Financial Analysis Solvency Tools (E) Working Group
Exposure Drafts


Exposure Draft and Comment Periods:

- **30-Day Comment Period (Ending August 15, 2024):**
  
  This comment period applies to the attached documents (listed below by topic), which are available in Word format upon request. Please submit comments related to these revisions to Rodney Good ([RGood@naic.org](mailto:RGood@naic.org)) or Ralph Villegas ([RVillegas@naic.org](mailto:RVillegas@naic.org)).

  - Complex Ownership Structures (Pages 2-22)
  - Property/Casualty Catastrophe Reinsurance Program (Pages 23-40)
  - ORSA Guidance and Form F Exemptions (Pages 41-54)
  - Pricing/Underwriting Risks of Health Insurers (Page 55)

- **45-Day Comment Period (Ending August 30, 2024):**
  
  This comment period applies to the *Draft Sample Revisions to the Credit Risk Repositories and Analyst Reference Guide*. Please note that both a clean and edited version of these documents are posted separately. Submit comments to Jane Koenigsman ([JKoenigsman@naic.org](mailto:JKoenigsman@naic.org)).
V.B. Domestic and/or Non-Lead State Analysis – Form A Procedures

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

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

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

Initial Review

1. Determine if the filing is complete, note the missing items and promptly send a deficiency letter to the Applicant. A filing may not be considered complete and active until all relevant information has been received. Enter any changes to the status of the filing or other data elements into the NAIC Form A database within 10 days of receipt of the Form A. Data and information should be entered by the state’s designated person.
   a. Identify attorneys, party contacts (all stakeholders), and other insurance regulators reviewing the Form A, including the lead regulator.
   b. Assign appropriate analyst, legal, and other professional staff to conduct regulatory review.
   c. Carefully consider whether regulatory review can be completed by Applicant’s target close date, including any interim deadlines and obtain deemer extension or waiver if appropriate.
   d. Schedule and notice hearing/consolidated hearing, if applicable, within statutory timeframes.
   e. Review the NAIC Form A database to determine whether the current Form A is pending or has been approved, denied, or withdrawn in another state. Assess any reasons noted for denial and document any risks or concerns.

2. Establish contacts with other states and regulators to discuss the status and/or disposition of the current and prior filings made with those states. Where multiple jurisdictions are involved, coordination of information between the states and functional regulators should be initiated by the lead states(s). Perform the following steps:
   a. The domestic state should notify the lead state regulator of the holding company group of any merger or acquisition of a domestic insurer in the group.
   b. The lead regulator should obtain key contact information from each state reviewing the Form A and consider organizing a regulator to regulator call to discuss concerns with the filing.
   c. Create a contact list of relevant persons and representatives.
   d. Separate confidential and public documents, information, and communications and maintain as appropriate.
   e. Contact and collaborate with other reviewing regulators involved in the review process, as appropriate, including the lead state regulator regarding ORSA and ERM reviews.
   f. As applicable, contact other regulators of noninsurance entities of the acquiring party or target.
   g. Based on the nature and materiality of the transaction, the lead state and domestic state(s) should regularly communicate with all states and other functional regulators, as necessary throughout the filing
review process, to provide updates on the transaction, states’ reviews, and to share feedback between regulators.

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

Compliance Assessment and Review

Transaction Details

3. Review details provided on the transaction for compliance with application filing requirements by determining whether the Form A application provides the required content, which may include the following:

a. Provides a brief description of how control is to be acquired.

b. Contains the following information:
   - Name and address (legal residence for an individual or street address if not an individual) of the applicant
   - States the nature of the applicant’s business operations for the past five years, if the applicant is not an individual
   - Describes the business to be performed by the applicant and its subsidiaries
   - Identifies and states the relationship of every member of the insurance holding company system on the organizational chart

c. Contains the required signature and certification, and include copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and of additional soliciting material relating thereto.

d. Contains any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by the Form A.

e. Contains an agreement to provide the information required by Form F – Enterprise Risk Report within the required timeframe.

f. Includes the number of each class of shares of the insurer’s voting securities that the applicant, its affiliates, and any person that plans to acquire; 2) the terms of the offer, request, invitation, agreement, or acquisition; and 3) the method by which the fairness of the proposal was determined.

g. States the amount of each class of any voting security of the insurer that is beneficially owned or concerning that there is a right to acquire beneficial ownership by the applicant, its affiliates, or any person.

h. Gives a full description of any contracts, arrangements, or understandings with respect to any voting security of the insurer in which the applicant, its affiliates, or any person is involved. Discussion includes, but is not limited to, the transfer of any of the securities, joint ventures, loan or option agreements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies.

4. Perform analysis review considerations, in addition to the compliance review in #3 as necessary, to analyze the details of the transaction, which may include, but is not limited to the following:
a. Document any risks or concerns by carefully reviewing transactional documents (e.g., merger, stock purchase, stock exchange).
   i. Consider disposition of all classes of target shares, including addressment of any beneficial owners.
   ii. Ascertain propriety of disposition of minority interests and concerns, if applicable.

b. Consider any affiliate or employee benefit as appropriate.

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

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

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

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

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

h. Determine if after the change of control:
   i. The insurer will be able to satisfy the requirements for the issuance of a license to write the classes of insurance for which it is presently licensed.
   ii. The insurer’s surplus will be reasonable in relation to its outstanding liabilities and adequate for its financial needs.

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

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

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

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

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

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

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

p. Consider with disfavor any plans to liquidate the target or sell its assets, consolidate or merge, that may be unfair, unreasonable, or hazardous to policyholders.
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q. Review required statutory deposits and authorized lines of business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. For structures with complex or unique share classes and voting carefully review the voting and non-voting share classes rights and agreements to determine who has rights to control and vote to make decisions.
3. Request and review corresponding investment, management or operational agreements as necessary to determine if any delegate control or decision making to another specific person or entity.

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

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

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

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

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

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

gh. Review and assess the UCP’s ability to provide future capital support to the insurer, if needed.

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

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

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

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

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

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

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

Purchase Consideration

7-8. Analyze the source, nature, and amount of consideration used (or to be used) in effecting the merger or acquisition of control and assess the ability of the entity to fund the insurance company.
a. Determine fairness (equivalency) of total amount to be paid to total value to be received, including derivation of price and value of target under standard valuation methodologies or to book value.

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

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

d. Consider source, type and valuation basis of funds to be used for consideration.
   i. If funds are from a regulated entity, confirm the existence and valuation of such assets with that entity’s regulator.

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

f. Review dividend expectations and projections, including amounts expected to be paid from the insurer to the owner.
   i. Will dividends from the insurer be required to support debt payments of the applicant or the applicant’s subsidiaries?

8-9. If amounts will be borrowed, consider the following:

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

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

c. Does the Form A:
   i. Describe any purchases of any voting securities of the insurer by the applicant, its affiliates, or any person during the 12 calendar months preceding the filing of the Form A.
   ii. Describe any recommendations to purchase any voting securities of the insurer made by the applicant, its affiliates, or any person—or by anyone, based on interviews or the suggestion of the applicant, its affiliates or any person—during the 12 calendar months preceding the filing of the Form A.
   iii. Describe the terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions, or other compensation to be paid to broker-dealers.

d. Perform additional review considerations as necessary to analyze the purchase conditions and implications of any debt financing, which may include, but is not limited to the following:
   i. The mechanics of any debt financing to be used to fund the transaction, whether funds are being borrowed in the ordinary course of business or on terms that are less favorable than generally commercial loans.
   ii. The percentage of debt versus non-debt funds to be used.
   iii. The source of funds or stream of income to be used by parent for repayment and the ability of the acquiring party to repay the debt from sources other than the target.
iv. Identity of the creditor(s) and creditors’ financial condition.

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

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

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

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

### Market Impact

9-10. Is the acquisition of control likely to lessen competition substantially or likely to lead to a monopoly in insurance in the state? If “yes,” has a Form E been filed?

10-11. Perform additional review considerations to analyze market impact, which may include, but is not limited to the following:

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

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

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

### Record Maintenance and Conclusion

11-12. Respond as appropriate to questions from third parties and interested regulators and keep the acquiring party representatives informed as to status of the review.

12-13. Receive and consider any information provided by external sources, including possible financial or other incentives or motivation of those commenting on a particular transaction.

   - File and maintain documents under state procedures

13-14. Has the application been publicized to all interested persons inside and outside of the insurance department, in accordance with the department’s policy or applicable laws?

14-15. Perform any additional procedures, as deemed relevant, to evaluate the Form A application in accordance with the specific circumstances identified, which may include, but is not limited to, the following:

   - Contact the insurer seeking explanations or additional information

   - Obtain the insurer’s business plan

   - Meet with the insurer’s management

15-16. Develop and document an overall summary and conclusion regarding the holding company Form A application.
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- If application approval is deemed appropriate, consider whether any conditions precedent, specific ongoing stipulations or conditions subsequent should be included with the approval.

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

Post-Approval

Post-Approval Considerations (if applicable)

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

18-19. Confirm compliance with conditions precedent.

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

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

Post-Acquisition Considerations

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

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

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

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

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

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

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

- Conduct a target financial and/or market conduct examination
- Hold a meeting, conference call or requesting additional information from the insurer or applicant
- Require additional interim reporting from the insurer
- Obtain a corrective plan from the insurer

Post-Closing Monitoring:

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

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

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

32. Review of subsequent Board minutes.

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

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

Summary and Conclusion

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

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

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

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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

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

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

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

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

Form B – Insurance Holding Company System Annual Registration Statement

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

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

Form D – Prior Notice of a Transaction

Model #440 requires each insurer to give notice of certain proposed transactions. Form D must be filed with the domestic state. Material transactions include but are not limited to sales, purchases, exchanges, loans, extensions of credit, guarantees, investments, reinsurance, management agreements, service agreements and cost-sharing agreements. The transaction is considered material if for non-life insurers, it is the lesser of 3% of the insurer’s admitted assets or 25% of surplus, and for life insurers, 3% of the insurer’s admitted assets, each as of the most recent prior Dec. 31. Some states have stricter definitions of materiality in their holding company regulations.

Holding company regulations require that affiliated transactions be fair and reasonable to the interests of the insurer. Generally, affiliated management or service agreements should be based on actual cost in order to meet the fair and reasonable standard.
The appropriate Statement of Statutory Accounting Principle should be reviewed within the NAIC *Accounting Practices and Procedures Manual* to ensure proper accounting.

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

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

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

**Extraordinary Dividend/Distribution**

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

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

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

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

**Determination of the Ultimate Controlling Person (UCP)**

*For all ownership structures, when reviewing Form A applications, it is most important for the analyst to understand the terms of the ownership documents, whether traditional stock ownership or other unique or complex ownerships structures such as trusts, limited partnerships, limited liability corporations, international owners, or structures with unique share classes and voting rights. Certain agreements within the structure may convey control through unique share classes and voting rights, or through certain management or operational agreements that delegate decision making and control to a specific person or entity. For all of these structures and unique situations, it is important to identify an individual ultimate controlling person (UCP) at the top of the organizational structure, i.e., to trace the ownership/control to the top person/entity. It is at the UCP level that financial statements and other insurance holding company filings will be submitted to the department, required to be submitted to the department, although other controlling entities (e.g., minority owners) may also be asked to provide such information when appropriate.*
The state insurance department should engage the state’s legal staff and other necessary internal or external expertise early in the Form A review process to assist in the review of organizational documents and agreements and in the determination of the UCP.

**Review Procedures**

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

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

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

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

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

**PROCEDURES #124-176** provides steps for completion of the approval or denial of the Form A application and developing an overall conclusion regarding the Form A.

**POST-APPROVAL PROCEDURES #187-2834** provide administrative steps for the conclusion of the Form A approval process as well as analytical steps for post-acquisition financial solvency analysis and compliance review. It is important for the department to conduct follow-up analysis and/or examination to ensure that stipulations or conditions of the acquisition approval have been met, that actual results are in line with the financial projections, business operations and strategy of the insurer that were provided with the Form A, and if not, to understand the reasons for variances.

**General Statutory Standards and Risk Assessment for Form A Review**

When performing the procedures listed above, it is appropriate to first consider the general statutory standards that regulators must apply in consideration of a Form A, namely that:
The financial stability of the insurer would not be jeopardized
Policyholders will not be prejudiced
The acquiring party’s future plans are not unfair and unreasonable to policyholders
The transaction is not likely to be hazardous or prejudicial to the insurance-buying public

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

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

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

**Non Insurance Affiliate Risks:** More often, the risks that may be most difficult to discern are those that may exist within non-insurance affiliates because such entities may be unregulated, thereby eliminating the ability to obtain information from another regulator as can be done with insurers. Generally speaking, such non-insurance affiliates will not carry pricing and underwriting and reserving risks because those risks tend to be thought of as insurance risks. Those affiliates may however have other comparable risks, (or unrelated risks) that may be evident from a review of the proforma information. In particular, something that may not be captured in the proforma information is the other types of risks not already discussed which include or pertains to credit, market and liquidity. For some non-insurance affiliates, these risks can be more pronounced, or at least by comparison to the relative risk from the insurers within the group because state investment laws may serve as a deterrent to
excessive amounts of such risks. Consequently, in addition to considering the information provided in proforma financial statements and even stressed proforma financial statements, analysts may need to obtain additional information in order to evaluate whether the proposed transaction meets the four previously identified general standards. In order to evaluate credit, market and liquidity risks, analysts should evaluate the potential enterprise risks posed to the insurer from other non-insurance affiliates, and may need to request information regarding the investment portfolio of the entire group. In all cases where information is sought relating to non-insurance affiliates, controlling individuals and other equity holders, care should be taken to ensure that confidentiality of such information can be appropriately protected.

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

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

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

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

Conditions and Stipulations for Form A Approval

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

Stipulations for limited period of time:
V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

- Requiring RBC to be maintained at a specified amount above company action level/trend test level. Because capital serves as a buffer that insurers use to absorb unexpected losses and financial shocks, this would better protect policyholders.

- Requiring quarterly RBC reports rather than annual reports as otherwise required by state law.

- Prohibiting the insurer from paying any ordinary or extraordinary dividends or other distributions to shareholders unless approved by the Commissioner.

- Requiring a capital maintenance agreement from or establishment of a prefunded trust account by the acquiring entity or appropriate holding company within the group.

- Enhancing the scrutiny of operations, dividends, investments, and reinsurance by requiring material changes in plans of operation to be filed with the commissioner (including revised projections), which, at a minimum, would include affiliated/related party investments, dividends, or reinsurance transactions to be approved prior to such change.

- Requiring a plan to be submitted by the group that allows all affiliated agreements and affiliated investments to be reviewed, despite being below any materiality thresholds otherwise required by state law. A review of agreements between the insurer and affiliated entities may be particularly helpful to verify there are no cost-sharing agreements that are abusive to policyholder funds.

Continuing stipulations:

- Requiring prior Commissioner approval of material arms-length, non-affiliated reinsurance treaties or risk-sharing agreements.

- Requiring notification within 30 days of any change in directors, executive officers or managers, or individuals in similar capacities of controlling entities, and biographical affidavits and such other information as shall reasonably be required by the commissioner.

- Requiring the filing of additional information regarding the corporate structure, controlling individuals, and other operations of the company.

- Requiring the filing of any offering memoranda, private placement memoranda, any investor disclosure statements or any other investor solicitation materials that were used related to the acquisition of control or the funding of such acquisition.

- Requiring disclosure of equity holders (both economic and voting) in all intermediate holding companies from the insurance company up to the ultimate controlling person or individual, but considering the burden on the acquiring party against the benefit to be received by the disclosure.

- Requiring the filing of audit reports/financial statements of each equity holder of all intermediate holding companies, but considering the burden on the acquiring party against the benefit to be received by the disclosure.

- Requiring the filing of personal financial statements for each controlling person or entity of the insurance company and the intermediate holding companies up to the ultimate controlling person or company. Controlling person could include for example, a person who has a management agreement with an intermediate holding company.

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

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

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

- Examining the insurer and its affiliates to ensure that the investment strategy provides a prudent approach for investing policyholder funds or does not create excessive contagion risk.

- Requiring ongoing annual stress testing of the insurer and the group in accordance with existing laws and regulations. This includes stress testing not only the investments but also the policyholder liabilities to ensure that the assets and liabilities continue to be properly matched.

- Conducting periodic and possible ongoing review of the investment management and other affiliated agreements, including a review of the equity firm fees and fee structure charged or to be charged to the insurer, if any, as well as arrangements with intercompany broker to ensure that they continue to be fair and reasonable. Also examine the flow of funds related to such agreements.

- Coordinating a meeting with multiple regulators and even all states to the extent there is a need for all regulators to better understand the business plan and operations of the group.

- Coordinating an examination with another regulator of a non-affiliated insurer where the direct writer has ceded a material portion of its risk to a separately controlled insurer.

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

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

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

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

The lead state(s) or designee should schedule regular conference calls or arrange for regular e-mail communications, as deemed necessary, to receive and share status updates from each regulator involved. As many states have strict timeframes within which to complete reviews and schedule hearings, the frequency of
conference calls and other communication will depend on the timelines of the particular states involved and the sensitivity of the transaction. Additionally, regulators can share comments regarding a filing in the Form A Database. The lead state(s) or designee should compile questions and issues identified by all domestics, licensed states and functional regulators in an unbiased manner in order to coordinate the resolution of the answers to the applicable parties and reduce duplicative requests.

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

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

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

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

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

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

### Acquisitions of Control Exemption

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

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

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

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

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

### Standards of Management of an Insurer Within a Holding Company System

#### Form A Exemptions

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

**Reputational Risk – Market Disruption Regarding 10% Investor Limitation**

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

**Best Practices**

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

**Operational Risk – Ability to Influence Management and Policy Decisions**

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

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

- Board governance should be reviewed.

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

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

Best Practice

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

Disclaimer of Control/Affiliation

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

Consideration should be given to situations where a disclaiming party may exert influence or control over the insurer such as: over management decisions, or the operations of the insurer; where there is a minority owner; where lending agreements may result in ownership of the insurer in the event of default; where non-voting shareholders have protective rights affording them the opportunity to acquire control in certain circumstances; any non-voting arrangement or contract that may convey an element of control (e.g., investment management, reinsurance, administrative service, employment); or passive investment companies with more than 10% ownership of voting shares within funds they manage, where the actions and activities do not support that the investment company’s assertion that it does not exert control.

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

Best Practices

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

- Monitor annual financial statements for minority ownership and disclaimer disclosures in Schedule Y, Part 3.

- If the disclaimer approval includes stipulations or conditions, consider the following:
  - In situations where ownership percentages may fluctuate, require a condition whereby the disclaiming party must reapply for the disclaimer if the percentage ownership exceeds a specified percentage.
In situations such as reinsurance side car or other similar arrangements where a third party appears to have influence through operational management, investment management or other agreements (e.g., the disclaimer is requested for tax purposes):

- As part of the approval of the disclaimer, require the service agreements between the domestic insurer and the third party be submitted for Department approval (not including all holding company filings).

**Inquiries to the Applicant**

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

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

**Post-Disclaimer Considerations**

- Additional disclosure requirements may be requested on an ongoing basis which may be part of the disclaimer approval.
- Review and monitor the Financial Statement for minority owner and disclaimer disclosures to make sure they are reporting Schedule Y Part 3 correctly.
- Consider if the disclaimer has an impact on who is designated the lead state for the group and therefore which state will perform holding company analysis in the future.
- The disclaiming person/entity should:
  - Provide notice before taking action on any of the rights and privileges of the non-voting shares.
  - Provide notice before transferring non-voting shares.
  - Provide notice before taking any position at the insurer or its affiliates.
  - If the facts and circumstances for which the approval of the disclaimer was based on change, they must notify the state insurance regulator.
V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

- Perform a review of annual statement related party disclosures (e.g., Schedule Y, Notes to the Financials, and the electronic column of the investment schedules) to ensure that despite the approval of a disclaimer of affiliation, the insurer is correctly reporting any disclaimed party as a related party for material transactions pursuant to SSAP No. 25.
### Pricing/Underwriting Risk: Pricing and underwriting practices are inadequate to provide for risks assumed.

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

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

### Underwriting Performance

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

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

<table>
<thead>
<tr>
<th>Other Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>g. Review the five-year trend with the Financial Profile Report and/or the Management Discussion and Analysis (MD&amp;A), for the following measures of operating performance, and note any unusual fluctuations, events (e.g., catastrophes) or trends between years for each ratio:</td>
</tr>
<tr>
<td>• Loss ratios for direct, assumed and ceded business</td>
</tr>
<tr>
<td>• Incurred loss and LAE by line of business</td>
</tr>
<tr>
<td>h. Compare, by line of business, the pure net loss ratio to the industry averages in the Financial Profile Report to determine any significant deviations.</td>
</tr>
<tr>
<td>i. Review each line of business included in the Annual Financial Statement, Schedule P, for trends in accident year loss ratios, on both a gross and net basis, that may indicate a deterioration in underwriting results.</td>
</tr>
<tr>
<td>j. If concerns exist regarding underwriting results, consider the following procedures:</td>
</tr>
<tr>
<td>i. Request and review additional information from the insurer on the causes of poor underwriting performance.</td>
</tr>
<tr>
<td>ii. Request, review, and evaluate information from the insurer regarding its plans to address poor underwriting performance (e.g., tightening underwriting standards, rate</td>
</tr>
</tbody>
</table>
## III.B.6.a. Pricing/Underwriting Risk Repository – P/C Annual

### Changes, etc.:

- **Inquire of the rates and forms unit of the state insurance department (if appropriate) to gain an understanding of work performed to evaluate rate adequacy.**

- **Review the write-ins for underwriting deductions in the Annual Financial Statement, Statement of Income and the Financial Profile Report and note any unusual fluctuations or trends.**

### Premium Production, Concentration and Writings Leverage

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

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

### Other Risks

i. **If significant changes in premium volume are identified, consider the following procedures:**

   - **Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume.**
   - **Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.**

j. **Review, by line of business, premiums written by year in the Financial Profile Report for shifts in the mix of business between years and to gain an understanding of lines of business written.**

k. **Determine whether the insurer has material exposure to losses resulting from acts of terrorism. If concerns are identified, consider the following procedures:**

   - **Request additional data/information from the insurer to gain an understanding of its exposure to terrorism risk.**
   - **If the insurer is subject to ORSA reporting, review information provided on terrorism exposure and risk assessment in the ORSA Summary Report or obtain the lead state's**

<table>
<thead>
<tr>
<th>Review (if applicable).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>iii.</strong> Gain an understanding of the insurer’s mitigation of terrorism risk through TRIA coverage.</td>
</tr>
<tr>
<td><strong>iv.</strong> Assess the reasonableness of the ultimate exposure based on the insurer’s business strategy and capital position.</td>
</tr>
<tr>
<td><strong>v.</strong> Consider the reasonableness of the insurer’s plan to limit exposures, such as policy limits, policy exclusions, location of risks, pricing modifications, non-renewal of certain policies, plans for diversification, or other risk mitigation strategies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>l. Review the Five-Year Historical Data of the Annual Financial Statement. Has there been a shift in the mix of gross premiums written or net premiums written from property lines to liability lines within the past five years? If so, evaluate the underwriting/marketing strategy of the insurer and its expertise in writing liability lines of business.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>m.</strong> Review Annual Financial Statement, Schedule T for new direct business written in any state where the insurer is not licensed and verify that the insurer is authorized to write all lines of business written.</td>
</tr>
<tr>
<td><strong>n.</strong> Review Annual Financial Statement, Schedule T and the writings section in the Financial Profile Report to evaluate the top states in terms of direct premiums and the percentage of total DPW in those states. Based on the lines of business written, determine whether large concentrations of premiums are written in areas prone to catastrophic events.</td>
</tr>
<tr>
<td><strong>o.</strong> Is the company diversified in terms of product lines and geographical exposure? If not, request and review information from the insurer regarding mitigation strategies to limit exposure concentrations.</td>
</tr>
<tr>
<td><strong>p.</strong> Review the insurer’s underwriting/marketing strategy included in its business plan.</td>
</tr>
<tr>
<td><strong>i.</strong> If 2.e is “yes,” evaluate the insurer’s marketing and expansion plans in that state.</td>
</tr>
<tr>
<td><strong>ii.</strong> Is the insurer planning expansion into new states or premium growth in the future?</td>
</tr>
<tr>
<td><strong>iii.</strong> Has the insurer applied for or received new licenses in other states?</td>
</tr>
<tr>
<td><strong>iv.</strong> Has the insurer reported that it has ceased writing new business, a line of business or writing in a certain geographical location?</td>
</tr>
<tr>
<td><strong>v.</strong> Does the insurer have closed block operations?</td>
</tr>
<tr>
<td><strong>vi.</strong> Does the insurer’s marketing strategy and projected premium growth match actual results reported in the current period? If materially different, evaluate the reasons why, or ask the insurer for an explanation.</td>
</tr>
<tr>
<td><strong>q.</strong> Determine whether the insurer has expertise (e.g., distribution network, underwriting, claims, and reserving) in the lines of business written. Consider reviewing the insurer’s MD&amp;A, business plan and/or additional information from the insurer to determine the expertise in the lines of business written.</td>
</tr>
<tr>
<td><strong>r.</strong> Review the insurer’s gross and net writings leverage positions to assist in evaluating risk exposure. Consider the following specific procedures in this area:</td>
</tr>
<tr>
<td><strong>i.</strong> Compare the gross writings leverage and net writings leverage ratios to the industry averages and determine any significant variances.</td>
</tr>
<tr>
<td><strong>ii.</strong> If the insurer is a member of a group, compute the gross premiums written to surplus ratio and the net premiums written to surplus ratio on a consolidated basis to...</td>
</tr>
</tbody>
</table>
determine if the group appears to be excessively leveraged.

iii. Obtain an explanation from the insurer for unusual results for P/C IRIS ratios #1 and #2.

### Exposure to Catastrophic Events

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

<table>
<thead>
<tr>
<th>a. Review Annual Financial Statement, Schedule T and the writings section in the Financial Profile Report (or the Mix of Business Dashboard) to evaluate the top states in terms of direct premiums and the percentage of total DPW in those states. Based on the lines of business written, determine whether there is a material concentration of premiums written in areas prone to catastrophic events.</th>
<th>Other Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
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</table>

<table>
<thead>
<tr>
<th>b. Review information provided by the insurer in the RCAT (PR027) section of its Risk Based Capital filing to identify and assess the insurer’s current exposure to catastrophic events at modeled worst year in 50, 100, 250, and 500 levels on both a gross (direct and assumed) and net basis (after reinsurance). Evaluate the potential impact of the company’s modeled loss results on its capital and surplus and RBC position.</th>
<th>Other Risks</th>
</tr>
</thead>
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</table>

<table>
<thead>
<tr>
<th>c. Review the Interrogatory on Catastrophe Risk Reinsurance Program RCAT (PR027) section of the insurer’s Risk Based Capital filing. If necessary, request additional information or clarification from the insurer to gain a comprehensive understanding of its catastrophe reinsurance program and any recent changes in coverage due to market conditions.</th>
<th>Other Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
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</tbody>
</table>

i. Evaluate the adequacy of reinsurance protection; for example, evaluate the impact that multiple, smaller events could have on the insurer’s financial position if they fall below retention levels.

ii. Identify any exclusions in the reinsurance treaties that could leave the insurer exposed to unexpected losses.

iii. Assess the financial strength and creditworthiness of the reinsurers involved. Assess any potential concentration risk where the insurer relies heavily on one reinsurer.

iv. Review the insurer’s claims handling practices for catastrophe events, including factors such as reserving adequacy, loss adjustment expenses, and reinsurance recoveries.

<table>
<thead>
<tr>
<th>c-d. Review information provided in the insurer’s response to the NAIC’s Climate Risk and Disclosure Survey (if available) on its exposure to physical losses impacted by climate change, as well as its related mitigation activity.</th>
<th>Other Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
<td></td>
</tr>
</tbody>
</table>

i. Determine whether any of the company’s responses require further investigation and inquiry.

<table>
<thead>
<tr>
<th>d-e. Review information provided in the ORSA Summary Report and/or SEC 10K or 10Q filings (if available) regarding the insurer’s exposure to physical losses impacted by climate change, as well as its related mitigation activity.</th>
<th>Other Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
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</tbody>
</table>

**e.f. Utilize the information gathered and/or request additional information as necessary to assess the insurer’s exposure to climate/catastrophic risks, as well as processes and strategies in place to limit exposures.**

i. Gain an understanding of how the company incorporates catastrophe modeling results into its underwriting processes (e.g., assessment of risk appetite or determination of net retained risk).

ii. Gain an understanding of and evaluate the potential impact of climate change on the company’s business and underwriting strategy over medium and longer-term time horizons.

iii. Determine whether there are any concerns regarding the company’s risk management processes in regard to climate change, both currently and prospectively.

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

**Inquire of the Insurer:**

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

**Marketing Strategy and Projections**

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

**Underwriting Performance**

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

**Premium Production and Writings Leverage**

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

**Use of CAT Modeling and Exposure Limits in Underwriting**

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

**Own Risk and Solvency Assessment (ORSA) Summary Report:**

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

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

**Holding Company Analysis:**

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

### Example Prospective Risk Considerations

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

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

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

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

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

Discussion of Annual Procedures

Using the Repository

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

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

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

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

ANALYSIS DOCUMENTATION: Results of pricing and underwriting risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the risk assessment analysis should be sufficiently robust to
explain the risks and reflect the strengths and weaknesses of the insurer. Analysts are not expected to respond to procedures, data or benchmark results directly in the repository document.

**Quantitative and Qualitative Data and Procedures – Property & Casualty**

**Underwriting Performance**

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

Key ratios included in assessing underwriting performance are the underwriting expense ratio, net loss ratio and the commissions to direct premium ratio. The procedure includes recommendations to look at Annual Financial Statement, Schedule P and trending on the Financial Profile Report. Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums written may be an indication of an insurer’s entrance into new lines of business or sales territories that might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses. Significant increases in incurred loss ratios may indicate premium pricing errors or reserve strengthening due to prior reserve understatements, whereas significant decreases in incurred loss ratios may be indicative of current reserve redundancies.

**Premium Production, Concentration and Writings Leverage**

**PROCEDURE #2** assists analysts in determining whether concerns exist regarding changes in the volume of premiums written or changes in the insurer’s mix of business. Significant increases or decreases in premiums written may indicate a lack of stability in the insurer’s operations. In addition, a significant increase in premiums written may be an indication of the insurer’s entrance into new lines of business or sales territories, which might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums written might also be an indication that the insurer is engaging in cash flow underwriting. Cash flow underwriting is the practice of writing a significant amount of business in order to invest and earn a greater investment return than the costs associated with potentially underpriced business. Cash flow underwriting can be a serious concern if it is accompanied by a shift in business written from short-tail property lines of business to long-tail liability lines.

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

Within several lines of business and policy types (most notably commercial property), property/casualty insurers may be exposed to losses resulting from acts of terrorism. Following the September 11, 2001, attacks on the New York World Trade Center and the U.S. Pentagon, terrorism coverage became prohibitively expensive, if offered at all. In response, the U.S. Congress passed the Terrorism Risk Insurance Act (TRIA) of 2002. TRIA was initially created as a temporary three-year federal program that required insurers to offer commercial policyholders with terrorism coverage, while allowing the Federal Government to share monetary losses with insurers on commercial property/casualty losses from a terrorist attack. Since then, it has been renewed four times and is due to expire on December 31, 2027. Before this backstop can be accessed, several stipulations and limits are applied, many of which have been adjusted under subsequent extensions of the Act to limit the support available to insurers. Analysts should assess the insurer’s exposure to losses related to acts of terrorism and consider any mitigation by TRIA. Procedure #2 also assists analysts in determining whether the insurer is excessively leveraged due to the
volume of premiums written. Surplus can be considered as underwriting capacity, and the ratios of gross and net writings leverage measure the extent to which that capacity is being utilized and the adequacy of the insurer’s surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross writings leverage ratio result greater than 900% may indicate that the insurer is excessively leveraged, and special attention should be given to the adequacy of the insurer’s reinsurance protection and the quality of the reinsurers. A net writings leverage ratio greater than 300% may also indicate that the insurer is excessively leveraged and lacks sufficient surplus to finance the business currently being written. In evaluating these ratios, analysts should also consider the nature of the insurer’s business. For example, an insurer that has historically written primarily short-tail property lines of business might not be considered excessively leveraged even though it has higher ratio results, because the risk of significant underpricing or adverse underwriting results is less than that of an insurer that writes primarily volatile long-tail liability lines of business such as medical professional liability.

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

**Exposure to Catastrophic Events**

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

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

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

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

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

Underwriting Performance

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

PROCEDURE #2 assists analysts in evaluating the underwriting performance of the Medicare Part D Prescription
Drug coverage. The procedures utilize data in the Annual Financial Statement, Medicare Part D Coverage
Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the
benchmarks, analysts should consider if the insurer writes an enhanced benefit plan that may contain more
exposure to losses. While Medicare business is funded through contracted government rates, risk exists when
utilization and benefit costs exceed that which was anticipated when the contract was made. If the insurer is
reporting unusual results, analysts should consider if any delays in payments from the federal Centers for
Medicare & Medicaid Services (CMS) are affecting results.

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

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

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

Premium Production, Concentration and Writings Leverage

PROCEDURE #5 assists analysts in determining whether concerns exist regarding changes in the volume of
premiums and deposit-type funds or changes in the insurer’s mix of business (lines of business written and/or
geographic location of premium written). Significant increases or decreases in premiums written may indicate a
lack of stability in the insurer’s operations. In addition, a significant increase in premiums written may be an
indication of the insurer’s entrance into new lines of business or sales territories that might result in financial
problems if the insurer does not have expertise in these new lines of business or sales territories. Significant
increases in premiums might also be an indication that the insurer is engaging in cash flow underwriting to increase
cash income in order to cover current benefit payments.
Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums may be an indication of an insurer’s entrance into new lines of business or sales territories which might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses, particularly if the insurer primarily writes A&H insurance.

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

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

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

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

HEALTH: Fluctuations in premium or enrollment may also indicate a reason for concern. Uncontrolled, excessive growth has been found to be one of the major causes of insolvency. If the growth is not accompanied by additional surplus, the capital and surplus may not be able to support the additional exposure. Growth is often times driven by a health entity’s desire for greater market share. Many times, the health entity is able to gain that market share by lowering its prices or setting prices below the rest of the market. This desire for greater market share can lead to considerable underpricing. This underpricing can increase the amount of risk to the health entity for every
dollar of premium written. Additionally, in many cases, the health entity may establish reserves as a percentage of premiums when it enters a new market, which can lead to additional risk. Therefore, if the product is underpriced, it’s possible the reserves may be understated. As a result, growth by a health entity is often associated with underpricing and under reserving, which is a risky combination. In effect, the company may need to establish a greater reserve when unsure about its pricing.

In addition, growth can make administering the operations difficult and can create claims inventory backlogs. A change in premium might also reflect a health entity’s entrance into new lines of business or sales regions. This could result in financial problems if the health entity does not have expertise in these new lines of business or regions. This is particularly true in the health insurance market where margins are traditionally very thin and critical mass is necessary in establishing new provider contracts. Finally, significant increases in premiums might also be an indication that the health entity is attempting to increase cash inflow in order to cover current benefit payments, particularly if the health entity is writing more longer tail insurance (e.g., long-term care).

In cases where premium or enrollment has not significantly changed, analysts should still assess the level of business written by the health entity by comparing premium and risk revenue to capital and surplus. This comparison should include premium and risk revenue recorded by the health entity in its income statement since both sources of revenue represent exposure to the health entity. This type of comparison is generally considered a measure of a health entity’s operating leverage and is important in determining the potential losses to the health entity. The higher the writings ratio, the more likely the health entity will record a material loss when morbidity spikes. For example, if a health entity is writing at a 5 to 1 ratio and reports a combined ratio of 105% (assuming no investment income and no federal income taxes) the health entity would report a 25% decrease in capital and surplus based upon the net loss alone. Therefore, for every $5 in writings at a loss of 5%, surplus would be impacted 5 times greater and incur a 25% loss. If a health entity is writing at a 10 to 1 ratio and reports a combined ratio of 105% (assuming no investment income and no federal income taxes) the health entity would report a 50% decrease in capital and surplus. Therefore, for every $10 in writings at a loss of 5%, surplus would be impacted 10 times greater and incur a 50% loss.

Financial Impact of the Federal Affordable Care Act

PROCEDURE #7A–F assists analysts in reviewing the underwriting gain or loss by line of business and assessing the impact of each line to the insurer’s total operating results and financial solvency. Note that the preliminary medical loss ratio (MLR) included in this supplemental health care exhibit (for any given state) is not the MLR that is used in calculating the federal mandated rebates.

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

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

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

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

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

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

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

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

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

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

Quantitative and Qualitative Data and Procedures – Health

Underwriting Performance

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

If there are concerns, analysts may also consider procedures to assess if one or more of the health entity’s products may be underpriced. Although it may be difficult to determine if any specific products are underpriced, one procedure analysts may want to consider is the level of losses on the individual statutory lines of business. To the extent the health entity had a combined ratio of greater than 105% on any line of business; it may be an indication that the product is underpriced. To the extent a health entity has underpriced a product; the financial impact could be significant depending upon the health entity’s leverage and the type of product. Analysts should also consider the need to determine if the health entity has established a premium deficiency reserve on a line of business. As discussed in the Health Reserves and Liabilities section, this reserve is established when future premiums and current reserves are not sufficient to pay future claims and expenses. This type of reserve is established because it meets the definition of a loss contingency and should therefore be considered in evaluating the current financial position of the health entity. Analysts should use the information, along with any information from the health entity, to better assess the current financial position of the health entity. Other information could include a monthly assessment from the health entity on the adequacy of the current deficiency reserve based upon updated information. Since the reserve is essentially an estimate of the expected losses from one or more contracts, updated information can assist in ensuring that the reserve continues to be adequate and that the health entity’s financial position has not materially deteriorated.

PROCEDURE #2 assists analysts in evaluating the underwriting performance of the Medicare Part D Prescription Drug coverage. The procedures utilize data in the Annual Financial Statement, Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, analysts should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated in the contract. If the insurer is reporting unusual results, analysts should consider if any delays in payments from the CMS are affecting results.

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

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

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

Premium Production, Concentration and Writings Leverage

**PROCEDURE #5**

**assists analysts in determining the business stability.** As previously discussed, a significant increase in premiums and enrollment may indicate rapid growth, which can present many different types of problems to a health entity or can also be an indication of the health entity’s entrance into new lines of business or sales regions. Significant increases in premiums might also be an indication that the health entity is attempting to increase cash inflow to cover current benefit payments, particularly if the health entity primarily writes longer tail insurance.

If there are concerns analysts may also consider procedures to assess the financial impact of fluctuations in premiums or changes in business mix (line of business written and/or geographic location of premiums written) may have on the insurer’s financial position. Analysts should consider comparing any significant changes in premiums to the health entity’s most recent projections and business plan. Variances could suggest that consumers have responded to the health entity differently than anticipated. As previously discussed, growth can have a material impact on the operations of a health entity, and analysts should gain more information from the health entity when this has occurred, including how current and future growth is expected to be supported. However, decreases in premium can also place some pressure on the health entity through forced expense reductions. Analysts should attempt to understand how decreases in premiums are expected to impact this issue.

If new lines of business are being written or if premiums are being written in new regions, analysts should review the health entity’s MD&A for related information. Otherwise, information may be requested from the health entity showing operating results vs. projections for the new lines of business or territories and describing any changes in implementation strategy or revisions in financial projections for future periods. Analysts should also consider determining if, as a result of increases in sales regions, how the health entity prices its products, the contracts used with providers and any future expected changes in the health entity’s business. The business of health insurance is very localized and the health entity must have a reasonable understanding of that market to be successful.

**PROCEDURE #6**

**assists analysts in determining whether the health entity is excessively leveraged due to its volume of business.** Capital and surplus can be considered as underwriting capacity. The ratios of net premiums and risk revenue to capital and surplus measures the extent to which that capacity is being utilized and the adequacy of the health entity’s capital and surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A net premium and risk revenue to capital and surplus ratio greater than 10 to 1 (8 to 1 for non-health maintenance organizations (HMOs)) may indicate that the health entity is excessively leveraged. Special attention should be given to the type of coverage provided and the extent to which the health entity is able to transfer some of the risk from the business to another entity. Two health entities both with a 10 to 1 ratio may have different leverage depending on the type of coverage that they write. For example, to the extent the health entity has written primarily comprehensive business for many years in the same region, and is able to capitate some of its business, it may not be as risky as a health entity which has just begun writing Medicare business in a new region and is unable to transfer any of its risk. Even if both of these health entities have the same leverage ratio results, the one starting Medicare Risk coverage will have a riskier financial position. Analysts should also specifically consider if a significant portion of the premium is written on longer tail lines. On these lines, the ultimate experience may not be known for some time, thereby increasing the risk of reserve understatement. Analysts should also determine whether there has been an increase in the writing’s ratio or an increase in the amount of long-tail business that is being written, to assist in identifying future trends.

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

**Financial Impact of the Federal Affordable Care Act**

**PROCEDURE #7A-F** assists analysts in reviewing the underwriting gain or loss by line of business and assessing the impact of each line to the health entity’s total operating results and financial solvency.

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

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

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

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

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

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

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

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

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

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

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

Additional Analysis and Follow-Up Procedures

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

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

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

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

**Example Prospective Risk Considerations**

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

**Discussion of Quarterly Procedures**

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

1) Concerns with the insurer’s underwriting performance

2) Concerns with the changes in volume of premiums written, changes in the insurer’s mix of business and changes in writing leverage

3) Determine whether the insurer is excessively leveraged due to the volume of premiums written

4) Concerns with the pricing of the insurer’s products

5) Concerns with the impact of the federal Affordable Care Act (ACA) (Life/A&H, and Health)

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

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

ORSA Summary Report

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

- **Lead State**: In the case where the insurance group chooses to submit one ORSA Summary Report for the group, it must be reviewed by the lead state. The lead state is to perform a detailed and thorough review of the information and initiate any communications about the ORSA with the group. The suggestions below set forth some possible considerations for such a review. At the completion of this review, the lead state should prepare a thorough summary of its review, which would include an initial assessment of each of the three sections. The lead state should also consider and include key information to share with other domestic states that are expected to place significant reliance on the lead state’s review. The lead state should share the analysis of ORSA with other states that have domestic insurers in the group. The group ORSA review and sharing with other domestic states should occur within 120 days of receipt of the ORSA filing.

- **Non-Lead State**: Non-lead states are not expected to perform an in-depth review of the ORSA, but instead rely on the review completed by the lead state. The non-lead states’ review of the lead state’s ORSA review should be performed only for the purpose of having a general understanding of the work performed by the lead state, and to understand the risks identified and monitored at the group-level so the non-lead state may better monitor and communicate to the lead state when its legal entity could affect the group. Any concerns or questions related to information in the ORSA or group risks should be directed to the lead state.

- **Single Insurer ORSA**: In the case where there is only one insurer within the insurance group, or the group decides to submit separate ORSA Summary Reports for each legal entity, the domestic state is to perform a detailed and thorough review of the information, which would include an initial assessment of each of the three sections and initiate any communications about the ORSA directly with the legal entity. Such a review should also be shared with the lead state (if applicable) so it can develop an understanding of the risks within the entire insurance group. Single insurer ORSA reviews should be completed within 180 days of receipt of the ORSA filing.
Throughout a significant portion of the remainder of this document, the term “insurer” is used to refer to both a single insurer for those situations where the report is prepared by the legal entity, as well as to refer to an insurance group. However, in some cases, the term group is used to reinforce the importance of the group-wide view. Similarly, throughout the remainder of this document, the term “lead state” is used before the term “analyst” with the understanding that in most situations, the ORSA Summary Report will be prepared on a group basis and therefore reviewed by the lead state.

Background Information

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

1. To foster an effective level of ERM at all insurers, through which each insurer identifies, assesses, monitors, prioritizes and reports on its material and relevant risks identified by the insurer, using techniques that are appropriate to the nature, scale and complexity of the insurer’s risks, in a manner that is adequate to support risk and capital decisions.

2. To provide a group-level perspective on risk and capital, as a supplement to the existing legal entity view.

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

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

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

General Summary of Guidance for Each Section

The guidance that follows is designed to assist the lead state analyst in the review of the ORSA and to allow for effective communication of analysis results with the non-lead states. It is worth noting that this guidance is expected to evolve over the years, with the first couple of years focused on developing a general understanding of ORSA and ERM. It should be noted that each of the sections can be informative to the other sections. As an example, Section II affords an insurer the opportunity to demonstrate the robustness of its process through its assessment of risk exposure. In some cases, it’s possible the lead state analyst may conclude the insurer did not summarize and include information about its framework and risk management tools in Section I in a way that
allowed the lead state analyst to conclude its effectiveness, but in practice by review of Section II, such a conclusion was able to be reached. Likewise, the lead state analyst may assess Section II as effective but may be unable to see through Section III how the totality of the insurer’s system is effective because of a lack of demonstrated rigor documented in Section III. Therefore, the assessment of each section requires the lead state analyst to consider other aspects of the ORSA Summary Report. This is particularly true of Section I, because as discussed in the following paragraphs, the other two sections have very distinct objectives, whereas the assessment of Section I is broader.

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

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

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

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

Background Information

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

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

- **Key Business Goals** – The report provides an overview of the insurer’s/group’s key business goals in order to demonstrate alignment with the relevant and material risks presented within the report.

- **Changes From Prior Filing(s)** – The report clearly discusses significant changes from the prior year filing(s) to highlight areas of focus in the current year review including significant changes to the ERM framework, risks assessed, stress scenarios, overall capital position, modeling assumptions, etc.

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

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

**Key Principles:**

A. **Risk Culture and Governance**

B. **Risk Identification and Prioritization**

C. **Risk Appetite, Tolerances and Limits**

D. **Risk Management and Controls**

E. **Risk Reporting and Communication**

### Documentation for Section I

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

### A. Risk Culture and Governance

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

- **Roles and Responsibilities** - Roles and responsibilities of key stakeholders in risk and capital management are clearly defined and documented in writing, including members of the board (or committee thereof), officers and senior executives, risk owners, etc.

- **Board or Committee Involvement** – The board of directors or appropriate committee thereof demonstrates active involvement in the oversight of ERM activities through receiving regular updates from management on ERM monitoring, reporting and recommendations.

- **Strategic Decisions** – Directors, officers and other members of senior management utilize information generated through ERM processes in making strategic decisions.

- **Staff Availability and Education** – The insurer maintains suitable staffing (e.g., sufficient number, educational background, and experience) to support its ERM framework and deliver on its risk strategy. Staff is kept current in its risk education in accordance with changes to the risk profile of the insurer.

- **Leadership** – The chief risk officer (CRO), or equivalent position, possesses an appropriate level of knowledge and experience related to ERM and receives an appropriate level of authority to effectively fulfill responsibilities. This includes clear and direct communication channels between the CRO and the

BOD or appropriate committee thereof.

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

B. Risk Identification and Prioritization

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

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

C. Risk Appetite, Tolerances and Limits

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

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

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

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

- **Risk Appetite Statement** – The insurer has developed an overall risk appetite statement consistent with its business plans and operations that is updated on a regular basis and subject to appropriate governance oversight.
- **Risk Tolerances/Limits** – Tolerances and limits are developed for key risks in accordance with the overall risk appetite statement.
- **Risk Owners** – Key risks are assigned to risk owners with responsibility for risk tolerances and limits, including actions to address any breaches.

**D. Risk Management and Controls**

The ORSA Guidance Manual stresses managing risk as an ongoing ERM activity, operating at many levels within the insurer. This principle is discussed within the governance section above from the standpoint that a key aspect of managing and controlling the reasonably foreseeable and relevant material risks of the insurer is the risk governance process put in place. For many companies, the day-to-day governance starts with the relevant business units. Those units put mechanisms in place to identify, quantify and monitor risks, which are reported up to the next level based upon the risk reporting triggers and risk limits put in place. In addition, controls are also put in place on the backend, by either the ERM function or the internal audit team, which are designed to ensure compliance and a continual enhancement approach. Therefore, one approach may be to put controls in place to ensure the insurer is abiding by its limits. Key considerations in reviewing and assessing risk management and controls might include, but not limited to:

- **Lines of Accountability** – Multiple lines of accountability (i.e., business unit or risk owners, ERM function, internal audit) are put in place to ensure that control processes are effectively implemented and maintained.
- **Control Processes** – Specific control activities and processes are put in place to manage, mitigate and monitor all key risks.
- **Implementation of Tolerances/Limits** – Risk tolerances and limits are translated into operational guidance and policies around key risks through all levels of the insurer.
- **Indicators/Metrics** – Key risk indicators or performance metrics are put in place to monitor exposures, provide early warnings and measure adherence to risk tolerances/limits.

**E. Risk Reporting and Communication**

The ORSA Guidance Manual indicates risk reporting and communication provides key constituents with transparency into the risk-management processes as well as facilitates active, informal decisions on risk-taking and management. Transparency is generally available because of reporting that can be made available to management, the board, or compliance departments, as appropriate. However, the most important is how the reports are being utilized to identify and manage reasonably foreseeable and relevant material risks at either the group, business unit or other level within the insurer where decisions are made. Therefore, one approach may be to have reporting in place that allows decisions to be made throughout the insurer by appropriately authorized people, with ultimate ownership by senior management or the board. Key considerations in reviewing and assessing risk reporting and communication might include, but not limited to:

- **Training** – The importance of ERM processes and changes to the risk strategy are clearly communicated to all impacted areas and business units through ongoing training.
- **Key Risk Indicator Reporting** – Summary reports on risk exposures (i.e., key risk indicators) and compliance with tolerances/limits are maintained and updated on a regular basis.

- **Oversight** – Summary reports are reviewed and discussed on a regular basis by the appropriate members of management, and when appropriate, directors.
- **Breach Management** – Breaches of limits and dashboard warning indicators are addressed in a timely manner through required action by management and, when appropriate, directors.
- **Feedback** – A feedback loop is embedded into ERM processes to ensure that results of monitoring and review discussions on key risks by senior management and the board are incorporated by business unit leaders and risk owners into ongoing risk-taking activities and risk management processes.

**Overall Section 1 Assessment**

After summarizing the information reviewed for each of the key principles individually, the lead state analyst should provide an overall assessment of the insurer’s ERM framework, including any concerns or areas requiring follow-up investigation or communication. In preparing the assessment, the lead state analyst should understand that ORSA summary reports may not always align with each of these specific principles. Therefore, the lead state analyst must use judgment and critical thinking in accumulating information to support their evaluation of each of these principles. The overall evaluation should focus on critical concerns associated with any of the individual principles and should also address any other ERM framework concerns that may not be captured within these principles.

The lead state analyst should also be aware that the lead state examiner is tasked with supplementing the lead state analyst’s assessment with additional onsite verification and testing. The lead state analyst should direct the lead state examiner to those areas where such additional verification and testing is appropriate and could not be performed by the lead state analyst. Where available from prior full scope or targeted examinations, information from the lead state examiner should be used as a starting point for the lead state analyst to update. Consequently, on an ongoing basis, the lead state analyst’s update may focus on changes to ERM processes and the ORSA Summary Report since the prior exam in directing targeted onsite verification and testing.

The lead state analyst, after completing a summary of Section I, should consider if the overall assessment, or any specific conclusions, should be used to update either the ERM section of the GPS (if the ORSA Summary Report is prepared on a group basis) or information in the IPS (if the ORSA Summary Report is prepared on a legal entity basis). In addition, key information from the review should be incorporated into or referenced in the Risk Assessment Worksheet (RAW) during the next full analysis (quarterly or annual) of the insurer where relevant.

**Review of Section II - Insurer’s Assessment of Risk Exposure**

Section II of the ORSA Summary Report is required to provide a high-level summary of the quantitative and/or qualitative assessments of risk exposure in both normal and stressed environments. The ORSA Guidance Manual does not require the insurer to address specified risks but it does provides examples of reasonably foreseeable and relevant material risk categories (e.g., credit, market, liquidity, underwriting, and operational risks). In reviewing the information provided in this section of the ORSA, lead state analysts may need to pay particular attention to risks and exposures that may be emerging or significantly increasing over time. To assist in identifying and understanding the changes in risk exposures, the lead state analyst may consider comparing the insurer’s risk exposures and/or results of stress scenarios to those provided in prior years.

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

Documentation for Section II
Prepare a summary and assessment of Section II by identifying and outlining key information associated with the significant reasonably foreseeable and material relevant (key) risks of the insurer per the ORSA Summary Report. Following the documentation on each key risk per the report, the lead state analysts should include an analysis of such risk. In developing such analysis, the lead state analyst is encouraged to use judgment and critical thinking in evaluating if the risks and quantification of such risks under normal and stressed conditions are reasonable and generally consistent with expectations. The lead state analyst should be aware that the lead state examiner is tasked to update the assessment by supplementing the lead state analyst’s assessment with additional on-site verification and testing. The lead state analyst should direct the lead state examiner to those areas where such additional verification and testing is appropriate and could not be performed by the lead state analyst. Suggested information to be documented on each key risk, including supporting considerations, is outlined below:

- **Risk Title and Description** – Provide the title for each key risk as identified/labeled by the insurer as well as a basic description.
- **Branded Risk** – Provide information on the primary branded risk classification(s) that apply to the key risk and briefly discuss how they apply/relate.
- **Controls/Mitigation** – Summarize information known about the controls and mitigation strategies put in place by the insurer to address the key risk.
- **Risk Limits** – Provide information on any specific risk tolerances or limits associated with the key risk and how they are monitored and enforced.
- **Assessment** – Discuss how the key risk is assessed by the insurer, including whether the assessment is performed on a quantitative or qualitative basis. Describe the methodology used, the key underlying assumptions and the process utilized to set these assumptions.
- **Normal Exposure** – Summarize the insurer’s normal exposure to this key risk based on budget information or historical experience.
- **Stress Scenario(s)** – Discuss the stress scenario(s) identified and applied to the key risk and how they were determined and validated by the insurer.
- **Stressed Exposure** – Provide information on the impact of the stress scenario(s) on the key risk and potential impact on the insurer’s surplus position and business strategy/operations.
- **Inclusion on IPS/GPS** – Discuss whether the key risk will be recognized on the IPS/GPS of the insurer, including the risk component it will be incorporated into.
- **Regulator Review and Assessment** – Assess the adequacy of the risk assessment performed by the insurer on each key risk (including the appropriateness of controls/limits and reasonableness of methodology, assumptions and stress scenarios used) and whether any specific issues or concerns are identified that would require further investigation or follow-up communication.

After completing a summary and assessment for each key risk addressed in Section II, the lead state analyst should use the information to update the risk assessment in either the GPS (if the ORSA is prepared on a group basis) or the IPS (if the ORSA is prepared on a legal entity basis) and supporting documentation if deemed necessary. In addition, key information from the review should be incorporated into or referenced in the RAW during the next full analysis (quarterly or annual) of the insurer where relevant.

Overall Section II Assessment
The lead state analyst should complete an overall assessment of the information provided in Section II, including an evaluation of the insurer’s risk assessment processes and whether all material and relevant risks were assessed and presented at an appropriate level of detail. This should include consideration of whether there is consistency between the insurer’s risk identification and prioritization process discussed in Section I and risks that are assessed and reported on in Section II (i.e., have all key risks been addressed). In addition, this should focus on critical concerns associated with the assessment of individual key risks as well as whether the insurer’s overall assessment process (i.e., methodology, assumptions and stress scenarios) is adequate and well-supported.
Review of Section III - Group Assessment of Risk Capital

In reviewing Section III of the ORSA Summary Report, the lead state analyst should recognize this section is generally presented in a summarized form. Although this section requires disclosure of aggregate available capital compared against the enterprise’s risk capital (i.e., the amount deemed necessary to withstand unexpected losses arising from key risks), the report may not provide sufficient detail to fully evaluate the group capital position. As such, the lead state analyst may need to request the assistance of staff actuaries when available in evaluating the reasonableness and adequacy of the stress tests selected, request additional detail from the insurer in order to understand and evaluate the group capital position and/or refer additional investigation to the financial examination function.

The ORSA Guidance Manual requires the insurer to estimate its prospective solvency under stressed conditions by identifying stress scenarios that would give rise to significant losses that have not been accounted for in reserves. Furthermore, the Manual requires the insurer to estimate its prospective solvency in Section III by projecting the aggregate capital available and comparing it against the enterprise’s risk capital. Insurers may include information in the ORSA Summary Report developed as part of their strategic planning and may include pro forma financial information that displays anticipated changes to key risks as well as projected capital adequacy in those future periods based on the insurer’s defined capital adequacy standard. In reviewing information on prospective solvency, the lead state analyst should carefully consider projected changes to the group capital position as well as significant shifts in the amount of capital allocated to different risks, which could signal changes in business strategy and risk exposures.

**In addition to evaluating the adequacy of capital, the insurer should also discuss the effect of liquidity risk on its overall solvency, including calls on the insurer’s cash position due to microeconomic factors—i.e., internal operational—and/or macro-economic factors; i.e., economic shifts. The insurer should assess its resilience against severe but plausible liquidity stresses and whether the current liquidity position is within any liquidity risk appetite and/or limits. The insurer should describe in the ORSA the policies and processes in place to manage liquidity risk, as well as contingency funding or other plans to mitigate potential liquidity stresses.**

Documentation for Section III

Insurance groups will use different means to manage capital and they will use different accounting and valuation frameworks. For example, they may determine the amount of capital they need to fulfil regulatory and rating agencies’ requirements, but also determine the amount of capital (risk capital) they need to absorb unexpected losses that are not accounted for in the reserves. The lead state analyst may need to request management to discuss their overall approach to capital management and the reasons and details for each approach so that they can be considered in the evaluation of estimated risk capital.

Many insurers use internally developed capital models to quantify the risk capital. In these cases, the ORSA Summary Report should summarize the insurer’s process for model validation to support the quantification methodology and assumptions chosen to determine risk capital. The lead state analyst should use the model validation information to assess the reasonableness of the quantification methodology and assumptions used. If the ORSA Summary Report does not provide a summary of the model validation process, the lead state analyst should request copy of the validation report prepared by the insurer. With regard to the determination of the risk capital under stressed conditions, because the risk profile of each insurer is unique, there is no standard set of stress conditions that each insurer should run. However, the lead state regulator should be prepared to dialogue with management about the selected stress scenarios if there is concern with the rigor of the scenario. In discussions with management, the lead state analyst should gain an understanding of the modeling methods used to project available and risk capital over the duration of the insurer’s business plan as well as the potential changes to the risk profile of the insurer over this time horizon (i.e., changes to the list of key risks) based on the business plan. The aforementioned dialogue may occur during either the financial analysis process and/or the financial examination process.
The lead state analyst, after completing a summary of Section III, should assess the overall reasonableness of the capital position compared to the group’s estimated risk capital. Additionally, the lead state analyst should also consider if any of the information, or any specific conclusions, should be used to update either the GPS or IPS.

An assessment of the reasonableness of group risk capital and the process to measure it should be provided by developing a narrative that provides the following for each individual element of the insurer’s assessment of risk capital:

- **Discussion of Capital Metric(s) Used** – Discuss the method(s) used by the group in assessing group risk capital and their basis for such a decision. Identify the capital metric(s) used to estimate group risk capital, as well as the level of calibration selected. Consider whether the capital metric(s) utilized to assess the group’s overall capital target are clearly presented and described. Metrics may consist of internally developed economic capital models (deterministic or stochastic) and/or externally developed models, such as regulatory capital requirements for risk-based capital (RBC) or A.M. Best’s Capital Adequacy Ratio (BCAR). In discussing calibration, consider both the method used (e.g., Value at Risk, Tail Value at Risk) and its level to evaluate whether the results are calibrated to an appropriate confidence level. Discuss whether the capital metric(s) selected address all key risks of the group. Of particular importance is considering whether the metric used fits the approach used to determine the group’s risk appetite. Document the extent to which the lead state analyst believes the approach used by the insurer is reasonable for the nature, scale and complexity of the group and if this has any impact on the lead state analyst’s assessment of the insurer’s overall risk management.

- **Group Risk Capital - By Risk and in Aggregate** – Provide information on the amount of risk capital determined for each individual key risk and in aggregate. In reviewing the results for each individual risk, evaluate whether all key risks are adequately accounted for in the metric by assessing the amount of capital allocated to each risk. Consider significant changes in group risk capital from the prior filing, the drivers of such change, and any decisions made as a result of such movement.

- **Impact of Diversification Benefit** – Discuss the impact of any diversification benefit calculated by the group in aggregating its group risk capital. Diversification benefit is typically calculated by aggregating individually modeled risk capital and then accounting for potential dependencies among those risks to allow for an offset or reduction in the total amount of required capital (group risk capital). In evaluating the group’s diversification benefit, consider whether the benefit is calculated based on dependencies/correlations in key risk components that are reasonable/appropriate.

- **Available Capital** – Provide information on and discuss the amount of capital available to absorb losses across the group, recognizing that there may be fungibility issues relating to capital trapped within various legal entities and jurisdictions for which regulatory restrictions and supervisory oversight constrain the extent and timing of capital movement across the group. Describe management’s strategy to obtain/deploy additional capital across the group should the need arise. Determine if there is any double counting of capital through the stacking of legal entities.

- **Excess Capital** – Discuss the extent to which the group available capital amount exceeds the group risk capital amount per the ORSA Summary Report. In evaluating the overall adequacy of excess capital, consider any concerns outlined above relating to the capital metric(s), group risk capital, impact of diversification and available capital. If the level of excess capital or its availability/liquidity is of concern, evaluate the group’s ability to remediate capital deficiencies by obtaining additional capital or reducing risk where required. If further concerns exist, contact the group to discuss and communicate with department senior management to determine whether additional investigation or regulatory action is necessary.

- **Impact of Stresses on Group Risk Capital** – Discuss whether additional stress scenarios have been applied to the model results to demonstrate the group’s resiliency to absorb extreme unexpected losses, including severe but plausible liquidity stresses. This step is particularly important when reviewing the use of external capital models that may not be tailored to address the enterprise’s specific exposures. Evaluate the range and adequacy of any stress scenarios applied and the resulting impact on the group’s ability to accomplish its business strategy, provide sufficient liquidity and meet the capital expectations of rating agencies and regulators.

- **Governance and Validation** – Discuss and evaluate the group’s model governance process and the means by which changes to models are overseen and approved. Consider whether members of senior management are adequately involved. Discuss the extent to which the group uses model validation (including validation of data inputs) and independent review to provide additional controls over the estimation of group capital.

- **Prospective Solvency Assessment** – Discuss the information provided by the group on its prospective solvency position, including any capital projections and liquidity considerations. Consider whether the business goals of the insurer and its strategic direction are adequately discussed and incorporated into the prospective solvency assessment. For example, are expected changes in risk profile presented and discussed? Also consider whether prospective solvency is projected across the duration of the current business plan. To the extent the prospective assessment suggests that the group capital or liquidity position will weaken, or recent trends may result in certain internal limits being breached, the lead state analyst should understand and discuss what actions the insurer expects to take as a result of such an assessment (e.g., reduce certain risk exposure, raise additional capital, implement contingency funding plans, etc.).

**Overall Section III Assessment**

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

The lead state analyst, after completing a summary of Section 3, should consider if the overall assessment, or any specific conclusions, should be used to update either the ERM section of the GPS (if the ORSA Summary Report is prepared on a group basis) or information in the IPS (if the ORSA Summary Report is prepared on a legal entity basis). In addition, key information from the review should be incorporated into or referenced in the RAW during the next full analysis (quarterly or annual) of the insurer if relevant.

**Feedback to the Insurer**

After completing a review of the ORSA Summary Report, the lead state should provide practical and constructive feedback to the insurer related to the review. Feedback plays a critical role in ensuring the compliance and effectiveness of future filings. Feedback also provides a means for asking follow-up questions or requesting additional information to facilitate the review and incorporation of ORSA information into ongoing solvency monitoring processes.

During the review, topics for feedback communication to the insurer can be accumulated on Appendix A of the template. The appendix encourages the lead state to accumulate positive attributes to reinforce the effectiveness of certain practices and information in the summary report. In addition, the appendix encourages the lead state to identify areas for constructive feedback to encourage the insurer to provide additional information or clarify the presentation of certain items in future filings. Finally, the appendix encourages the lead state to list requests for additional information that may be necessary to complete a review and evaluation of the insurer’s ORSA/ERM processes.

**Suggested Follow-up by the Examination Team**

After completing a review of the ORSA Summary Report, the lead state analyst should direct the lead state examiner to those areas that could benefit from focused inquiries and interviews during an on-site risk-focused examination. In some instances, the analyst may want the examiner to determine, through limited testing, if the data provided and processes described in the ORSA Summary Report are consistent with the insurer’s ERM/ORSA operations. These items can be accumulated on Appendix B of the template for follow-up and communication. If there are specific reports, information and/or control processes addressed in the ORSA Summary Report that the
lead state analyst feels should be subject to additional review and verification by the examination team, the lead state analyst is expected to provide direction as to its findings of specific items and/or recommended testing and such amounts should be listed in the template by the lead state analyst. During planning for a financial examination, the lead state examiner and lead state analyst should work together to develop a plan for additional testing and follow-up where necessary. The plan should consider that the lead state examiner may need to expand work to address areas of inquiry that may not be identifiable by the lead state analyst.

In addition to this specific expectation, during each coordinated financial condition examination, the exam team as directed by the lead state examiner and with input from the lead state analyst will be expected to review and assess the insurer’s risk management function through utilization of the most current ORSA Summary Report received from the insurer. Also, the lead state analyst will ask the examination team to address the unresolved questions and concerns arising from the analyst’s review of the ORSA documented in the template (see Appendix B), through focused inquiries and interviews and testing during an on-site risk-focused examination. Information included in the report and the operating effectiveness of various risk management processes can be supported/tested on a sample basis (e.g., reviewing certain supporting documentation from Section I; assessing the reasonableness of certain inputs into stress testing from Section II; and reviewing certain inputs, assumptions and outputs from internal capital models).

U.S.-Based Internationally Active Insurance Group Risk Management Assessment Considerations

While the considerations covered in this chapter are generally applicable to all insurers/insurance groups filing an ORSA Summary Report, there are additional risk management assessment considerations for the supervision of internationally active insurance groups (IAIGs) that are outlined in the ORSA Guidance Manual. As such, U.S. lead states functioning as group-wide supervisors should document their assessment of the specific IAIG risk management practices, as highlighted in Appendix C of the template. If such practices are already assessed and documented in the general review template, the documentation provided in this appendix can state and cross-reference to where those practices are covered.

To complete the IAIG assessment, the group-wide supervisor may need to request and review additional information from the head of the IAIG, which could include an ORSA Summary Report, CGAD, and/or additional information on risk management practices at the head of the IAIG level. The group-wide supervisor should utilize other filings and resources already available to the department, including holding company filings—i.e., Form B, Form F—and public information sources, before requesting additional information to complete the assessment.

In completing the assessment, the group-wide supervisor should consider whether certain elements are more appropriately assessed and addressed, as necessary, during an on-site examination and coordinate with the examination function. In addition, the analysis function should follow up on findings from the previous examination, as well as identify and assess significant changes in operations and risk management functions at the head of the IAIG since the last examination, as appropriate.

Form F - Enterprise Risk Report

The 2010 revisions to Model #440 and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) introduced a new filing requirement for a Form F. The Form F requires the ultimate controlling person to identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The Form F may be completed using information contained in the financial statement, annual report, proxy statement, statement filed with a governmental authority, or other documents if such information meets the disclosure requirements. Form F is focused on disclosing the enterprise risk associated with the entire insurance holding company system including non-regulated entities. The Form F is filed with the lead state commissioner of the insurance holding company system for every insurer subject to
registration under Model #440. Adoption of the applicable Form F and related confidentiality provisions outlined in the 2010 revisions to Model #440 is required for a state to be designated the lead state for Form F filings. Lead states and other domestic states receiving and sharing the Form F must have in place confidentiality agreements as prescribed in #Model 440.

**Lead State Responsibility for Analysis of Form F**
The Lead State should take primary responsibility for reviewing the Form F filing and should incorporate any takeaways, risks or concerns into the GPS. Takeaways, risks and concerns should be incorporated into the ERM summary in the GPS and/or the discussion of various branded risks, as deemed appropriate. There is no requirement or expectation to create a separate Form F checklist or create additional review documentation for sharing with another state or for internal documentation purposes.

If the Form F highlights any issues or risks that are only relevant to a particular insurance entity in the group, the Lead State should notify the domestic state of the issue and share the relevant information from the Form F with that state in a timely manner.

**Non-Lead State Reliance on the Lead State Analysis of Form F**
The Form F must be reviewed by the lead state and significant findings incorporated into the GPS. The non-lead state is encouraged to review the ERM summary and other information provided by the lead state in the GPS to access relevant information shared through Form F. There is no expectation of additional information shared by the lead state in this area, unless Form F highlights issues or risks that are only relevant to a particular insurance entity in the group. In that case, the non-lead state(s) should rely on the Lead State to proactively provide this information in a timely manner.

If there are material concerns noted in the GPS and additional information is needed, the non-lead state should request additional information from the lead state or company, if available. Such information could include additional information from the Form F filing, if relevant.

Upon the receipt of any additional information, the non-lead state should document any material concerns regarding enterprise risk that could impact the financial condition of the domestic insurer and conclude whether any of the risks identified pose an immediate material risk to the insurer’s policyholder surplus or risk- based capital position, insurance operations (e.g., changes in writings, licensure, and organizational structure), balance sheet, leverage, or liquidity.

**NAIC Enterprise Risk Report (Form F) Implementation Guide**
In March 2018, the Group Solvency Issues (E) Working Group adopted the NAIC Enterprise Risk Report (Form F) Implementation Guide, which is located at:

https://content.naic.org/sites/default/files/inline-files/committees_e_isftf_group_solvency_related_form_f_guide.pdf

As outlined in the Guide, it is intended to assist insurers and regulators in maximizing the usefulness of the Form F by proposing best practices for consideration in preparing and reviewing filings. Therefore, while the Guide does not constitute authoritative guidance for information to be included in a Form F filing, filers are requested to consider the best practices outlined within the Guide when preparing their Form F filing. By adhering to the best practices outlined within the Guide, registrants will be able to reduce the extent of regulator follow-up and correspondence necessary to utilize the information provided, which should lead to a more effective and efficient process. The regulators’ goal in developing this document was to provide some consistency and uniformity across states in reviewing and utilizing information obtained through the Form F. Therefore, it is recommended that states utilize the best practices outlined in the Guide to support their review and feedback process.

**Insurance holding company systems are expected to provide a Form F filing to the appropriate regulator on an annual basis, unless they have been granted an individual exemption from the reporting provisions. Situations where it might be appropriate to consider granting an exemption could include the following:**

- An ORSA Summary Report has been filed with the commissioner at the ultimate controlling person (UCP) level and addresses all enterprise risk exposures that would be disclosed in a Form F filing.
• Based on the very limited size, structure and nature of an insurance holding company system, the Form F filing would not provide additional valuable information to the commissioner.

PROCEDURES #1 - 2 provides a guide to assist analysts in reviewing the Form F filing for completeness and help guide analysts through each of the major items of information required by Form F. Analysts should review Form F in conjunction with a review of Form B and should document any nondisclosure of information. As noted above, concerns should be documented in the GPS, as there is no requirement or expectation for the analyst to create a separate Form F checklist or create additional review documentation.

PROCEDURES #3 - 7 provides a guide to assist analysts in evaluating the risks described within Form F. Analysts should consider whether any enterprise risks not reported in Form F exist, and for all risks identified both within Form F and by analysts, analysts should review information available and document any concerns. Analysts should also evaluate whether the risks identified result in an impact to the insurer’s financial condition (e.g., surplus, RBC, insurance operations, balance sheet, leverage, and liquidity). Risks and concerns should be documented in the GPS.
Pricing/Underwriting Risk Repository – Health Annual Additional Procedures

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

Analyst Reference Guide – Pricing/Underwriting

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

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

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