, sales or exchanges of loans, securities, real estate, mortgage loans, or other investments, the concern to analysts is primarily one of valuation. These types of transfers should be at arm's length and recorded at fair value.

Analysts should also be alert to possible abuses regarding the transfer of assets between property/casualty and life/health affiliates merely to impact the RBC calculation of the affiliates. For management agreements and service contracts, the main concerns to analysts relate to the type of service being performed and the reasonableness of the cost. This is a common area for abuse when parent companies desire to withdraw funds from the insurer but do not want to or would not be permitted to classify it as a shareholder dividend. Analysts should understand why the parties were motivated to enter into such contracts and particularly, the benefit to the insurer. For those services provided by an affiliate where a market already exists (such as data processing, actuarial, or investment management), an effective way for analysts to determine whether an arm's length transaction exists is to contact one of the vendors and request a proposal or fee estimate for a similar service.

In understanding and evaluating these transactions, analysts should identify any discrepancies in reporting across the various information sources. In addition, analysts should verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.

PROCEDURE #8 assists analysts in determining whether other affiliated transactions are legitimate and properly accounted for. Analysts' primary objective in this area is to understand the substance of the transactions and to determine whether the transactions are economic-based. Analysts should review the extent of transactions with officers and directors to ensure that the transactions are at arm's length and are not detrimental to the financial condition of the insurer. Analysts should closely monitor other affiliated transactions to ensure that the insurer is not exposed to significant collectability risk. For example, if the insurer is included in a consolidated federal income tax return and a significant asset for federal income tax recoverable is recorded on the financial

statements of the insurer, analysts should closely review the financial statements of the parent to determine the parent's ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectability risk to the insurer. When the amounts of structured settlements are significant, analysts should review and understand the financial statements of the life insurance affiliate.

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Additional Analysis and Follow-Up Procedures

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

OVERALL OPERATING PERFORMANCE directs analysts to perform additional steps, as necessary, to understand and evaluate issues related to the insurer's operating performance. Such steps include comparing actual results to projections, reviewing details of expenses by comparing to prior years and industry averages, and requesting additional information from the insurer and/or third parties (i.e., federal Centers for Medicare & Medicaid Services—CMS) to evaluate performance.

MEDICARE PART D OPERATING PERFORMANCE (LIFE/HEALTH) directs analysts to obtain and review supporting documents if concerns are identified related to the operating performance of Medicare Part D business. Supporting documents may include information on contracted benefits, premium and cost sharing with the CMS, and support for reserve, utilization and benefit cost assumptions projected in the development of the contract.

CORPORATE GOVERNANCE directs analysts to use the CGAD and/or request additional information from the insurer to review and evaluate relevant policies and processes such as board/committee charters, code of conduct policy, conflict of interest policy, bylaws, compensation policies, etc.

AFFILIATED TRANSACTIONS direct analysts to take additional steps if concerns regarding the economic substance of an affliated transaction are identified. Such steps include independent appraisals, comparisons to third-party services/bids, detailed review of contracts, review of the financial condition of the affiliate, reviewing collection, etc. In addition, the analyst should consider recommending procedures for the next examination (targeted or full-scope) to verify information reported on affiliated transactions and to further evaluate the fairness and reasonableness of expense allocations. In so doing, the analyst should consider additional guidance regarding criteria to be considered in determining whether an affiliated agreement merits review during an onsite examination at V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide (Form D - Prior Notice of a Transaction).

MGAs AND TPAs direct analysts to take additional steps if concerns regarding significant MGAs, TPAs and IPAs are identified. Such steps include comparing the performance of MGA/TPA/IPA business to other business written by the insurer, reviewing the reasonableness of commissions and fees paid, performing detailed contract review, obtaining audited financial statements, etc.

RISK TRANSFER OTHER THAN REINSURANCE directs analysts to take additional steps if concerns are identified in this area, including requesting and reviewing provider contracts, requesting and reviewing liability amounts for the top five provider groups, and contacting the appointed actuary regarding the nature and scope of the review of provider contracts during the actuarial review.

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

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

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.

Example Prospective Risk Considerations

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

Discussion of Quarterly Procedures

The Quarterly Operational Risk Repository procedures are designed to identify the following:

1. Concerns with the insurer's Statement of Income or operating performance
2. Whether all securities owned are under the control of the insurer and in the insurer's possession
3. Whether the insurer is a member of a holding company group and whether the corporate structure elevates concerns about affiliated transactions
4. Whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines
5. Whether the insurer's use of bonus withhold arrangements are significant
6. Concerns with the insurer's separate accounts

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

Special Notes:

The following procedures do not supersede state regulation but are merely additional guidance analysts may consider useful only if the state has adopted the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions*, (#450).

Form D – Prior Notice of a Transaction

Form D is transaction specific and is not part of the regular annual/quarterly analysis process. The review of these transactions may vary as some states may have regulations that differ for Form D.

Compliance Assessment

1. If a material transaction has occurred, did the insurer file a Form D with its domestic state? (Section 5 of the NAIC *Insurance Holding Company System Regulatory Act* (#440) requires each insurer to give prior notice of certain proposed transactions).

2. Did Form D include the following information for each party to the transaction (Form D of *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions*, (#450):

   - Name
   - Home office address
   - Principal executive office address
   - The organizational structure
   - A description of the nature of the parties' business operations
   - The relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties
   - The name(s) of the affiliate(s) that will receive, in whole or in substantial part, the proceeds of the transaction, when the transaction is with a non-affiliate

3. Does Form D include the following information for each transaction for which notice is being given:

   - A statement as to the section of the holding company regulation Form D filing is being made
   - A statement as to the nature of the transaction
   - A statement of how the transaction meets the 'fair and reasonable' standard of the state's insurance holding company law or regulation; and
   - The proposed effective date of the transaction

4. Does Form D provide a brief description of the following:

   - Amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment
   - Whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice
   - A description of the terms of any securities being received, if any
   - A description of any other agreements relating to the transaction, such as contracts or agreements for services, consulting agreements and the like

----------*Detail Eliminated to Conserve Space*----------

12. For management and service agreements, does Form D include the following:
    - A brief description of the managerial responsibilities or services to be performed
    - A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made (compensation bases other than actual cost should be closely evaluated)

13. For cost-sharing arrangements, determine whether the Form D includes the following:
    - A brief description of the purpose of the agreement
    - A description of the period of time during which the agreement is to be in effect
    - A brief description of each party's expenses or costs covered by the agreement
    - A brief description of the accounting basis to be used in calculating each party's costs under the agreement
    - A brief statement as to the effect of the transaction upon the insurer's surplus
    - A statement regarding the cost allocation methods that specifies whether proposed charges are based on 'cost or market.' If market based, include the rationale for using market instead of cost, including justification for the company's determination that amounts are fair and reasonable
    - A statement regarding compliance with the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) regarding expense allocation

14. For management, service and cost-sharing agreements, in accordance with the holding company act and regulation of the state, does the agreement[1]:
    - Identify the person providing services and the nature of such services
    - Set forth the methods to allocate costs
    - Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the AP&P Manual
    - Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement
    - State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance
    - Define ~~books and~~ records and data of the insurer to include all ~~books and~~ records and data developed or maintained under or related to the agreement that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate
    - Specify that all ~~books and~~ records and data of the insurer are and remain the property of the insurer, and:

[1] All underlined text in Procedure 14 represents amendments to *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (Model #450) Section 19 as adopted by the NAIC on Aug. 17, 2021. As state insurance departments are still in the process of adopting these amendments into state law, analysts should refer to their own state's holding company law or regulation regarding compliance with Form D filings of management, service and cost-sharing agreements.

- ~~a~~Are subject to control of the insurer
- Are identifiable
- Are segregated from all other persons' records and data or are readily capable of segregation at no additional cost to the insurer[2]

- State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer
- Include standards for termination of the agreement with and without cause
- Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services and for any actions by the affiliate that violate provisions of the agreement required in Subsections 19B(11), 19B(12), 19B(13), 19B(14) and 19B(15) of this regulation
- Specify that, if the insurer is placed in supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts]~~receivership or seized by the insurance commissioner under the State Receivership Act~~:
  - All of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by [law of the state]
  - All records and data of the insurer shall be identifiable and segregated from all other persons' records and data or readily capable of segregation at no additional cost to the receiver or the commissioner
  - A complete set of ~~All books and~~ records and data will immediately be made available to the receiver or the insurance commissioner, shall be made available in a usable format and shall be turned over to the receiver or insurance commissioner immediately upon the receiver or the commissioner's request and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable[3]
  - The affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or commissioner
- Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts]~~the State Receivership Act~~
- Specify that the affiliate will provide the essential services for a minimum period of time [specified in the agreement] after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], as ordered or directed by the receiver or commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court
- Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts]~~a seizure by the insurance commissioner under the State Receivership Act~~, and will make them available to the receiver~~,~~ or commissioner as ordered or directed by the receiver or commissioner

[2] In Model #450, the "at no additional cost to the insurer" language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer, receiver or commissioner. Since records and data of the insurer are the property of the insurer, the insurer, receiver or commissioner should not pay a cost to segregate commingled records and data from other data of the affiliate.

[3] In Model #450, the fair and reasonable cost to transfer data to the receiver or commissioner refers to the cost associated with physically or electronically transferring records and data files to the receiver or commissioner. This cost does not include costs to separate comingled data and records that should have been segregated or readily capable of segregation.

for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court

- Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver's authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], and portions of the insurer's policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate's commitments under Subsections 19B(11), 19B(12), 19B(13) and 19B(14) of this regulation will extend to such guaranty association(s)

15. For any Form D affiliated agreement, in accordance with the holding company regulation, processes and procedures of the state, review and consider compliance with any state-specific requirements.

Assessment of Form D – Prior Notice of a Transaction

1~~5~~6. Review Form D for any significant and/or unusual items or inconsistencies. Determine if the transaction ~~appears~~ is fair and reasonable as required under Section 5A(1)(a) of Model #440 by considering~~in relation to~~ the following:

a. ~~a.~~ For reinsurance agreements, are the general terms, settlement provision, and pricing consistent with those of non-affiliated agreements?

b. ~~b.~~ For management, service or cost-sharing agreement, are the charges or fees to be paid by/to the insurer reasonable in relation to the cost of such services?

c. ~~c.~~ Are fees paid for related party transactions consistent with the applicable section of the state's Insurance Holding Company Act? (Note: Insurers should not use related-party transactions as a method for transferring profits of the insurance company to an affiliate or related party.)

d. ~~d.~~ Will the insurer have adequate surplus upon completion of the transaction?

e. ~~e.~~ Does the transaction comply with the NAIC AP&P Manual? Are expenses incurred and payment received allocated to the insurer in conformity with customary insurance accounting practices consistently applied?

f. Are books, accounts and records of each party maintained clearly and accurately to disclose the nature and details of the transactions, including such information as is necessary to support the reasonableness of charges or fees to the respective parties?

~~e.~~g. Does the transaction comply with the state's requirements regarding the insurer's ownership of data and records that are held by an affiliate, and control of premium or other funds belonging to the insurer that are collected or held by an affiliate?[4]

h. ~~f.~~ Do unusual circumstances, risks or concerns exist?

~~f.~~i. Any other state-specific requirements for determining and reviewing fair and reasonableness.

1~~6~~7. Determine whether the transaction was accounted for properly, based on statutory accounting principles, with the NAIC AP&P Manual.

[4] Procedure 16.h represents amendments to *Insurance Holding Company System Model Act* (Model #440) Section 5A(1)(h) and 5A(1)(i) as adopted by the NAIC on Aug. 17, 2021. As state insurance departments are still in the process of adopting these amendments into state law, analysts should refer to their own state's holding company law or regulation regarding compliance with Form D filings of management, service and cost-sharing agreements.

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Summary and Conclusion

Develop and document an overall summary and conclusion regarding the review of the holding company Form D.

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

- Contact the insurer seeking explanations or additional information
- Obtain the insurer's business plan
- Require additional interim reporting from the insurer, particularly if the agreement is market-based or if there are other ongoing concerns noted
- Refer concerns to the examination section for targeted examination or follow-up on the next full-scope examination. Consider suggesting specific procedures to be performed by placing them in the supervisory plan section of the IPS.
- Engage external resources to assist in the review of complex affiliated agreements (i.e., ~~an~~ independent actuary or other reinsurance expert to review specific reinsurance contracts, investment expert to review affiliated investment management agreements)
- Meet with the insurer's management
- Other (explain)

Notice to Insurer

In the notice back to the insurer, state that approval of the agreement is based upon representations made in the filing, all of which are subject to verification on examination. In addition, state that the department reserves the right to review the charges and fees for fairness and reasonableness as part of future financial examinations or at any time validation is warranted. For any issues found on exam, a correction may be required on a going forward basis.

Consider whether any additional stipulations or orders should be imposed on the agreement as a result of the review and communicated in the notice to the insurer, such as the interim reporting outlined above.

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

Non-Lead State Holding Company System Analysis Procedures

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

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

----------*Detail Eliminated to Conserve Space*----------

Form D – Prior Notice of a Transaction

PROCEDURES #1-16 assist analysts in reviewing the Form D filing for completeness and help guide analysts through major items of information required by Form D.

Best Practices for Affiliated Management and Service Agreements

Charges for Fees for Services

SSAPs 25 and 70 and Appendix A-440 discuss the Transactions Involving Services, Allocation of Costs, and Other Management Requirements

Transactions entered into at arm's length by unaffiliated parties who willingly and freely (not under compulsion) enter into a transaction and arrive by negotiation at an agreed upon price (value) are by definition fair and reasonable. In the case of two or more affiliates, transactions can be deemed to be at arm's length (and therefore fair and reasonable) if the transactions are entered into at rates equivalent to current market rates or on an allocation of actual costs. Some regulators consider transactions of an allocation of "costs plus a mark-up or discount" as neither at market nor at cost because these transactions may not be deemed to be an arm's length transaction and may require more analysis to determine if it is fair and reasonable.

Transactions at Market Rate – there are at least three ways to establish fairness and reasonability with substantiating documents:

- The entity providing the service performs a substantial portion of its business with non-affiliated entities and can establish a price for affiliates similar to charges to non-affiliates, since the non-affiliates are assumed to have negotiated at arm's length.
- The entity receiving the services analyzes and retains up-to-date documentation of localized market rates of services that could be provided to the entity by non-affiliated parties. Since each transaction of service is unique, determining a fair and reasonable charge is very difficult and time consuming. This method is the least relevant and reliable, and not efficient in establishing the rate.
- Transactions at cost plus mark-up that is equal to market rate should be reviewed carefully and should be deemed fair and reasonable. Transactions at cost plus mark-up that is less than market rate should be reviewed carefully to determine if it is fair and reasonable.

Transactions at Cost – this is the simplest method to determine fair and reasonable. The costs borne by the entity providing the agreed upon services are simply allocated to the entity receiving those services. As stated in the SSAPs, cost allocation must be done in ways that yield the most accurate results. Theoretically the service provider should not make a profit or incur a loss if the transaction is at cost.

- Can be apportioned directly as if the entity incurring the expense had paid for it directly, or

- Allocated using pertinent factors or ratios such as studies of employee activities, salary ratios or similar analysis.
- Transactions at cost less a discount should be reviewed carefully to determine if it is fair and reasonable.

If cost is the method used (or required) to establish "reasonability," identifying a "rate per unit" estimated on the amount of costs and number of units, does not in and of itself make the charge reasonable. This rate per unit is a close approximation of the actual costs. Using a rate per unit is merely a method for easily calculating interim payments that are due to the provider of the service. If a rate per unit is used to allocate costs, an expense "true-up" needs to be prepared and settled at least annually to reconcile the estimated costs (payments) with the actual costs incurred. The expense "true up" essentially replaces the estimated amounts with the actual amounts and includes the subsequent settlement of any differences.

Note: Alien transactions will need additional deliberation due to potential conflicts between international tax laws and provision of services at cost vs. market.

Regulator Considerations

Items for initial filing review—the actual document(s) should be filed, not merely a summary:

- Identify and document:
  - The specific services that will be provided
    - The specific expenses and/or costs that are to be covered by each party
  - The entity(ies) providing and receiving each of those services
    - Separate affiliate entities from non-affiliates
  - Allocation method (market or cost) of the agreement
    - The charges or fees for the services indicated
  - The accounting basis used to apportion expenses
  - Confirm that contract provisions will be accounted for in accordance with SSAPs
  - Invoicing and settlement terms (should allow for admittance under SSAP 96)
  - The effective date and termination date
  - The records rights and policies of each entity that is a party in the contract
  - The governing law
  - Any unique and relevant clauses not covered above
  - Financial statements of the entity providing the services
- Other Considerations for Review of the Agreement:
  - Determine the reasonableness of the allocation method and the charges or fees
  - Determine the agreement does not divert funds that could be considered a dividend
  - Determine the agreement does not result in the insurer's fair share of expenses being retained by or allocated to a parent/affiliate, thereby masking the true performance of insurance operations
  - Summarize the business rationale for purpose and need of the agreement
  - Summarize the financial impact of the agreement on the company's surplus or financial condition
  - Summarize the impact the agreement would have on the priority status of the company
  - Summarize the reasons to approve/disapprove the agreement

Examination Verification and Validation

While the analyst is encouraged to take steps to assess and evaluate the information provided in the Form D filing as outlined above, it may be necessary to reevaluate the appropriateness of affiliated management and service agreements during an onsite examination. In determining which affiliated agreements merit consideration during an onsite examination, the analyst should assess agreements according to the following general criteria:

- Is the agreement new or significantly modified since the prior examination?
- What is the nature and extent of services provided under the agreement?
- What is the basis for expense allocation under the agreement and what support is provided for that basis (i.e., market-based allocations with limited support would be of highest concern)?
- Does the ongoing performance of the agreement raise concerns (i.e., excessive profitability of affiliated service provider and/or high expense structure of insurer)?

If concerns are noted based on these criteria, the analyst should consider recommending specific follow-up procedures to be performed during an onsite examination, as appropriate. For example, the examination team may be able to verify and validate assertions made by management in the Form D filing, as well as verify that the agreement has been implemented and is functioning as approved by the department. In addition, the examination team may be in a better position to assess the fairness and reasonableness of expense allocations after the agreement has been in place for a period of time. Suggested follow-up procedures can be included in the Supervisory Plan section of the IPS and/or covered in the examination planning meeting between the assigned analyst and the examination team.

Proposed Revisions to Financial Condition Examiners Handbook

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

F. Outsourcing of Critical Functions

The examiner is faced with additional challenges when the insurer under examination outsources critical business functions to third-parties. It is the responsibility of management to determine whether processes which have been outsourced are being effectively and efficiently performed and controlled. This oversight may be performed through a number of methods including performing site visits to the third-party or through a review of SSAE 18 work that has been performed. In some cases, performance of site visits may even be mandated by state law. However, regardless of where the business process occurs or who performs it, the examination must conclude whether financial solvency risks to the insurer have been effectively mitigated. Therefore, if the insurer has failed to determine whether a significant outsourced business process is functioning appropriately, the examiner may have to perform testing of the outsourced functions to ensure that all material risks relating to the business process have been appropriately mitigated. The guidance below provides examiners additional information about the outsourcing of critical functions a typical insurance company may utilize. The guidance does not create additional requirements for insurers to comply with beyond what is included in state law, but may assist in outlining existing requirements that may be included in state law and should be used by examiners to assess the appropriateness of the company's outsourced functions. Within the guidance, references to relevant NAIC Model Laws have been included to provide examiners with guidance as to whether compliance in certain areas is required by law. To assist in determining whether an individual state has adopted the provisions contained within the referenced NAIC models, examiners may want to review the state pages provided within the NAIC's *Model Laws, Regulations and Guidelines* publication to understand related legislative or regulatory activity undertaken in their state.

Affiliated Service Providers

Specific requirements related to an insurance company's utilization of cost sharing services and management services with affiliates are included in the NAIC's *Insurance Holding Company System Model Regulation* (Model # 450). Prior to entering into one of these agreements, an insurer must first give notice to the State Insurance Department of the proposed transaction via the Form D filing. As the receipt and review of the Form D filing is typically the responsibility of the Department Analyst, the examiner should leverage that review to the extent possible. If the agreement has not been obtained and reviewed by the analyst, or if significant agreements have not been modified since 12/31/14 (date that new provisions were effective in Model #450), the examiner should obtain and evaluate whether the agreement includes the provisions listed below:

Agreements for cost sharing services and management services shall at a minimum and as applicable:

1. Identify the person providing services and the nature of such services;

2. Set forth the methods to allocate costs;

3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;

4. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;

5. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;

6. Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement;

7. Specify that all books and records of the insurer are and remain the property of the insurer and are subject to control of the insurer;

8. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;

9. Include standards for termination of the agreement with and without cause;

10. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services;

11. Specify that, if the insurer is placed in receivership or seized by the commissioner under the State Receivership Act:

    a. all of the rights of the insurer under the agreement extend to the receiver or commissioner; and,

    b. all books and records will immediately be made available to the receiver or the commissioner, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner's request;

12. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to the State Receivership Act; and

13. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the commissioner under the State Receivership Act, and will make them available to the receiver, for so long as the affiliate continues to receive timely payment for services rendered.

If certain provisions are missing from affiliate service agreements, the examination team should encourage/require revisions to include all appropriate provisions, depending upon the date of the agreement and provisions required by Model #450 at that date. In addition, in accordance with the risk-focused examination process and utilizing guidance from the Related Party Repository, the examiner should consider whether terms of significant affiliated agreements are fair and equitable. Examiners should also note that additional guidance for reviewing individual affiliated transactions is located in Section 1, Part IV D in this Handbook.

Affiliated Service Agreements

An affiliated service agreement should specify whether the charges are based on 'cost or market'. Agreements with a cost-based structure utilize the actual cost to the service provider, requiring less judgment in setting the price charged by the affiliate. As such, there is no profit or loss to the service provider with the transaction. Within cost-based expense agreements, ensuring proper allocation of costs is essential so the insurance company is not being charged for additional or inappropriate costs. Agreements utilizing a market-based rate, however, require more judgment when setting the price charged by the affiliate. If a market-based structure is utilized, the rationale for using market instead of cost, as well as the

justification for the company's determination that amounts are fair and reasonable, should be thoroughly documented by management. It is vital to ensure the fairness and reasonability of market-based rates to ensure that the price charged by the affiliate does not enable the transfer of excessive profits from the insurance company to the affiliate.

Typically, the department analyst (or other assigned regulator) conducts the initial assessment of such agreements through its review and approval of Form D filings. However, due to the inherent complexity of a market-based agreement, it may be prudent for the exam team to verify the initial approval by performing additional procedures to evaluate the appropriateness of the rate used after the agreement has been placed in service. For example, if several years have elapsed since entering into the affiliated service agreement, the examiner can review whether and to what extent the service provider profited due to the terms of the agreement. Based upon recommendations from the department analyst during examination planning and/or the examination's risk assessment procedures, it may be appropriate to review significant affiliated transactions that utilize market-based expense structures for in-depth review (see Related Party Repository for possible procedures). Any findings from this review should be reported back to the analyst via the Summary Review Memorandum (SRM), exit conference, etc.

EXAMINATION REPOSITORY – RELATED PARTY

Identification of Risks:

To ensure that the examiner appropriately identifies and addresses all relevant risks, it is important that examiners consider information contained within the Own Risk and Solvency Assessment (ORSA), Group Profile Summary (GPS), and insights shared from the Department's Financial Analysts. An understanding of the group, including the Ultimate Controlling Party, will provide the examiner with a roadmap to help in effectively addressing the risks posted to the insurer by its related parties.

Annual Statement Blank Line Items

Listed below are the corresponding Annual Statement line items that are related to the identified risks contained in this exam repository:

Receivables from Parent, Subsidiaries and Affiliates
Payable to Parent, Subsidiaries and Affiliates
Amount Provisionally Held for Deferred Dividend Policies *(Life Companies)*
Dividends to Stockholders Declared and Unpaid *(Life Companies)*

Please Note:

- Transactions resulting from related party tax sharing and reinsurance agreements are typically reported on the appropriate tax and reinsurance financial statement line items, which are not listed above.
- The examiner should consider the company's compliance with the state statutory guidelines when reviewing affiliate and other related-party contracts.
- For additional guidance on affiliated service agreements, see Section 1, Part III, F – Outsourcing of Critical Functions.
- For additional guidance on related party and intercompany transactions, see Section 1, Part IV, D - Related Party/Holding Company Considerations.

Relevant Statements of Statutory Accounting Principles (SSAPs)

All of the relevant SSAPs related to the related party process, regardless of whether or not the corresponding risks are included within this exam repository, are listed below:

No. 15 Debt and Holding Company Obligations
No. 25 Affiliates and Other Related Parties
No. 64 Offsetting and Netting of Assets and Liabilities
No. 67 Other Liabilities
No. 70 Allocation of Expenses
No. 97 Investments in Subsidiary, Controlled and Affiliated Entities

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
Other Than Financial Reporting Risks						
A related party (including holding company) is overly reliant on the insurer for ongoing surplus support.	LQ	Other	RPHCC	The insurer has policies in place to ensure that dividends paid to affiliates are within regulatory limits, are approved by the board of directors (or committee thereof) and have received regulatory approval (if required) prior to payment. The insurer (or parent) manages its debt levels and leverage position through capital contributions and other forms of financing, as well as cash flow analysis to ensure that debt burdens do not cause a solvency/liquidity strain at the parent or its insurance subsidiaries.	Review insurer documentation showing that dividends are within regulatory limits, are approved by the board of directors (or committee thereof) and have received regulatory approval (if required) prior to payment. Review documentation on internal strategies and practices to ensure debt levels are properly managed and that sufficient liquidity is available to meet obligations.	Assess the insurance holding company organization's structure, overall group structure and the holding company's reliance on its subsidiaries for dividends. Consider the profitability and success of other companies within the holding company, as well as capital resources and debt maturities as part of the assessment. Review historical cash flows from the insurer to its affiliated companies since the last examination, and compare to statutory dividend capacity currently available. Trace all dividends requiring regulatory approval to insurance department documentation.
The insurer is overly reliant on an affiliate for ongoing surplus support. **Please Note**: Review of this risk should be performed in conjunction with the Capital and Surplus Repository.	CR LQ	Other	RPHCC	The insurer monitors the financial position of the affiliate providing surplus support. The affiliate provides a guarantee of its ongoing support for the insurer. The insurer monitors all guarantee agreements and analyzes the guarantor's	Management reviews financial results of the affiliate on a quarterly or annual basis. Obtain documentation supporting the guarantee provided by the affiliate. Verify that management performs an assessment of the guarantor's ability	Review the affiliate's financial position to determine the ability to provide the needed support. Compare the amount guaranteed by the parent/affiliate with the surplus of the insurer receiving the guarantee. Evaluate the possibility the

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
				ability to fulfill the agreement if necessary.	to fulfill the agreement on a periodic basis.	guarantee will not be fulfilled and the potential impact to the insurer. Verify any collateral maintained in accordance with the guarantee.
Parent, holding companies or other affiliates might become insolvent or have liquidity issues. **Please Note:** This risk is intended to focus on the strategic or reputational impact if affiliates experience solvency or liquidity issues.	ST RP	Other	RPHCC	The insurer monitors parent or holding companies for financial solvency/liquidity issues. The board of directors (or committee thereof) reviews strategic business plans and financial reports for other members of the holding company system and evaluates any risks and new initiatives that could impact the insurer including reputational risks and legal risks. Other entities in the holding company system make presentations to the board to explain operations and risks.	Obtain evidence of review of parent or holding company financial information by the insurer. Ensure liquidity is appropriately considered. Review meeting minutes of the board of directors (or committee thereof) for evidence of discussions and actions taken to mitigate any contagion risks.	Obtain and review parent or holding company financial information (including the Enterprise Risk Report/ORSA if available) for indications of financial solvency or liquidity issues. If significant issues are identified, perform procedures to evaluate the potential solvency impacts. If necessary, notify the financial analyst of the concern and request additional monitoring of the insurer.
Financial Reporting Risks						
The insurer is not properly identifying related-party activities.	OP ST	AC VA PD CM CO	RPHCC	The insurer maintains a list of all related parties — including pension funds and other trusts established for employees, major borrowers and lenders, and significant agents, brokers, producers and providers — that is approved by management	Obtain the related-party listing and verify/assess the method management uses to ensure completeness and utilization of the list. Review updates to the related party listing to	Perform procedures to identify related parties such as: • Reviewing minutes • Reviewing shareholder listings of closely

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
				and provided to key employees. As significant transactions occur, management considers whether new related party relationships have been established which are then added to the list of related parties.	ensure the listing is being properly maintained.	held companies to identify principal shareholders • Reviewing material investment transactions during the period under examination to determine whether they cause another entity to become a related party • Reviewing conflict-of-interest statements obtained by the entity from management and directors. Prepare a list of entities and/or persons that appear to be related parties and compare to management's listing, if one exists. Ask management about the insurer's relationships with these entities and/or persons. Determine whether the entities and/or persons meet the definition of a "related party" under the domiciliary state's insurance code. Review accounting records for large, unusual or non-recurring transactions or balances, paying particular

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
						attention to transactions recognized at or near the end of the accounting period, which may indicate transactions with related parties that should be disclosed.
The insurer is not properly recording and disclosing related-party activities.	OP ST	AC VA PD CM CO	RPHCC	For identified related parties, the insurer maintains records (e.g. consolidated schedule of intercompany allocations, balances, etc.) so that individual allocations and balances are easily identifiable and amounts that have been offset are identifiable. The insurer has procedures, including supervisory review, in place to ensure that all related-party activities are properly disclosed and reported. Management reviews contract terms periodically to ensure that they are reasonable and properly reflect current operations.. The insurer has a process	Verify that a review of intercompany balances is performed. Consider whether service transactions are occurring but are not being given accounting recognition, such as receiving or providing accounting, management or other services at no charge to a related party. Determine the materiality of such transactions and the impact on the insurer. Review the procedures to ensure that related party activities are properly disclosed, reported and reviewed by supervisory personnel. Verify that contracts are periodically reviewed and updated for changes in operations. Review a sample of past	For a sample of identified related parties, review transactions to ensure they are being properly reported and disclosed. Review all other related-party disclosures for reasonableness.* Confirm whether the related-party relationship is disclosed in the insurer's holding company registration statement. Review the insurer's transactions with the suspected related party and determine whether the transactions are subject to any prior approval requirements in the domiciliary state's insurance code. Review the contracted transactions with affiliates and determine whether they are at arm's length and properly reported as economic or non-economic, in accordance with SSAP No. 25.

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
				that identifies transactions that are subject to regulator approval and ensures that transactions are approved as appropriate. The insurer has a policy in place that requires written approval from the board of directors (or committee thereof) prior to entering into any loan transaction (lending or borrowing), or guarantees (parental/affiliated surplus support or loan repayment/collateralization) to ensure that transactions meet "fair and reasonable" and "arm's-length" standards.	transactions to confirm management's process was executed, as appropriate. Review meeting minutes of the board of directors (or committee thereof) for evidence of written approval of related-party loans or guarantees.	Obtain the loan document(s) or written guarantee and verify that the terms of the contract are equitable and reasonable. Verify the guarantee or loan was properly disclosed in the annual financial statement and filed with the domiciliary state insurance department, if applicable.
The insurer engages in transactions and service agreements with affiliates that have inequitable terms.	OP ST	CM AC VA	RPHCC	Management reviews related-party transactions ~~agreements~~ to ensure ~~that all agreements~~they are at arm's length and properly reported as economic or non-economic. Management reviews affiliated service agreements to ensure the terms of the agreement are fair and reasonable. The insurer maintains written contracts for significant transactions (expense allocations, tax-sharing agreements, etc.)	Obtain evidence of management's review of related-party transactions and/or affiliated service agreements, as applicable. Obtain and review the significant contracts between the insurer and its affiliates. Verify that the insurer reviews the	Select a sample of related party ~~agreements and~~ transactions for review to verify the ~~agreements~~ transactions are consummated at arm's length and ~~the transactions~~ are in accordance with the agreements. If the related party transaction is not at arm's length, verify that the transaction is appropriately accounted for as non-economic. Select a sample of affiliated service agreements and perform procedures to ensure the

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
				with related parties that are reviewed to ensure fair and reasonable terms and are approved by the board of directors (or committee thereof) or other appropriate personnel. Management reviews contract terms and actual transactions periodically to ensure that they are reasonable and properly reflect current operations and are in compliance with related party agreements. Management is subject to specific authority limits regarding the ability to execute affiliated agreements Management documents its rationale and maintains supporting documentation (i.e., a third-party quote, third-party opinion, etc.) for the rate utilized in the affiliated agreement.	agreements to ensure fair and reasonable terms and approval by the board of directors (or committee thereof) or other appropriate personnel. Verify that contracts are periodically reviewed and updated for changes in operations. Test the controls in place to ensure that affiliated agreements are executed in accordance with documented authority limits. Obtain the company's supporting documentation and evaluate the appropriateness of the rate used.	terms are fair and reasonable, such as: • Obtain support from the affiliated service provider to evaluate the reasonableness of the service provider's profit margin on services rendered. • Obtain a sample of related party /affiliated contracts and compare the terms to unaffiliated contracts. Inquire of any material differences. —Obtain a third-party quote or access benchmarking data (if available) for similar services and compare to the rate utilized in the affiliated service agreement.
Intercompany allocation of general and administrative expenses among affiliates is inappropriate.	OP	VA PD CO	RPHCC	Management reviews ~~cost allocation~~ contracts with affiliates ~~-~~to ensure that the basis for expense allocation is fair and reasonable. Expenses to be allocated are	Review the insurer's expense allocation worksheets and supporting documentation to determine whether the	Test the insurer's calculation of material expense allocation for compliance with the terms of the contract. Reconcile amounts to the general

Identified Risk	Branded Risk	Exam Asrt.	Critical Risk	Possible Controls	Possible Test of Controls	Possible Detail Tests
				identified and reasonable metrics are defined, developed and used for each type of expense. Management also reviews the basis of allocation periodically to ensure that it is still reasonable and properly reflects current operations.	method of allocation follows the contract and is reasonable. Inquire with management regarding changes in operations that might affect expense allocation and verify that those changes are properly reflected.	ledger and Underwriting & Investment Exhibit, Part 3, and trace to receipt or payment documentation as applicable.
Intercompany allocation of tax expenses among affiliates is inappropriate.	OP	AC CO OB/OW CM	RPHCC	The insurer has a policy in place to disclose the names of the entities with whom the entity's tax return is consolidated, in accordance with statutory accounting principles (SAP) and applicable tax law. The insurer maintains a written agreement, approved by its board of directors (or committee thereof) that sets forth the manner in which the total combined tax is allocable to each consolidated entity.	Review the insurer's process to accumulate and disclose entities with which a consolidated tax return is filed. Review the written agreement and verify approval by the board of directors (or committee thereof) and the domiciliary state insurance department.	Review the insurer's allocation methodology for appropriateness and verify the accuracy of the allocation. Verify that tax-related intercompany balances are settled in accordance with written agreements.

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EXHIBIT D
PLANNING MEETING WITH THE FINANCIAL ANALYST

Overview

This document is intended as an optional tool highlighting items that may be discussed during a planning meeting with the assigned financial analyst in support of the financial exam process. This meeting should ensure that the examiner both understands the company that will be examined and also receives details on work that has already been performed in supervising the company's operations. An effective exchange of information will promote efficiencies in the financial examination process by allowing the examiner to leverage the knowledge and work performed by the financial analyst. It may also prove useful to supplement this meeting with a discussion of the Exam Planning Questionnaire (Exhibit B) so that the analyst can review during the discussion to highlight or indicate if a document being requested has been obtained and/or reviewed by the department. Although this exhibit focuses on discussions with the assigned analyst, it may be appropriate to incorporate this discussion into a broader planning meeting with members of department management and representatives from other areas of the department. However, if such an approach is taken, it should not reduce or diminish the level of discussion between the analyst and the examiner.

Given the importance of the Insurer Profile Summary (IPS) in communicating the results of the Department's Financial Analyst's review of the company's operations, the planning meeting with the analyst is intended to generally follow the format of the IPS Template.

Depending on the significance of operations at the group level, the examiner should consider whether additional agenda items should be added to focus on risks posed and discussed on the Group Profile Summary that are relevant for consideration during the examination.

NOTE: The exhibit was prepared to assist examiners in obtaining a general knowledge of the company through the meeting with the analyst. The examiner leading the discussion should not rely exclusively on these topics and should tailor agenda items based on knowledge of the company and based on knowledge of work that has been performed by the department.

Planning Meeting with the Financial Analyst – Agenda Items

1. **Business Summary** – Discuss a summary of the business operations and lines of business of the insurer.
    a. Discuss whether the department has received a recent business plan from the company and has identified any significant changes in strategy/operations.
    b. Discuss any recent meetings with the company and their potential impact on the examination.
    c. Discuss the corporate governance in place at the company and any recent changes or concerns identified.

2. **Regulatory Actions** – Discuss any significant recent steps taken in supervising the company, including, but not limited to:
    a. Granting of permitted practices;
    b. Identification of issues of non-compliance;
    c. Follow-up on items from the last financial examination;
    d. Review of items filed with the department for approval and the need to verify or reevaluate approvals during the exam (e.g. – Form A, Form D, Form E, etc.); and
    e. Recent or pending regulatory actions (such as forfeitures, cease & desist orders, or restrictions on the company's writings or operations).

3. **Financial Snapshot/Overview of Financial Position** – Discuss the company's recent financial results, including, but not limited to:
    a. Changes in profitability trends;
    b. Deterioration in asset quality, liquidity, or capital adequacy;
    c. Changes in investment holdings and strategy;
    d. Changes in key annual statement balances;
    e. Changes in reinsurance balances and program structure;
    f. Significant results noted in financial analysis solvency tools; and
    g. Deterioration in reserve development trend.

4. **Branded Risk Assessments** – Discuss individual branded risk assessments with a focus on moderate and significant areas of concern. For example:
    a. Discuss a summary of detailed analysis work performed to address key issues.
    b. Discuss the status of any outstanding inquiries or requests for the company.
    c. Discuss any management representations to the department that should be verified or corroborated during the exam.
    d. Discuss any recommended exam procedures and/or follow-up on key issues.
    e. Discuss any risks assessed as "minor" which appear to be escalating.

5. **Impact of Holding Company on Insurer** – Discuss the impact of the holding company system on the domestic insurer. For example:
    a. Discuss and obtain the Group Profile Summary and non-lead state holding company analysis work as necessary.
    b. Discuss whether the analyst's review of the Corporate Governance Annual Disclosure, ORSA Summary Report and/or Form F reporting indicate a need for additional follow-up and review during the exam.
    c. Discuss any developments or follow-up items resulting from recent supervisory college sessions.

6. **Overall Conclusion and Priority Rating** – Discuss the analyst's overall conclusion on the company's financial condition, strengths, weaknesses and priority rating assigned to the company.

7. **Supervisory Plan** – Discuss the analyst's plans for the ongoing supervision of the company, including any specific examination procedures identified.

8. **Access to Workpapers and Company Documents –** Discuss the best way that the analyst's work can be reviewed/obtained. As the number of files that examiners wish to review and obtain increases, they may consider obtaining access the analyst's workpapers and receiving specific locations (i.e. workpaper references) for all requested documents.

9. **Input from Other Areas of the Department** – Discuss whether the analyst has received recent communications from other areas of the insurance department regarding issues that could impact the financial examination including, but not limited to units in charge of:
    a. Approving rates and forms filings;
    b. Legal and administrative matters; and
    c. Market conduct examinations/filings.

10. **General Observations** – Depending on the information already provided, determine whether there are any additional topics relevant for discussion, such as:
    a. If you were going onsite to examine this company, where would you focus your time?
    b. What are your biggest concerns in terms of things that could go wrong at this company to result in a solvency concern?
    c. Are you aware of any fraud allegations or concerns at the company? Are there any fraud risk factors that the exam team should be aware of?

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